STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(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 March 5, 2017 and completed on March 8, 2017, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 248 SS=E	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, confidential group resident interview, family interview, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet physical, mental, and psychosocial needs during the evening and weekends for 10 of 10 residents (Resident A, B, C, D, E, F, G, H, I, and J) who attended the group interview, 6 of 13 sampled residents (Resident #3, #4, #5, #8, #10, and #12), 1 of 4 sampled residents (#8) interviewed, 1 of 2 family members (Family #1) interviewed, and 1 resident (Resident K) interviewed	F 248	F248 1. Activities department will provide more weekend and evening activities. 2. All residents have the potential to be affected by this practice. 3. The Activity Director will provide education to staff on their role and responsibilities regarding additional weekend and evening activities on 4/19/2017.	4/19/17

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

Electronically Signed | 04/11/2017

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F 248	Continued From page 1 confidentially. Activities are a valuable component of residents' lives and vital to achieve their highest level of well-being. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to negatively impact a resident's sense of self-worth and belonging. Findings include: During a confidential interview on 03/05/17, Resident K stated the facility does not have enough activities for residents on the weekends. During a group interview at 3:30 p.m. on 03/06/17, 10 residents (Resident A, B, C, D, E, F, G, H, I, and J) were asked if the activity programs provided met their interests and needs. The residents identified the following: * Lack of activities during the weekend and not much to do * Would like more music activities especially on the weekend and evenings * The residents love cooking and bingo and would like more of both of these activities * Would like more outings during the year especially going to the casino once the weather gets nice * Would like more card game activities Review of the facility activity calendars from 01/01/17 through 3/05/17, occurred on 03/08/17. Activities scheduled during the weekend and evenings (28 days total) included: * January - Group activity (folding clothes) offered eleven times. - Coffee social offered nine times.	F 248	4. The Activity Director will audit activity attendance and participation records for the trends regarding weekend and evening activities weekly times one month and monthly times one quarter. The audit results will be reported to QA committee and the Resident Council. The QA committee completes a Resident Satisfaction Questionnaire each quarter on an ongoing basis. The results are compiled by the Compliance Coordinator and changes made as residents desire.	

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F 248	Continued From page 2 - Religious activity offered four times. - Music activity offered one time. * February - Group activity (folding clothes) offered nine times. - Coffee social offered eight times. - Religious activity offered four times. - Music activity offered two times. * March - Group activity (folding clothes) offered three times. - Coffee social offered two times. - Religious activity offered two times. - Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included dementia and depression. The annual Minimum Data Set (MDS), dated 02/05/17, identified moderately impaired cognition, extensive assistance of one for locomotion, and activity preferences included reading materials, music, animals, news, groups, going outside, and religion. Resident #4's current care plan stated, ". . . Problem Onset: . . . Need for continued activity participation to end of life. Resident will participate in a daily activity . . . Resident has history of enjoying: outings, playing cards, music, visiting, Mass, reading, outdoors and animals. . . . Impaired cognition, short term memory . . . Reminisce with resident about past occupation of being a farmer. . . ." Review of Resident #4's Activity Report Roster for January 1, 2017 - March 5, 2017 during the weekends and evenings, showed the following: * January 1-31, 2017: Participated in one	F 248		

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F 248	Continued From page 3	F 248		

religious activity one weekend and one game one weekend.
* February 1-28, 2017: Participated in one music activity during an evening, and one religious activity, one music activity and one social party on weekends.
* March 1-5, 2017: No participation in facility scheduled activities identified.

- Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included major depressive disorder, Alzheimer's disease, dementia, stroke, weakness, and compression fractures to the back. The quarterly MDS, dated 11/11/16, identified moderately impaired cognition, extensive assistance for locomotion, and activity preferences included reading materials, news, groups, music, outside actives, and religion.

Resident #5's current care plan stated, ". . . Problem Onset: Need for continued activity participation. . . . Invite, assist and remind of daily activities. . . . enjoys music, chapel, TV, crafts, outings, outdoors, card games, reading, visiting with family and friends . . . Alteration in mood related to depression, . . . Approaches . . . Individual activity for redirection such as: visiting and playing cards . . . Problem Onset: Alteration in cognition, short term memory impairment. . . . Approaches . . . Reminisce with resident. Encourage activity participation and socialization . . ."

Review of Resident #5's Activity Report Roster for January 1, 2017 - March 5, 2017 for weekends and evenings showed the following:
* January 1-31, 2017: Participated in three food

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 248	Continued From page 4	F 248		

related activities on two weekends.
* February 1-28, 2017: Did not participate in scheduled facility activities.
* March 1-5, 2017: Did not participate in scheduled facility activities.

The facility failed to provide meaningful activities designed to reflect each resident's interests and lifestyle during the weekends and evenings during the period reviewed of January 1 - March 5, 2017. The facility staff failed to consistently record participation in or refusal of activities during the same time period, although review of the activity calendar for these months revealed some activities scheduled that are consistent with Resident #4 and #5's interests' (chapel, music, visiting, groups, and folding towels).

During an interview at 10:10 a.m. on 03/08/17, a staff activity manager (#10) stated they have one evening activity a month and usually no activity staff work during the weekends.

- Review of Resident #8's medical record occurred on all days of survey. The annual MDS, dated 01/31/17, identified being intact cognition and activity preferences including religion being very important; reading, music, groups, and being outside being somewhat important. The current care plan stated, ". . . Needed for continued activity participation, Resident will participate in a daily activity. . . Invite, assist and remind of daily activities. . . ."

During an interview on 03/15/17 at 3:37 p.m., Resident #8, stated, "The facility does not have much for activities available on the weekends, but have mass that I go to. My faith is my life." An

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 5	F 248		

observation during the interview showed Resident #8's room had many religious photos and items.

Review of Resident #8's "Activity Report Roster" for January 1, 2017 - March 7, 2017, identified this resident attended two weekend religious services, one social activity, and one music activity on 3 of 10weekends during this time frame.

- Review of Resident #10's medical record occurred on March 7 - 8, 2017. The annual MDS, dated 08/31/16, identified activities of religion and being outside to be very important; reading materials, music, news, groups, and favorite activities somewhat important. The current care plan stated, ". . . Need for continued activity participation. . . . Invite and assist to daily activities. . . ."

