STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	06/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	804 MAIN ST W CAVALIER, ND 58220

RECEIVED
JUL 20 2009
Division of Health Facilities

(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 06/14/09 and completed on 06/17/09, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review. The sample included 10 additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	To ensure privacy and confidentiality of Resident #2, #4,and #20, and any resident that may have the potential to be affected : Resident # 20 and all residents upon waking will be offered a robe and the privacy curtain will be pulled to allow the resident privacy in their room and the door shut if they so desire. A mandatory in-service will be held for all employees to review resident rights specifically related to "Personal and Privacy Rights." The staff will continue to be in-serviced on resident rights upon hire, annually and as needed. All staff will be instructed and in-serviced to close the door during any cares. When door is closed, staff is to knock prior to entering, identify themselves and ask permission prior to entering a room. For resident #2 and #4 and any other resident that may have the potential to be affected during the bathing process or a treatment, a sign will be posted on	7/21/09 7/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patti Johnson	Administrator	07/7/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure each resident's personal privacy during bathing (Resident #4), treatment (Resident #2), and personal care (Resident #20), for 2 of 12 sampled residents and one random observation. Findings include: - A random observation, on 06/16/09 at 7:45 a.m., identified Resident #20 seated in a wheelchair in his room in his underwear, the door open to the hall. Observation failed to identify any facility staff members in the area providing cares for the resident. The resident's room is at approximately the middle of the hall length. Any visitors or other residents passing by in the hall could have observed Resident #20. - On 06/15/09 between 8:13 a.m. and 8:45 a.m., a certified nursing assistant (CNA) (#25) dressed Resident #4 behind a curtain in the bathing room on the resident's wing. The bathing room also contained garbage and soiled linen containers. Observations during this episode of care identified one staff member enter the room without knocking or asking permission and two other staff members knock and enter without asking permission. - On 06/15/09 at 10:30 a.m., a licensed nurse (#3) provided a dressing change to Resident #2's foot in his semi-private room. Observations during this dressing change identified two staff members knock and enter without asking permission.	F 164	the door "Do not disturb room in use." All employees will be instructed to place soiled linen or dispose of garbage in the soiled work room when the central bathroom is in use. The CRA Coordinator or appropriate designee in her absence will monitor weekly x 1 month, monthly x 3 months and quarterly thereafter that employees are ensuring privacy with cares. The Administrator will be notified of any issues. If any issues are identified, immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA committee during the scheduled monthly meetings.	7/25/09

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F 164	Continued From page 2 During interview, on 06/17/09 at 10:30 a.m., with two administrative staff members (#1 and #2), and a management staff member (#6), one staff member (#6) indicated facility staff should not have entered the bathing room or Resident #2's room without asking permission.	F 164		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure physical restraints were used to treat medical symptoms and not imposed for staff convenience, for 2 of 4 sampled residents (Resident #2 and #4) and one supplemental resident (Resident #21) with wedges in bed. Failure to evaluate wedges for the least restrictive device necessary and failure to use the wedges for a medical symptom permitted the facility staff to use the wedges as restraints at their convenience. Findings include: - During the initial tour, on 06/14/09 at approximately 2:30 p.m., observation identified Resident #21 supine in bed with a triangular wedge at his right side between his body and the edge of the bed. The wedge did not support nor was in contact with his body. During interview, on 06/14/09 at approximately 3:30 p.m., following the initial tour, a supervisory	F 221	Resident #2, #4, #21 and any other resident that may be affected by this practice will have an assessment completed by OT or PT to assure that the least restrictive device is appropriately used. The assessment will include a review of the resident's capabilities with bed mobility and transfers. A mandatory in-service on Resident Rights specifically on the topic of "Freedom to be Free of Restraints" will be held for all employees. Resident rights will also continue to be reviewed with all new hires, annually and as needed. Policy on "Restraint Use" was revised (see att. A) and will be reviewed with employees during the mandatory meeting. Resident's #2,#4, #21 and any other resident that may be impacted will have a care plan that specifically addresses interventions to attain their highest level of function to maintain their physical and psycho-social well-being. This will be reviewed upon admission, quarterly,	7/25/09 7/21/09 7/21/09 7/25/09

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F 221	Continued From page 3 nursing staff member (#3) reported Resident #21 fell off the edge of the bed the previous evening (06/13/09) and did not sustain any injuries. A random observation, on 06/16/09 at approximately 2:30 p.m., identified Resident #21 supine in bed with a triangular wedge at his right side between his body and the edge of the bed. The wedge did not support nor was in contact with his body. - Review of Resident #2's medical record, June 14-17, 2009, identified the facility admitted the resident in February 2009. Current diagnoses included renal failure, compression fracture, and foot ulcer. The resident's Minimum Data Sets (MDSs), dated 05/19/09 (quarterly) and 02/23/09 (admission), identified short term memory problems, moderately impaired daily decision making, and extensive assistance of one person with transfers. Resident #2's current care plan, dated 05/27/09, stated "Problem, Self Care Deficit, Related to: *Cognition: Alert/forgetful, *Per transfer "vague" . . . Approaches . . . *1/2 Siderails to aid in positioning. Request side rails up x [times] 2 (half) . . . *Transferring: i-ii [one-two] assist as needed . . . Problem, Potential for injury, Related to: *Fall risk score: high . . .*Cognition: ST [short term] memory loss/ LT [long term] memory intact (mostly) . . . Approaches . . . *1/2 side rail to assist in positioning . . ." Resident #2's Progress Notes, dated 03/11/09 at 12:08 a.m., stated "Resident attempting to get out of bed without assist-applied wedge to the bed to see if this will remind him not to get out of bed without assist. Increased confusion . . .	F 221	annually, and as needed with any significant change in the resident's condition. The Rehab Coordinator/Adm. or appropriate designee in her absence will monitor that residents are free from restraints and are using the least restrictive device necessary to maintain their optimal level of function weekly x 1 month, monthly x 3 months, and quarterly thereafter. If any issues are identified, immediate corrective action will occur. The Rehab Coordinator/Adm. will submit a report of the monitoring results to the QA committee during the scheduled monthly meetings.	7/25/09

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F 221	Continued From page 4 Repositioned into bed. Notified Rehab [Rehabilitation] coordinator of adding the wedge.;" dated 03/12/09 at 1:08 a.m., stated "Resident sitting at the edge of the bed-wanted to sit up for awhile. . . . Repositioned for comfort-wedge in place. . . .;" and, dated 03/12/09 at 10:34 p.m., stated "We have placed a reclining chair from A-wing lounge in residents [sic] room [,] he is at risk of falling when sitting at edge of bed to assist breathing. Is very pleased with the chair . . ." - Review of Resident #4's medical record, June 14-17, 2009, identified the facility admitted the resident in September 2008, discharged the resident to an acute care facility on 03/12/09 for treatment of pneumonia, and re-admitted the resident on 03/16/09. Current diagnoses included post stroke, hypertension, and renal failure. The quarterly Minimum Data Set (MDS), dated 03/23/09, identified no short or long term memory problems and extensive assistance of two or more persons with transfers. Resident #4's current care plan, dated 04/01/09, stated "Problem, Self Care Deficit, Related to: . . . *Weakness . . . Approaches . . . *1/2 side rails - both up-to aid in positioning . . . *Transferring: Standaide [sic] as needed, i-ii [one-two] assist for transfers and gait belt . . . Problem, Potential for injury, Related to: *Fall risk score: High . . . *Cognition: alert, but not able to communicate very well. . . . Approaches *Low rise bed. See safety check list . . ." Resident #4's Progress Notes, dated 05/20/09 at 5:00 a.m., stated, "Resident slid out of bed onto mat-no injuries. . . . Assisted into bed and repositioned for comfort. . . . Wedge added to bed to prevent resident from sliding out of bed. . . .;"	F 221		