Review of Resident #10's "Activity Report Roster" for January 1, 2017 - March 7, 2017 (ten weeks), identified this resident was not invited and assisted to daily scheduled activities consistent with this residents care plan on the following dates:
* 01/01/17: Independent, television, and family
* 01/14/17 - 01/15/17: Independent, television, other, and family
* 01/29/17: Independent, passive, and television
* 02/05/17: Independent, exercise, television, and family
* 02/18/17 - 02/19/17: Independent, television, family, puzzle, and food related
* 02/25/17 - 02/26/17: Independent, other, television, and family
* 03/05/17: Independent, television, and family

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 6	F 248		

During an interview on 03/06/17 at 1:45 p.m., a family member (#1), stated, "I wish the facility activities would be more involved with what Resident #10 would like."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, anxiety and depression. The quarterly MDS, dated 01/05/17, identified unclear speech, usually understands others, severely impaired cognition, extensive assist with transfers and eating, and non ambulatory. The current Care Plan stated, "Need for continued activity participation related to impaired cognition. . . . Activity calendar in room. Invite, assist and remind of daily activities. Resident enjoys : music, chapel, movies, outdoors, reading, television and visiting. . . . Encourage activity participation and socialization. . . ."

Review of Resident #3's Activity Report Roster for January 1 - March 6, 2017, (ten weekends), identified Resident #3 attended religious service on 2 of 9 Saturdays, Coffee socials (Saturdays and Sundays) showed no attendance over the ten weekends, and attended Special evening music on 1 of 2 evenings offered.

- Review of Resident #12's medical record occurred on March 7-8, 2017. Diagnoses included dementia with behavioral disturbance and Alzheimer's disease. The quarterly MDS, dated 01/18/17, identified sometimes makes self understood and understands others, severely impaired cognition, extensive assist with ADLS (activities of daily living), and non ambulatory. The current Care Plan stated, "Need for

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 7 continued activity participation related to confusional (sic) state. Resident will participate in a daily activity . . . Provide with encouragement for activity participation. . . . Alteration in cognition . . . reminisce with Resident. Encourage socialization. . . ." Review of Resident #12's Activity Report Roster for January 1- March 6, 2017 (ten weekends), identified Resident #12 attended 5 scheduled activities and chose not to participate in 9 activities over this 65 day timeframe.	F 248		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		4/19/17

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F 280	Continued From page 8 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 9 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plans for 1 of 2 sampled residents (Resident #3) observed coughing during meals. Failure to review and revise the residents' care plans limits communication of resident care needs between staff and does not ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Careplan Policy and Procedure" occurred on 03/08/17. This undated policy, stated, ". . . The careplan will be periodically reviewed and revised by a team of qualified persons after each assessment and also as the resident's condition changes. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included	F 280	F280 1. On 3/8/2017 the care plan for resident #3 was updated to include swallowing difficulty, coughing, and monitor for signs and symptoms of aspiration when drinking thin liquids. 2. All residents have the potential to be affected by this practice. 3. A new policy Reviewing and Revising the Care Plan has been implemented. The interdisciplinary team will be in serviced by the MDS coordinator on the new policy. 4. Resident Care Coordinator or designee will review Care Plans two times per week for two weeks for residents experiencing a change of status (nurse notified, physicians orders, and QA	

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F 280	Continued From page 10 dementia, anxiety disorder and weakness. The quarterly Minimum Data Set (MDS), dated 01/05/17, identified severely impaired cognition and extensive assist of one with eating. Resident #3's current care plan stated, "Potential for dehydration related to impaired cognition. . . . Encourage, provide and assist to consume adequate fluids. . . . Requires prompting and cueing to dine. Potential for weight loss. . . . Prompt and cueing to dine, CNA [certified nursing assistant] to assist resident as needed to finish. . . ." Observations identified the following: * 03/05/17 at 3:30 p.m.: Resident took sips of water (thin consistency) with coughing after drinking. * 03/05/17 at 4:08 p.m.: Resident experienced coughing after sips of water (thin consistency). * 03/06/17 at 8:20 a.m.: Coughing at dining room table when drinking thin liquids. * 03/06/17 at 12:20 p.m.: CNA (#7) feeding resident. Occasional coughing noted with drinking of thin fluids. Review of Resident #3's progress notes identified the following: * 01/30/17 at 8:41 a.m.: "Sounds congested, clear nasal drainage. . . . Ate well for breakfast with coughing noted . . ." * 01/30/17 at 11;15 a.m.: ". . . no coughing noted unless with liquids . . ." * 01/31/17 at 4:26 p.m.: ". . . occasional congested sounding cough . . ." * 02/01/17 at 9:01 a.m.: ". . . coughing continued during breakfast with nectar thick liquids . . ." * 02/01/17 at 10:24 a.m.: ". . . continues to sound	F 280	changes) to assure changes have been made to the care plan. Then DON or designee will review CP weekly times one month to assure review and revisions of care plans.	

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F 280	Continued From page 11	F 280		

congested . . . coughing still noted while drinking. . . ."
* 02/01/17 at 9:49 p.m.: ". . . Resident did not tolerate thickened liquids well. Resident coughed quite a few times."
* 02/02/17 at 6:41 a.m.: ". . . Resident continues to cough while drinking . . ."
* 02/04/17 at 10:44 a.m.: ". . . Resident coughed frequently while drinking his grape juice . . ."
* 02/05/17 at 11:21 a.m.: "Resident does have minimal coughing at times with his juice . . ."
* 02/06/17 at 1:17 p.m.: ". . . occasional coughing with eating and drinking . . ."
*02/06/17 at 4:58 p.m.: ". . . continues with trial use of nectar think liquids, minimal cough still present . . ."
*02/08/17 at 11:42 a.m.: "Resident still continues to cough while drinking liquids . . ."
* 02/14/17 at 4:24 p.m.: ". . . does cough in between every ounce of supplement. . . ."
* 02/15/17 at 6:18 p.m.: ". . . has episodes of coughing with thin and nectar thick liquids."

During an interview on 03/05/17 at 4:08 p.m., a CNA (#7), stated that Resident #3 "coughs a lot with liquids and resident was tried on thickened liquids with no improvement."

During an interview on 03/07/17 at 3:00 p.m., an administrative staff member (#6) identified that the Quality Assurance committee had met regarding Resident #3's coughing with dining and had tried nectar liquids with no improvement. The resident had shown decreased intake and was returned to regular liquids.