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F 221	Continued From page 5 and, dated 05/20/09 at 1:00 p.m., stated "Updated the first contact and MD [physician] on the fall this morning. No concerns voiced. . . ." - During interview, on 06/16/09 at approximately 5:00 p.m., regarding the use of wedges to keep Residents #2, #4, and #21 in bed and as potential restraints, an administrative staff member (#2) reported the facility did not have a restraint assessment process and any potential restraints are assessed or monitored on the facility's "Safety Check List." Requested information at this time included documentation regarding assessments, least restrictive environment, and physician orders for the wedges. On 06/17/09 at 7:45 a.m., as requested, an administrative staff member (#2) provided the following information for the above residents: *Resident #21 - A copy of care plan, dated 05/27/09, which identified the facility admitted the resident in May 2009 and stated "Problem, Potential for injury, Related to: . . . Cognition: ST/LT [short term/long term] memory deficit . . . Restless, crawls OOB [out of bed], frequent periods of lethargy & agitation, Recent fall . . . Approaches . . . *1/2 side rail to assist in positioning . . . [undated handwritten entry] Low rise bed, Sensor in bed, See safety check list. 06/15, blue wedge outside edge of bed for body alignment in bed. Blue roll for positioning in sidelying [with] pillow between knees. . . . Problem, Pot [Potential] altered comfort . . . Approaches . . . 6/15, positioning (when sidelying) [with] knee roll et [and] pillow between knees. blue wedge on outside of bed for body alignment maintenance."	F 221		

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F 221	Continued From page 6 - A Therapy Treatment Note, dated 06/15/09, stated, "Bed positioning: lowest position [with] mat on floor for safety. Blue wedge on outside edge for body alignment maintenance in bed, blue roll for positioning in sidelying ([with] pillow between knees.) Also, utilize bedrails for safety & falls reduction." - Staff member (#2) failed to provide a copy of Resident #21's Safety Check List for June 2009. *Resident #2 - Copy of Safety Check List for June 2009 which did not include the wedge in bed. The staff member (#2) did not provide a Safety Check List for the month of March 2009. *Resident #4 - Safety Check List for June 2009 which included "Interventions specific to resident WHEELCHAIR: 1. Gripper pad on top of wheelchair cushion, 2. Gripper pad below wheelchair cushion . . . BED . . . 12. Mat on floor, 13. Low rise bed, 14. Appropriate Support Devices Used, wedge for support . . . 16. Misc. [Miscellaneous] non-skid grip bed/bathroom." The Safety Check List also stated "1). Safety Check List will be initiated on any resident requiring an alert/assistance device. 2). A designated staff member will complete a Safety Check List on equipment at least 2 X [times] per week after any fall to ensure proper functioning. . . ." Resident #4's Safety Check List for June 2009 was blank. Observation throughout the survey identified the facility staff implemented the gripper pads in the wheelchair and the low rise bed. The staff member did not provide a Safety Check List for May 2009.	F 221		