During an interview on 03/08/17 at 11:00 a.m., an administrative staff member (#5) verified that

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F 280	Continued From page 12 Resident #3 should have been care planned for coughing with liquids. The facility failed to address the resident's problem of coughing with liquids and possible risk for aspiration with goals and interventions in the care plan.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 309	Continued From page 13 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: REASSESSMENT OF AS NEEDED MEDICATIONS 1. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications in a timely manner and address unrelieved pain for 1 of 12 sampled residents (Resident #5) identified with pain. Failure to timely reassess after administrating a PRN pain medication and offer further pain relief interventions limits staff's ability to assess the effectiveness of the pain medication and may result in the resident experiencing unrelieved pain. Findings include: Review of the facility policy titled "Administering Medications" occurred on 03/08/17. This policy, revised 04/07/14, stated, ". . . As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: . . . Any results achieved and when those results were observed . . . If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from	F 309	F309 A. 1. Resident #5□s pain will be assessed in accordance with our policy and other interventions used if necessary. 2. All residents who have a diagnosis of pain or potential for pain have the potential to be affected by this practice. 3. A new Pain Management Policy will be implemented. All nurses will be in services on the new policy on 4/19/2017. 4. QA committee will complete random pain assessment audits to assure follow up to pain management has been completed with the appropriate actions taken weekly times one month and monthly times one quarter. Audits will be reviewed by the QA coordinator with reports to the QA committee.	

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 309	Continued From page 14 the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequently PRN use, and consider whether a standing dose of medication is clinically indicated." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, Ninth Edition", Pearson Education, Inc., New Jersey, page 862-870, states, ". . . Process of Administering Medications: When administering any drug, regardless of the route of administration, the nurse must do the following: . . . 6. Evaluate the client's response to the drug . . . In all nursing activities, nurses need to be aware of the medications that a client is taking and record their effectiveness as assessed by the client and the nurse on the client's chart. . . . Skill 35-1 Administering Oral Medications: . . . Evaluation: Return to the client when the medication is expected to take effect (usually 30 minutes) to evaluate the effects of the medication on the client. . . ." Review of Resident #5's medical record occurred on all days of survey and included diagnoses of osteoarthritis and a compression fracture of the back. The current care plan stated, ". . . Problem Onset: . . . Alteration in comfort, pain related to pain, arthritis . . . compression fractures to lumbar/vertebra. . . . Attempt non-pharmacologic pain relief measures such as repositioning, back rubs. Document effectiveness. Pain medications as needed. Document effectiveness. . . ." Review of the physician's orders identified the following PRN pain medications, Percocet 5	F 309	B. 1. Neurological assessment will be completed on resident #8 in accordance with facility policy. 2. All residents who have a history of falls are at risk for falls have the potential to be affected by this practice. 3. The Neurological Assessment Policy has been updated to include initiation of neurological assessments with a physicians order, witnessed or unwitnessed falls with suspected head injury and when injury to head is noted within 24 hours of the fall. 4. Compliance Coordinator will audit the fall 24-48-72 hour nursing assessments for evidence of head injury and verify that neurological assessments have been initiated per policy weekly times on month then monthly times one quarter. C. 1. Resident #9 has passed away.	

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F 309	Continued From page 15 milligrams (mg)/325 mg one tablet every four hours for pain, Tylenol 325 mg one to two tablets for discomfort or fever, Tramadol 50 mg one tablet three times daily for pain. Review of Resident #5's Electronic Medication Administration Record (EMAR) and progress notes for 02/02/17 through 02/28/17 showed the following administration times and resident responses to the PRN pain medications: *Percocet - 02/22/17 at 9:36 a.m., response documented approximately two hours later, "medication not effective." Staff failed to offer further interventions to relieve the resident's pain. - 02/23/17 at 11:51 a.m., response documented approximately an hour later, "medication was not effective: Resident still yelling "lots of pain, back pain." Staff failed to offer further interventions to relieve the resident's pain. - On six other occasions staff failed to reassess the resident's pain within one hour after administering Percocet. *Tylenol - 02/08/17 at 7:56 a.m., response documented at 9:01 a.m., "medication was not effective: Resident stated that he feels terrible and his back is killing him." Staff failed to offer further interventions to relieve the resident's pain. - On five other occasions staff failed to reassess the resident's pain within one hour after administering Tylenol. *Tramadol - 02/08/17 at 9:05 a.m., response documented at 10:08 a.m., "medication was not effective: Resident is still stating that he is in pain." The	F 309	2. All residents who are immobile or dependant for repositioning have the potential to be affected by this practice. 3. The Repositioning Policy has been reviewed. The Nurses and CNA's will be reeducated on 3/19/2017 4. QA committee will monitor residents who are immobile or dependant for repositioning to assure the individual plan of care has been followed weekly times one month and monthly times one quarter. Audits will be reviewed by the QA coordinator with reports to the QA committee. D. 1. Resident #9 has passed away. 2. All residents who have the diagnosis of constipation or potential for constipation have the potential to be affected by this practice. 3. Bowel Protocol has been updated. The Nurses will be reeducated on the updated protocol 3/19/2017. 4. Administrative nurses will monitor the use of laxatives to assure compliance with the revised Bowel Protocal weekly	

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F 309	Continued From page 16 staff failed to offer further interventions to relieve the resident's pain. - 02/23/17 at 10:07 a.m., response documented approximately two hours later, "Medication was not effective: Rates pain 10/10." The staff failed to offer further interventions to relieve the resident's pain. - On nine other occasions staff failed to reassess the resident's pain within one hour after administering Tramadol. During an interview on 03/07/17 at 3:00 p.m., an administrative nurse (#1) stated she expected staff to reassess and chart the effectiveness of as needed oral pain medication within one hour of administration and if ineffective, to try other interventions and chart the response within in 30-60 minutes. CARE AND ASSESSMENT NEEDS 2. Based on observation, record review, review of facility policies, and staff interview, the facility failed to provide the necessary care and services to ensure overall well-being of 2 of 9 sampled residents (Resident #8 and #9). Failure to follow-up with neurological assessments in a timely manner, reposition residents as care planned, and follow bowel protocols may result in negative outcomes and impact the residents' quality of life. Findings include: Review of the facility policy titled "Neurological Assessment" occurred on 03/08/17. This policy, revised October 2010, stated, ". . . Neurological assessments are indicated: . . . Following a	F 309	times one month and monthly times one quarter.	

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F 309	Continued From page 17	F 309		

witnessed or unwitnessed fall with suspected head injury; When indicated by resident's condition. . . . this procedure . . . should be recorded in the resident's medical record. . . . Neurological Flow Sheet, vital signs and neuro check: [for 26 hours post incident] . . ."

Review of the facility policy titled "Repositioning" occurred on 03/08/17. This policy, revised October 2010, stated, ". . . to promote comfort for all bed- or chairbound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. . . . Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. . . ."

Review of the facility policy titled "Bowel Protocol" occurred on 03/07/17. This undated policy, stated, ". . . Day 1 - No intervention . . . Day 2 - 15 mL (milliliter) Hy (high) Fiber . . . Day 3 - 15 mL Hy Fiber and Resident specific PRN (as needed) order or PRN oral standing order: Peri-colace (laxative), Dulcolax (laxative) Tab , Milk of Magnesia (laxative) . . . Day 4 15 mL Hy Fiber and PRN Dulcolax Supp (rectal) or enema . . ."

- Review of Resident #8's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 08/01/16, identified Resident #8 required one person extensive assist with transfers and personal hygiene. The resident's current care plan stated, ". . . Requires assistance with daily cares related to weakness. . . . Impaired mobility with potential for falls . . ."

Review of Resident #8's progress notes identified

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F 309	Continued From page 18 the following: * 03/14/16 at 7:20 p.m., "CNA [certified nurses assistant] entered room et [and] [resident] found lying on left side on floor in BRM [bathroom], stes [sic] he was standing up to put his razor in the medicine cabinet et his knees gave out, resident refused to have vitals taken 'that is not necessary it was just my knees gave out.'" * 03/15/16 at 10:55 a.m., "Wife notified of last evening fall incident. . . . I also told her I noticed a bruise on the upper back of his head this morning that I hadn't noticed yesterday. . . . Informed her we would monitor status but have not noted anything out of the ordinary with him." * 03/18/16 at 6:05 p.m., "This nurse noted resident to have a yellow/purple bruise on the back of his head approximately 2.5 cm in diameter. Resident denies any discomfort." Staff failed to complete and document follow-up neurological assessments after the fall. During an interview on 03/07/17 at 3:30 p.m., an administrative nurse (#5) confirmed staff failed to complete neurological checks after Resident #8's fall on 03/14/16. - Review of Resident #9's medical record occurred on all days of survey. The significant change MDS, dated 02/20/17, identified a skin tear (coccyx). The resident's current care plan stated, ". . . Potential for skin breakdown related to incontinence, decrease mobility and peripheral vascular disease. Skin fragile, bruises and skin tears easily. Frequent moisture related skin breakdown to . . . coccyx. . . . Approaches: Extensive assist to dependent 1-2 assist with turning/repositioning every 2-3 hours. . . ."	F 309		

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F 309	Continued From page 19 Observation of Resident #9 identified the following: * 03/05/17 at 4:47 p.m., two CNA's (#14 and #15) assisted Resident #9 with cares. She had a skin tear to her coccyx. * 03/06/17 at 7:45 a.m., Resident #9 laying on her back in bed resting. * 03/06/17 at 9:32 a.m., Resident #9 laying on her back, continued to rest despite CNA (#11) trying to arouse her. * 03/06/17 at 10:10 a.m., Resident #9 sitting upright in bed, as CNA (#13) fed her. * 03/06/17 at 11:07 a.m., staff informed surveyor they were going to transfer Resident #9 from bed to wheelchair. During an interview on 03/06/17 at 12:58 p.m., a CNA (#13) confirmed staff failed to reposition Resident #9 from 7:45 a.m. to 11:07 a.m. (3 hours 22 minutes). During an interview on 03/08/17 at 9:40 a.m., a nurse manager (#1) confirmed staff are expected to reposition Resident #9 every 2 to 3 hours as careplanned. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included constipation. The "BM (bowel movement) consistency roster" noted bowel movements on both 02/15/17 and 02/16/17. The current progress note dated 02/17/17, stated, ". . . While in the Hoyer resident began to have a BM. Stool noted to be stuck in rectum. This nurse assisted resident by massaging around rectum and was able to assist the stool that was visible, I did give her a rectal suppository as it felt that	F 309		

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F 309	Continued From page 20 resident had a large amount of stool present." The significant change MDS, dated 02/20/17, identified always incontinent of bowel. The resident's current care plan stated, ". . . Incontinent of bowel . . . Dependent assist for toileting as needed . . . may use bedpan also as needed . . ." Facility staff failed to follow the Bowel Protocol policy of no intervention after day one of a bowel movement when they administered a suppository to Resident #9. During an interview on 03/07/17 at 2:45 p.m., two nurse managers (#5 and #6) confirmed that staff are expected to follow the Bowel Protocol.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 315		4/19/17

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F 315	Continued From page 21 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide toileting cares in a timely manner for 2 of 11 sampled residents (Residents #4 and #5) requiring assistance with toileting. Failure to provide toileting cares in a timely manner did not allow Residents #4 and #5 to attain/maintain their highest practicable physical and psychosocial well-being and may result in avoidable incontinence. Findings include: Review of facility policy titled "Toileting" occurred on 03/08/17. This policy, revised on 10/10/12, stated, " . . . Policy Statement . . . It is the policy of Golden Acres Manor to help all residents maintain highest level of continence possible. . . . The CNA's [sic] [certified nursing assistants] will toilet the residents as outlined on their individual	F 315	315 1. Residents #4 and #5 will be toileted every 2-3 hours per individualized care plan. 2. All residents who require extensive assist to dependant with toileting have the potential to be affected by this practice. 3. The toileting policy has been reviewed. All nurses and CNA□s will be reeducated on 4/19/2017 On the Toileting Policy. 4. QA committee will audit a random sampling of residents who require extensive assist to dependent assistance with	

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F 315	Continued From page 22 careplan. Residents on a check and change program will be checked for incontinence every 2 hours, or per individual schedule based on resident's needs . . . A resident prompted toileting will be reminded to use the bathroom according to their individual schedule. . . . Residents who have been tracked, and determined not to benefit from toileting, will be placed on a check and change program / incontinence cares . . ." - Review of #4's medical record occurred on all days of survey. Diagnoses included dementia, benign prostatic hyperplasia (BPH, inflammation of the prostate), and nocturia (urinary urgency at night).The resident's annual Minimum Data Set (MDS), dated 02/05/17, identified moderately impaired cognition, extensive assistance of one needed for toileting and all activities of daily living, and frequently incontinent of bowel and bladder. The current care plan identified, ". . . Problem/Need Alteration in elimination related to benign prostatic hypertrophy and nocturia. Frequent bladder incontinence. Potential constipation. . . . Approaches Extensive assist with incontinence cares. Check and change every 2-3 hours. . . ." Observation on 03/06/17 identified the following. * 8:00 a.m., Resident #4 sat in the wheel chair in the dining room eating breakfast. * 8:55 a.m., 11:15 a.m., 12:15 p.m., and 12:25 p.m., Resident #4 sat in the wheel chair in his room. During an interview on 03/06/17 at 11:15 a.m., a staff member (#16) stated she gave Resident #4	F 315	toileting or incontinence care weekly times one month then monthly times one quarter. Audits will be reviewed by the QA coordinator with reports to the QA committee.	