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F 221	Continued From page 7 The facility staff implemented wedges for Resident #2, #4 and #21 after the resident fell or attempted to crawl out of bed. The times documented are between midnight and 5:00 a.m. and reported "evening." Resident #21's therapy documentation identified facility staff used the wedge to maintain body alignment. Observation identified the resident supine on the bed away from the wedge without benefit for body alignment. Facility staff initiated Resident #21's wedge two days after a fall from bed and six weeks after admission. The documentation in the medical records and provided by an administrative staff member (#2) failed to show the facility staff considered alternative methods to the wedges to prevent falls for these residents. Facility staff did implement a reclining chair for Resident #2, two days after using the wedge. Care plans for Resident #2 and #4 failed to identify use of the wedges. Assessments for these residents' use of the wedges is limited to the therapy documentation for Resident #21. Physician orders and medical symptoms for use of the wedges were not present or provided. Failure to consider alternative least restrictive methods to prevent resident falls from bed resulted in the use of wedges in bed as restraints for staff convenience. Use of wedges in this manner placed the residents at risk of injury related to attempts to get out of bed by crawling over the wedges.	F 221		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 8 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that maintains resident's dignity for 1 of 10 sampled residents (#7) requiring assistance with transfers/standing. Failure to assist Resident #7 to a standing position or assist her back into a sitting position using acceptable procedures does not allow her to receive care in a dignified manner. Findings include: - Observation at 8:00 a.m. on 06/15/09, revealed Resident #7 seated in a wheelchair. A certified nursing assistant (CNA #7) pushed the resident in her wheelchair until they were inside the resident's room. Once inside the room, while the door remained open, the CNA locked the brakes on the wheelchair. The CNA then assisted Resident #7 into a standing position by reaching over the back of the wheelchair and pulling the resident up by the back of her pants. Once standing, observation revealed the resident's pants pulled up to the middle of her back. Resident #7 walked into the bathroom using a walker after the CNA assisted her to stand. This observation occurred from the hallway because the CNA did not push Resident #7's wheelchair all the way into the room before assisting her. - Observation at 9:20 a.m. and at 2:15 p.m. on 06/15/09, revealed Resident #7 seated in a recliner in her room. A certified nursing assistant	F 241	To ensure dignity with resident #7, and other residents that may affected, a mandatory in-service on resident rights specifically addressing a review of "Dignity and Respect" will be reviewed by all employees. Resident Rights will also continue to be reviewed upon hire, annually and as needed. To assure appropriate transfers/standing occurs with resident # 7 and any other resident that may be affected a session given by the OT and/or PT for transfer training techniques will be reviewed with all direct care staff ie; (see policy on Safe Resident Lifting and Repositioning) CRA's, Activity Aides, and nurses. Resident #7 and each individual resident's care plan addresses the individual's needs related to the appropriate transfer technique to be used. Resident #7 and each resident's plan of care is reviewed by the Interdisciplinary Team on admission, quarterly, annually and with any significant change in condition. The CRA Coordinator or appropriate designee in her absence will monitor transfer techniques on resident #7 and a random sample of residents weekly x 1 month, monthly x 3 months and quarterly thereafter. The Administrator will be notified of any	7/21/09 7/21/09 7/25/09

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F 241	Continued From page 9 (CNA #7) entered the room and told the resident she needed to stand for a few minutes. The CNA placed a gait belt around the resident's waist, raised the chair forward/up using the remote control, and assisted Resident #7 to stand. Once the resident stood, the CNA lowered the chair. When Resident #7 decided she no longer wanted to stand, she fell back into the chair with minimal assistance from the CNA. Resident #7's current Comprehensive Care Plan, last reviewed/updated by the facility on 05/13/09 and reviewed June 14-17, 2009, identified a problem with potential for skin integrity. One approach under this problem is "Gait Belt with transfers as needed. Occasionally needs assist to standing position." Another approach under this same problem is for Resident #7 to ". . .stand hourly [for] 5 minutes while awake as resident allows." The most recent quarterly Minimum Data Set, dated 05/11/09, indicated Resident #7 requires limited assistance of one person to transfer and walk in room. During interview on 06/17/09 at 11:00 a.m., after hearing of the above observation, the CNA Coordinator (#6) indicated a gait belt should be used when assisting residents.	F 241	issues. If issues are identified immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings	
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	To ensure Resident A, B, and C have the opportunity to make choices regarding their bedtime and to ensure other residents are also making choices on their preferred bedtime: the Social Service Designee (SSD) visited with resident A, B, and C to ensure that direct care staff know	7/14/09