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F 315	Continued From page 23 a tub bath at 7:00 a.m. and brought him back to his room at 7:30 a.m. Resident #4 did not void during that time. During an interview on 03/06/17 at 1:05 p.m., a staff member (#8) stated she assisted Resident #4 to the toilet at 12:00 p.m., and he was incontinent of a large amount of urine and voided. Review of Completed Care Tasks form which reported the times this resident was checked to determine if the resident had voided identified the following times that resident #4 was not checked for a period of more than 3 hours: * 03/01/17, 3:41 p.m. to 10:09 p.m. (over 6 hours between documented checks). * 03/02/17, 5:28 a.m. to 2:39 p.m. (over 9 hours between documented checks). * 03/02/17, 2:39 p.m. to 9:53 p.m. (over 7 hours between documented checks). * 03/03/17. 4:56 a.m. to 1:57 p.m. (over 9 hours between documented checks). * 03/03/17, 1:58 pm to 7:07 p.m. (over 5 hours since last documented check. * 03/03/17, 7:07 p.m. to 03/04/17, 1:20 a.m. (over 6 hours since last documented check). * 03/04/17, 3:14 a.m. to 1:47 p.m. (over 10 hours since last documented check). * 03/04/17, 6:21 p.m. to 03/05/17, 12:47 a.m. (over 6 hours since last documented check). * 03/05/17, 7:53 a.m. to 6:19 p.m. (over 10 hours since last documented check). * 03/05/17, 6:19 pm to 03/06/17, 12:25 a.m. (over 6 hours since last documented change). * 03/06/17, 4:47 a.m. to 11:40 a.m. (over 6 hours since last documented check). * 03/06/17, 2:03 p.m. to 10:03 p.m. (8 hours since last documented check).	F 315		

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F 315	Continued From page 24 * 03/07/17, 5:39 a.m. to 2:24 p.m. (over 8 hours since last documented check). * 03/07/17, 2:25 p.m. to 10:28 pm (over 10 hours since last documented check). - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, BPH, compression fractures of the back, and a stroke. The resident's quarterly MDS, dated 11/11/16, identified moderately impaired cognition, extensive assistance of one for toileting and transfers, and frequent urinary incontinence. The current care plan identified, ". . . Problem/Need Alteration in elimination, frequently incontinent of bladder, continent of bowel enlarged prostate . . . Approaches . . . Encourage resident to call for assistance promptly with toileting, answer call light promptly, extensive assist of one for toileting. Give diuretic medications in the morning. . . ." Observation of Resident #5 on 03/06/17 identified the following: * 7:40 a.m. and 8:10 a.m., laying in bed. * 8:30 a.m., staff nurse (#3) stated she just turned resident onto his right side. * 8:50 a.m. and 9:35 a.m., laying in bed. * 11:15 a.m., laying in bed. * 12:10 p.m., in wheel chair. A staff member (#8) stated, "We just got him up and his brief was wet." Review of "Completed Care Tasks" form which reported "Toilet Use" and the "Completed Care Tasks" form which responded to the question "Did resident void?" for the same time period	F 315		

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(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 315	Continued From page 25 identified the following times resident #5 was recorded to have voided, with no documentation of assistance with "Toilet Use" consistent with the care plan: * 03/01/17 at 2:18 a.m. * 03/01/17 at 7:55 a.m. * 03/02/17 at 3:07 a.m. * 03/02/17 at 5:33 a.m. * 03/03/17 at 2:23 a.m. * 03/03/17 at 4:54 a.m. * 03/04/17 at 3:11 a.m. * 03/05/17 at 2:43 a.m. * 03/05/17 at 5:22 a.m. * 03/06/17 at 2:59 a.m. * 03/06/17 at 4:44 a.m. * 03/07/17 at 2:45 a.m. * 03/07/17 at 5:45 a.m. During an interview on 03/07/17 at 11:15 a.m., a staff member (#8) stated she had not completed any cares for Resident #5 all morning except to feed him breakfast. During an interview on 03/07/17 at 11:20 a.m., a staff member (#16) stated she gave Resident #5 his tub bath at 6:30 a.m. and then laid him down in his bed at 6:55 a.m. He did not void during this time. During an interview on 03/07/17 at 3:00 p.m., an administrative staff member (#1) stated all staff are expected to document when residents are toileted and/or checked and changed.	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 323	Continued From page 26 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure 2 of 4 nursing units (Units 1 and 2) maintained acceptable ranges for hot water temperatures. Failure to maintain acceptable range creates the potential for burn injuries to residents and staff. Findings include: Review of facility policy titled "Water Temperature Policy" occurred on 03/08/17. This undated policy stated, "Water that is supplied to the resident rooms, bathing suites, and public	F 323	F323 1. Mixing valve was adjusted immediately and Plummer notified. Staff was immediately made aware of water temperatures and of the need to make adjustments as needed. 2. All residents have the potential to be affected by this. 3. Accident and Supervision Policy has been reviewed. All staff will be reeducated on the policy on 4/19/2017.	

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F 323	Continued From page 27 restrooms must be at a maximum of 110 degrees F [Fahrenheit]. . . ." Observation of water temperatures occurred on 03/06/17 between 5:00 p.m. - 5:30 p.m. in resident bathrooms on all units, therapy room, 100 bath suite and woman's restroom by the 100 nurses' station, and showed the following: * Women's restroom: 136 F * Room 102: 128.8 F * Room 105: 126.7 F * Therapy room: 132.4 F * Room 201: 128.7 F * Room 202: 128 F * Room 208: 127.8 F Observations of water temperatures with an administrative staff member (#5) occurred on 03/06/17 at 5:45 p.m. Facility thermometer readings were compared to surveyor thermometer readings with varying difference of around 0.5- 0.7 degrees F, confirming elevated water temperatures. During an interview on 03/06/17 at 5:45 p.m., two administrative staff members (#4 and #5) stated water temperatures are monitored, but were unsure of the frequency. Review of water temperature monitoring documentation for 10/21/16-02/24/17 identified the facility checked temperatures weekly on all units of the facility, with the highest temperature documented at 120 degress F.	F 323	4. Maintenance Supervisor will monitor water temperatures weekly times one month and monthly times one quarter. The results will be reported to the Compliance Coordinator and the QA committee.	
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 329		4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 28 unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy,	F 329	F329	