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F 242	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, and staff interview, the facility staff failed to provide 2 of 12 sampled residents (Resident A and C) and one supplemental resident (Resident B) the opportunity to make choices significant to the resident regarding their bedtimes. Failure to allow each resident to determine the time he/she wishes to go to bed does not respect the individual's right to make choices that are important to him/her. Findings include: - During confidential interview, on 06/14/09 at 7:30 p.m., Resident A's family member (#1) reported the resident expressed dissatisfaction to Family Member #1 regarding going to bed too early, "7:30 [p.m.]," especially in the summer "when it's still light out [side]." Review of Resident A's Minimum Data Set (MDS), on June 14-17, 2009, identified no short or long term memory problems and modified independence in daily decision making. During interview on 06/16/09 at 11:25 a.m., Resident A reported facility staff members assist the resident to bed as early as "6:30 [p.m.]," "with the chickens," and the resident prefers to go to bed later. - During the Initial Tour of the facility, which began at 2:30 p.m. on 06/14/09, Resident B and a family member discussed how Resident B liked living at this facility. Resident B expressed overall satisfaction, but indicated he/she would prefer not to have to go to bed so early, "sometimes as early	F 242	what time the residents prefer to go to bed and this information was addressed on their plan of care. The SSD or appropriate person in her absence, will review with all resident's upon admission, quarterly, annually and with any significant change their preference for bedtime and this will be addressed on their individual plan of care reflecting their preferences. This was added to the quarterly social service assessment/documentation to ensure it is completed (see att. C). To ensure residents are being given choices regarding their bedtime. This will be reviewed with direct care staff during their mandatory meeting. Monitoring by the SSD and CRA Coordinator will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. Any issues will be brought to the attention of the Administrator and immediate corrective action will occur. The SSD will submit a report of the monitoring results to the QA Committee during their regularly scheduled monthly meeting.	7/16/09 7/21/09 7/25/09

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	355087	A. BUILDING _____ B. WING _____	06/17/2009

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 242	Continued From page 11 as 7:30 p.m." Resident B's family member (#2) also expressed satisfaction and said, the only thing [Resident B] has ever said anything about is "going to bed too early". - Resident C's medical record, reviewed on June 14-17, 2009, identified the facility admitted the resident on 01/25/06. Resident C's quarterly Minimum Data Set (MDS), dated 03/22/09, identified no problems with short or long term memory and as being independent with daily decision-making. The facility identified Resident C as being interviewable. In an interview at 12:45 p.m. on 06/15/09, when asked whether residents have a choice in their bedtime routine, Resident C stated, "I made a deal with the staff. I'm the last one to go to bed in this wing . . . at 8:00 p.m. The nurse goes home when she's done with me." When asked if he would choose a different bedtime if given a choice, Resident C stated, "It's okay. I'm used to it now. At home, we used to go to bed between 11:00 p.m. and midnight. It's quite a difference." During interview on 06/17/09 at 11:00 a.m., with administrative staff members (#1 and #2) and a management staff member (#6), the staff members expressed unawareness of these residents early bedtimes. Staff member #6 reported the residents could determine when they wished to go to bed.	F 242		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246		

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F 246	Continued From page 12 endangered. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure reasonable accommodations of individual needs and preferences regarding wheelchair positioning and/or positioning at the dining room table for 2 of 12 sampled residents (Resident #6 and #11). Failure to provide wheelchair and dining room table positioning to meet individual needs and preferences, limited the resident's access to meal items, limited the quality of the dining experience, and may cause discomfort related to improper positioning. Findings include: - Observation in the facility's C Wing Lounge and Dining Room identified the following: * 06/14/09 at 4:55 p.m., Resident #6 sat in her wheelchair, with her lap buddy in place, at a table in the C Wing Lounge. She leaned forward in her wheelchair at a 45 degree angle. Resident #6's nose rested on the edge of the table and/or her lip rested on the ridge of the tray throughout her meal. Resident #6 attempted to self feed, spooning ground meat onto her nose or pushing food directly off of her plate into her mouth. * 06/15/09 at 4:50 p.m., Resident #6 sat in her wheelchair, with her lap buddy in place, at a table in the Dining Room. She leaned forward in her wheelchair at a 45 degree angle. Resident #6's chin rested near the edge of the table while she ate her meal. * 06/16/09 at 9:15 a.m., Resident #6 sat in her	F 246	Resident #6 and #11 will have a wc assessment completed specifically looking at table positioning to meet their individual needs and preferences, promote independence and access to their meal items, enhance their dining experience, and promote comfort (see Mealtime Policy, att. D). OT and/or PT will complete a facility dining assessment to assure that all residents needs are being met. The plan of care will be revised for resident #6, #11, and other residents identified after the completion of the therapy assessment to reflect their individual needs and promote their highest level of function. Monitoring will occur by OT and/or PT weekly x 1 month, monthly x 3 and quarterly thereafter x 1 year. If concerns are identified, immediate corrective action will be implemented. The COTA will submit a report of the monitoring to the QA Committee during the scheduled monthly meeting.	7/25/09 7/25/09 7/25/09

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F 246	Continued From page 13 wheelchair, with her lap buddy in place, at a table in the C Wing Lounge following breakfast. The table reached Resident #6's upper chest area. Resident #6's medical record, reviewed on June 14-17, 2009, identified the facility admitted the resident on 04/14/05. Current diagnoses included back pain, dementia, depression, insomnia, osteoporosis, Parkinson's disease, and peripheral neuropathy. The resident's quarterly Minimum Data Set, dated 05/07/09, identified short and long term memory problems, moderately impaired daily decision making, and limited assistance with eating. Resident #6's care plan, dated 04/14/05 and reviewed by the facility on 05/13/09, stated, "Problem: Self Care Deficit: . . . Approach: . . . OT [occupational therapy] eval [evaluation] completed to assist with w/c [wheelchair] positioning for functional seated position . . . Pot. [potential] Alt. [alterations] in nutrition . . . Meals served on C Wing Lounge, in room, or Dining Room depending on day. When in Dining Room or Lounge sits at a monitored table. Assist required as allows. Feeds self after set up. Dependent on cognition . . . Compartment plate . . . Offer high calorie foods/fluids. Encourage intake. . . . 2 scoops protein powder every day. 1.5 oz [ounce] Benecalorie daily." Resident #6's Occupational Therapy Updated Plan of Treatment, dated 04/01/09, identified, " . . . OT would like to cont [continue] to work on w/c positioning. The SNF [skilled nursing facility] currently has positioning devices on order, OT plans to utilize these to promote a fxnl [functional] seated position . . . and dated 04/23/09, identified, " . . . Res [resident] leans forward minimally when	F 246		

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F 246	Continued From page 14 alert . . . When fatigued/[increased] confusion leans forward more regardless of chair . . ." - During the evening meals, at 5:15 p.m. on 06/14/09 and at 5:05 p.m. on 06/15/09, observation identified Resident #11 seated in a wheelchair with her arms on her lap or on the wheelchair arm rests and positioned partially elevated and away from her body and the dining room table at the resident's shoulder height. Her knees were elevated and not at a 90 degree angle for proper body alignment. She sat a distance from the table requiring full arm's length to access meal items. A staff member seated next to the resident failed to offer or attempt to reposition the resident in her wheelchair or at the dining room table. Resident #11's medical record, reviewed June 16-17, 2009, revealed the current quarterly Minimum Data Set, dated 04/28/09, which identified short and long term memory problems, moderately impaired daily decision making, set up help with eating, and mild pain less than daily (soft tissue and other). An Occupational Therapy Inpatient Plan of Treatment, dated 12/04/08, indicated ". . . w/c [wheelchair] positioning: Res [Resident] was fit [with] half lap tray and [both] foot pedals to prevent self transfers when in w/c and [decrease] risk of falls. Res has [no] c/o [complaints of] pain sitting in w/c and demos [demonstrates] good l/e [lower extremity] positioning. . ." This Plan of Treatment failed to assess Resident #7's upper extremities and the proper fit of the arm rests on the wheelchair.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES	F 248		