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F 329	Continued From page 29 and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 4 of 12 sampled residents (Resident #2, #6, #7, and #8) who have orders for as needed medications (PRN). Failure to monitor the effectiveness of the medication placed residents at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Administering Medications" occurred on 03/08/17. This policy, dated 04/07/14, stated, ". . . As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: . . . e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; . . ." Kozier and Erb's "Fundamentals of Nursing: Concepts , Process, and Practice, Tenth ed., Pearson Education, Inc., New Jersey, page 1109, states, "Nursing Responsibilities, Assess pain prior to and 60 minutes after administration. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included osteoarthritis, fracture of the fourth and fifth lumbar vertebra, multiple fractures of ribs (left side), and nondisplaced fracture of the sacrum. Review of the physicians orders identified Tramadol HCL 50 milligrams (mg) every six hours as needed (prn) for pain. Review of Resident #2's MARs (Medication	F 329	1. Resident #2 □ 6 □ 7 □ and 8 effectiveness of pain medication will be assessed in accordance with facility policy manner and other interventions used if necessary. 2. All residents who have a diagnosis of pain or potential for pain and are using prn pain medication have the potential to be affected by this practice. 3. A new Pain Management Policy has been implemented. All nurses will be in serviced 4/19/2017 on the new Pain Management policy. 4. QA committee will complete random pain assessment audits to assure follow up to pain management has been completed with the appropriate actions taken weekly times one month and monthly times one quarter. Audits will be reviewed by the QA coordinator with reports to the QA committee.	

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F 329	Continued From page 30	F 329		

Administration Record) for the month of January 2017 identified the following:
* On 15 occasions staff administered PRN Tramadol. On four occasions staff failed to assess the efficacy of the medication 60 minutes after administration. The follow-up times ranged from 2-3 hours.

During an interview on 03/07/17 at 3:00 p.m., an administrative nurse (#1) stated she expected staff to reassess and chart the effectiveness of as needed oral pain medication within one hour of administration and if ineffective, to try other interventions and chart the response within 30-60 minutes.

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included pain and osteoarthritis. Review of the physicians orders identified Tylenol 325 mg tablet - Take 1-2 tablets (325-650mg) every 6 hours PRN discomfort or fever.

Review of Resident #8's MARs from December 25, 2016 through January 23, 2017 identified the following:
* On three occasions staff failed to assess the efficacy of the PRN Tylenol within the 60 minute timeframe. The follow-up times ranged from 1.75 to 4 hours.
- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included osteoarthritis. Review of the physician orders identified Norco (hydrocodone-acetaminophen) 5-325 mg tablets, 1-2 tablets every 6 hours PRN for back pain.

Review of Resident #6's MARs from January 1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 329	Continued From page 31 2017 through March 7, 2017 identified the following: * On 11 occasions staff administered PRN Norco and failed to assess the efficacy of the medication within the 60 minute timeframe. The follow-up times ranged from 2 to 3.5 hours. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, joint weakness, osteoarthritis, and fibromyalgia. Review of the physician orders identified Norco 5-325 mg tablets, 1-2 tablets every 6 hours PRN for pain. Review of Resident #7's MARs from January 1, 2017 through March 7, 2017 identified the following: * On 11 occasions staff administered PRN Norco and failed to assess the efficacy of the medication within the 60 minute timeframe. The follow-up times ranged from 2 to 4 hours.	F 329		
F 371 SS=C	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 371		4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 32 from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store and serve food under sanitary conditions in 1 of 1 kitchen. Failure to ensure maintenance of the water filter on the automatic coffee maker and failure to clean fans of dust and debris has the potential to cause contamination of food and water. Findings include: Observation during the initial kitchen tour, on 03/05/17 at 10:45 a.m., showed a heavy accumulation of dust/debris on two fans in two separate areas of the walk-in cooler and on the fan of the walk-in freezer. The main tour of the kitchen occurred on 03/07/17 at 4:00 p.m. with an administrative dietary staff member (#17). Observation showed the heavy accumulation of dust/debris remained on the fans in the walk-in coolers and the walk-in freezer. Observation of the water filter on the automatic coffee machine showed a hand-written date of 06/16/15. When asked how often the filter should be changed, the dietary manager stated	F 371	F371 1. Dust/debris has been cleaned from the fans in the cooler and walk in freezer. The water filter has been replaced. 2. All residents have the potential to be affected by this practice. 3. Dietary manager will educate the maintenance staff on the scheduled water filter changes on the coffee machine per manufactures instructions. Interim Department of Plant Opperations Manager will reeducate the maintenance staff on the routine cleaning schedule for the fans in the dietary department. 4. Dietary manager will monitor the water filter on the coffee machine to confirm date of placement monthly time 6 months. Report will be given to	

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 371	Continued From page 33 she would check the manufacturer's directions. On the morning of 03/08/17, the dietary manager (#17) stated the fans in the coolers are on a quarterly cleaning schedule and documentation showed staff had last cleaned the fans in July 2016. The facility did not provide the manufacturer's directions for the water filter, however, the dietary manager (#17) stated the filter on the same type of coffee maker in the staff break room had been changed in 2016, and confirmed the filter on the coffee maker in the kitchen should have been changed at that time.	F 371	the compliance coordinator and plant manager. Dietary manager will monitor cooler and walk in freezer fans weekly times one month and monthly times one quarter and quarterly times one year.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 428		4/19/17

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F 428	Continued From page 34 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility's consulting pharmacist failed to recommend a gradual dose reduction (GDR) to the attending physician for 1 of 7 sampled residents (Resident #9) receiving psychotropic medications. Failure to report any irregularities to the attending physician regarding the adequate indications and gradual dose reductions has the potential for residents to	F 428	F428 1. Resident #9 had passed away. 2. Any resident who is on a Psychotropic medication has the potential to be affected by this practice. 3. Pharmacy Drug Review forms have been revised to include a column titled GDR	

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 428	Continued From page 35 receive unnecessary medications and experience adverse side effects. Findings include: Review of the facility policy titled "Addressing Medication Regimen Review Irregularities" occurred on 03/08/17. This policy, revised March 2017, stated, ". . . The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. . . . Adverse consequence refers to an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. . . . Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. . . ." Semla, Beizer, & Hibgee (2007) "Geriatric Dosage Handbook" 12th ed., Lexi-Comp, Inc., Ohio, page 1787, states, ". . . Antipsychotic medication guidelines . . . In residents with organic mental syndromes (e.g.[example], dementia, delirium), clinically contraindicated means that a gradual does reduction has been attempted twice in 1 year and that attempt resulted in the return of symptoms for which the drug was prescribed . . ." - Review of Resident #9 medical record occurred on all days of survey. Diagnoses included dementia, major depression, generalized anxiety,	F 428	Indicated. The Pharmacist is then instructed to complete the Pharmacy Recommendation Form. The Pharmacy Consultant will be educated on the updated form on 4/19/2017. 4. Director of Nursing will do a random audit of Pharmacy and drug review forms on residents who are on psychotropic Medications monthly times one quarter and quarterly times one year. Audits will be reviewed by the QA coordinator with reports to the QA committee.	

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 428	Continued From page 36	F 428		

psychosis, and restlessness. The current care plan states, ". . . Resident will have no side effects to the psychotropic medications . . ."

Current psychopharmacological medication orders and start date include:
* 02/10/15, Citalopram hbr (antidepressant) 10 mg (milligrams) tablet - Give one tablet by mouth daily
* 03/10/15, Lorazepam (antianxiety) 0.5 mg tablet - Give 1/2 tablet (0.25 mg) by mouth three times daily
* 12/08/15, Risperidone (antipsychotic) 0.25 mg tablet - Give 1/2 tablet (0.125 mg) by mouth daily in AM, and 0.25 mg tablet at HS (evening) started 11/10/15.
* 07/28/16, Olanzapine (antipsychotic) 5 mg tablet - Take 1/2 tablet (2.5 mg) orally at bedtime

Review of Resident #9's "PHARMACY AND DRUG REVIEW" forms, reviewed February 2016 through February 2017, failed to address the use of the following scheduled medication: Citalopram, Lorazepam, and Risperdal. The reviews between August 2016 and February 2017 failed to address the use of scheduled Olanzapine.

An observation of care on 03/06/17 at 9:32 a.m., showed a certified nurse assistant (CNA) (#12) unable to arouse Resident #9 from sleep by speaking to her and rubbing her shoulders. The resident did not respond to the stimuli. The CNA (#12) stated the resident is tired at times and doesn't always arouse easy, she would try again later.

During an interview on 03/07/17 at 2:40 p.m., a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 428	Continued From page 37 pharmacist (#13) stated a GDR review for psychotropic medications should be at least every six months. The pharmacist (#13) confirmed Resident #9 had no GDR recommendation by the pharmacist in the last year.	F 428		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		4/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	03/08/2017

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(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 441	Continued From page 38 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: CLEANING OF GLUCOMETERS AND INSULIN PENS	F 441	F441 A.	

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	355046	A. BUILDING _____ B. WING _____	03/08/2017

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F 441	Continued From page 39 1. Based on observation, review of professional reference, review of manufacturer's instructions, and staff interview, the facility failed to follow infection control practices for 1 of 1 sampled resident (Resident #5) and 1 supplemental resident (Resident #16) observed during glucometer testing and insulin administration. Failure to properly disinfect the glucose meter between residents and disinfect the insulin pen prior to leaving an isolation room may result in the transmission of organisms and pathogens to other residents, staff, and visitors. Findings include: Review of a facility policy titled "Obtaining a Fingerstick Glucose Level" occurred on 03/08/17. This policy, revised 01/22/13, stated, ". . . Always ensure glucose meters intended for reuse are cleaned and disinfected between resident uses. . . . Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. . . ." Review of a facility policy titled "Cleaning and Disinfection of Resident-Care Items and Equipment" occurred on 03/08/17. This policy, revised 10/05/11, stated, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC [Centers for Disease Control] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard. . . . Reusable items are cleaned and disinfected or sterilized between	F 441	1. The nurse identified was immediately in-serviced on the proper procedures for glucometer disinfection and disinfection of the insulin pen after being in an isolation room. 2. All residents requiring glucose monitoring and the use of insulin have the potential to be affected by this practice. 3. A new policy was developed for Glucometer Disinfection and the policy Cleaning and Disinfection of Resident-Care Items and Equipment was revised. All nurses will be inserviced on both policies 4/19/2017. 4. Administrative nurses will complete random audit of glucometer cleaning/disinfecting weekly times one month and monthly times one quarter. Audits will be reviewed by the Compliance Coordinator with reports to the QA committee and nursing Nursing staff. F441 B 1. Resident #5 will have proper hand hygiene before meals per facility policy. CNA's will perform hand hygiene using soap and water after contact with resident□s mucous membranes and body fluids or excretions at all times after glove removal when caring for	

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F 441	Continued From page 40 residents . . ." Review of an owner's booklet titled "TRUE METRIX" occurred on 03/08/17. This booklet, dated 2015, stated, ". . . Meter Care, Cleaning and Disinfecting . . . If the meter is being operated by a second person who provides testing assistance, the meter . . . should be disinfected prior to use by the second person. . . . To Clean: . . . With ONLY PDI [Professional Disposables International] Super Sani Cloth Wipes . . . rub the entire outside of the meter using 3 circular motions with pressure . . . To Disinfect: . . . make sure that all outside surfaces of meter remain wet for 2 minutes. . . . Let meter air dry thoroughly before using to test. Wash hands thoroughly again after handling meter. . . ." Review of the general guidelines for use titled "Super Sani-Cloth" occurred on 03/13/17. The guidelines, dated 2014, stated, "Allow treated surface to remain wet for a full two (2) minutes. . . . Allow to air dry . . ." Review of a facility document titled "Isolation room responsibilities" occurred on 03/07/17. This undated document posted outside of Resident #16's room, stated, ". . . wipe down all equipment taken into and out of room with either a Clorox bleach wipe or Oxivir [effective against key pathogens such as vancomycin-sensitive enterococci, a bacteria registrant to the antibiotic vancomycin] wipe, wiping off toilet or sink, bed, or bedside table with wipes if contaminated (after resident's use). . . ." Review of facility policy titled "ISOLATION PRECAUTIONS" occurred on 03/08/17. This	F 441	resident's # 6 & 9. 2. All resident have the potential to be affected by this practice. 3. Handwashing/Hand Hygiene Policy and Preparing the Resident for a Meal Policy have been reviewed. The Nursing staff and CNA□s will be reeducated on these policies on 4/19/2017. With emphasis on resident hand hygiene prior to meals and hand hygiene upon removal of gloves. 4. QA committee will audit hand hygiene focusing on glove removal and placement weekly times one month and monthly times one quarter. Audits will be compiled by the Compliance coordinator with reports to the QA committee. QA committee will audit resident hand hygiene prior to meals weekly time one month monthly times One quarter. Audits will be compiled by the Compliance Coordinator with report to the QA Committee.	

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F 441	Continued From page 41 policy undated, stated, ". . . CONTACT PRECAUTIONS . . . Clean and disinfect reusable equipment . . . prior to removing from resident's room . . . Only essential supplies in the room . . ." Observation during medication pass on 03/05/17 at 4:45 p.m. showed a staff nurse (#2) entered Resident #16's room, identified as on contact precautions, placed a plastic supply tote on the resident's wheeled walker seat, performed a blood glucose test, and wiped off the glucometer with a sani-cloth. The staff nurse placed the visibly wet glucose monitor into the plastic tote with the clean supplies (cotton swabs, lancets, test strips, and alcohol swab packets), removed gloves, washed hands, picked up the plastic tote, and exited the room. Observation on 03/05/17 at 5:25 p.m., showed a staff nurse (#2) entered Resident #16's room with two insulin pens. The nurse placed the two insulin pens on the bedside table, washed her hands and applied gloves. The staff nurse adjusted the resident's clothing to expose her abdomen, cleansed her skin, administered two insulin injections, readjusted her clothing, removed the gloves, washed her hands, and exited the room. The staff nurse (#2) placed the two insulin pens into the drawer of the medication cart containing other resident's insulin pens. The staff nurse failed to disinfect the two insulin pens prior to exiting the isolation room (contact precautions) and prior to returning them to the medication cart. Observation on 03/06/17 at 7:45 a.m., showed a staff nurse (#3) entered Resident #16's room wearing gloves and holding an insulin pen and an	F 441		

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F 441	Continued From page 42	F 441		

alcohol swab. The staff nurse adjusted Resident #16's clothing to expose her left arm, cleansed her skin, administered one insulin injection, readjusted her clothing, removed her gloves, and exited the room. The staff nurse (#3) placed the insulin pen into the drawer of the medication cart containing other resident's insulin pens. The staff nurse failed to disinfect the insulin pen and sanitize her hands prior to exiting an isolation room and prior to returning the insulin pen to the medication cart.

Observation on 03/06/17 at 5:20 p.m., showed a staff nurse (#3) entered Resident #16's room wearing gloves and holding a plastic supply tote. The staff nurse placed a paper towel on the resident's wheeled walker seat and placed the plastic tote on top of it, performed a blood glucose test, removed the test strip, placed the glucose monitor into the plastic tote with the clean supplies (cotton swabs, lancets, test strips, and alcohol swab packets), removed gloves, cleansed hands with foam sanitizer, picked up the plastic tote, and exited the room. The staff nurse failed to disinfect the glucose monitor after completing a blood glucose test and prior to placing the meter back into the plastic tote with the clean supplies.

Observation on 03/06/17 at 5:30 p.m., showed the same staff nurse (#3) entered Resident #5's room wearing gloves and carrying a plastic tote of glucose monitoring supplies (which had previous been in Resident #16's room (contact isolation). The staff nurse performed the blood glucose test, placed the glucometer in the plastic tote, and removed her gloves. She then carried the plastic tote into the resident's bathroom,

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F 441	Continued From page 43	F 441		

placed it on the edge of the sink, washed her hands, picked up the tote and exited the room. The staff nurse (#3) placed the plastic tote on the top of the medication cart and stated, "Oh I probably should wash off the bottom of the plastic container since I placed it on the sink in the bathroom." The staff nurse (#3) wiped off the bottom of the plastic tote with a super sani-cloth and placed the wet tote on the top of the medication cart. The staff nurse failed to disinfect the glucose monitor prior to and after completing a blood glucose test for Resident #5.

During an interview on 03/05/17 at 4:55 p.m., a staff nurse (#2) confirmed the glucometer is used on multiple residents in the 200 wing.

During an interview on the afternoon of 03/07/17, an administrative staff (#1) stated staff should sanitize the glucometer with a sani-cloth and after each resident and allow it to completely dry before placing it back into the plastic tote with the clean supplies. She also stated the insulin pen should be sanitized with an Oxivir wipe after being used in an isolation room and prior to placing it back into the medication cart/drawer containing other resident's insulin pens. Hand hygiene should be completed before completing tasks, after removing gloves and prior to leaving each resident room.

HAND HYGIENE

2. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 13 sampled residents (Resident #5, #6, and #9) observed during personal cares. Failure to follow infection

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F 441	Continued From page 44	F 441		

control practices related to hand hygiene during perineal cares has the potential to spread infection within the facility.

Findings include:

Review of a facility policy titled "Handwashing/Hand Hygiene" occurred on 03/08/17. This policy revised 09/30/11 stated, "The facility considers hand hygiene the primary means to prevent the spread of infections. . . . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. . . . Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . . . Before and after entering isolation precaution settings; . . . before and after removing gloves . . . Hand hygiene is always the final step after removing and disposing of personal protective equipment. . . ."

- Review of Resident #5's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/11/16, identified moderately impaired cognition, frequently incontinent of urine, and extensive assistance of one for personal hygiene.

Observation on 03/05/17 at 5:05 p.m., showed two certified nursing assistants (CNAs) (#7 and #9) assisted Resident #5 with toileting cares after urine and stool incontinence. Both CNAs (#7 and #9) washed their hands, donned gloves, and removed Resident #5's soiled incontinence brief. While turned on to his right side, Resident #5

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F 441	Continued From page 45 voided a small amount of urine onto his right thigh. The CNAs (#7 & #9) repositioned Resident #5 onto his back. The CNA (#7) used a disposable cleansing wipe to clean urine from the right thigh, but failed to cleanse the front perineal area. Resident #5 reached down into his groin area with his left hand and scratched himself. Staff transferred Resident #5 from the bed to his wheelchair and transported him to the dining room for supper. The CNAs failed to provide adequate perineal care and wash Resident #5's hands prior to supper. - Observation on 03/06/17 at 9:00 a.m. showed a CNA (#11) donned gloves and provided perineal care to Resident #6 after she voided in the toilet. The CNA then removed her gloves, and without performing hand hygiene, assisted the resident to the wheelchair and then to the recliner, removed the resident's gait belt and left the room. The CNA failed to wash or sanitize hands after removing her gloves following perineal care, before performing other tasks, and before exiting the room. - Observation on 03/06/17 at 1:55 p.m. showed a CNA (#11) donned gloves and provided perineal care to Resident #9 in bed after the resident had a large, loose, incontinent bowel movement. The CNA removed her gloves after incontinence cares and without performing hand hygiene, donned new gloves, applied a new brief, removed Resident #9's soiled shirt, applied a clean shirt, removed her gloves, gathered the garbage bags, and exited the room. The CNA failed to wash or sanitize hands after removing her gloves following perineal care, before performing other tasks, and leaving the room.	F 441		

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F 441	Continued From page 46 During an interview on the afternoon of 03/07/17, an administrative staff member (#1) stated staff should perform hand hygiene before completing other tasks, after removing gloves, and prior to leaving each resident room. During an interview at 8:45 a.m. on 03/08/17, an administrative staff member (#1) stated staff would be expected to assist and/or encourage a resident to wash their hands after toileting cares and prior to eating a meal.	F 441		