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F 248	Continued From page 15 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident activity participation records, family interview and staff interview, the facility failed to provide an on-going individualized program of activities, designed to respond to each resident's interests, and provide opportunities to maximize their highest practicable quality of life and overall well-being for 3 of 12 sampled residents (Resident #6, #10 & #15) cognitively impaired and/or dependent on staff to initiate/provide activities. Findings include: - Observations in Resident #6's room and the facility's C Wing Lounge identified the following: * 06/15/09 at 9:15 a.m. and 12:45 p.m., Resident #6 slept in her wheelchair in the facility's C Wing Lounge. * 06/15/09 at 1:10 p.m., Resident #6 slept in her room. * 06/16/09 at 9:15 a.m., Resident #6 sat in her wheelchair, facing the wall, in the facility's C Wing Lounge. * 06/16/09 at 11:00 a.m., Resident #6 sat in her wheelchair, attempting to remove her lap-buddy, in the facility's C Wing Lounge. * 06/16/09 at 1:45 p.m., Resident #6 sat in her wheelchair, watching other residents, in the facility's C Wing Lounge. Facility staff did not	F 248	For residents #6, #10, #15, and all residents, including those with cognitive and sensory deficits, or physical limitations; they will be invited, reminded, et encouraged to attend out of room activities prior to each activity by the Activity Staff and other direct care staff. Assistance will be provided for those unable to attend independently by Activity Staff and direct care staff. All residents are provided with an Activity calendar prior to the first of the month, activities are announced over the intercom prior to starting, as well as by personal invites. The activity calendar will reflect the population and needs of all residents prior to producing the final calendar on the first of the month (ie: Sundowner Groups, Sensory Stimulation Groups). One to ones will continue to be provided 3 x per week to residents #6, #10, #15 and those identified by the Activity Staff. The Activity Participation Record will reflect each of the resident's participation level following the activity and the one to one interaction. The process of activity documentation was changed. Change in Flowsheets from the electronic medical record to a paper	7/25/09 7/25/09 7/01/09

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F 248	Continued From page 16 engage the residents in an activity at this time. * 06/17/09 at 10:20 a.m., Resident #6 slept in her wheelchair in the facility's C Wing Lounge. Resident #6's medical record, reviewed June 14-17, 2009, identified the resident's current diagnoses included back pain, dementia and depression. The resident's quarterly Minimum Data Set, dated 05/07/09, identified short and long term memory problems, moderately impaired daily decision making, extensive assistance with transfers and locomotion on/off unit, awake mornings and evenings, involvement in activities 1/3 to 2/3 of the time. Specific activity preferences included: cards/other games, crafts/arts, exercise/sports, music, reading/writing, spiritual/religious activity, walking/wheeling outdoors, TV, gardening of plants, talking or conversing, helping others. The resident's Resident Assessment Protocol (RAP), dated 03/16/09, identified, "Psychosocial Well-being Rap: . . . "She is invited, reminded, and escorted prn [as needed] to OOR [out of room] activities of interest such as, but not limited to: devotions, church, all types of music, coffee time, hair care, bingo, special events, outings, gardening, baking, and more. She also enjoys watching TV, phone visiting, listening to music, washing dishes, folding clothes/rags, filling bird feeders, going outside for w/c [wheelchair] rides, and more. Her family is supportive and visit occasionally. She currently is experiencing a decline in heath status and is requiring more 1:1's [one-on-one activities], diversional activities, et [and] more." Resident #6's care plan, dated 04/14/05 and reviewed by the facility on 05/13/09, stated,	F 248	copy to aide staff in tracking that each resident is participating in desired activities. An assessment was created to assess the resident's needs and activity preferences (See Attachment E). This assessment will be completed on admission, quarterly, annually, upon hospital return or with a significant change to ensure the residents are provided with an ongoing program of activities designed to meet the needs and interests to promote physical, mental, and psychosocial well-being of each resident. On an ongoing basis each resident's care plan will identify their individual interests, needs, and leisure pursuits with specific interventions and accommodations as needed to ensure individual needs are met. All direct care staff (Nursing, CRA's, Activity) will be inserviced on the importance of providing an on-going program of activities for all residents (See Activity Policy att. F). The Activity Director or designated staff member in her absence, will monitor resident #6, #10, #15 and a sample population of residents to ensure the facility is providing and encouraging an on-going activity program to meet the residents highest level of physical, mental, and	7/17/09 7/21/09 7/25/09

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F 248	Continued From page 17 "Problem: Pot. [Potential] Alt. [alterations] in Mood . . . Approach: . . . Encourage participation with Activity program. Assist to activities of choice. . . . One to one's as needed. Encourage diversional activities ex [example]: baking, folding clothes, gardening. Offer Stephen Ministry. . . . Problem: Alt. in Leisure Pursuits . . . Approach: . . . Remind, invite & escort as needed to oor [out of room] act [activity] of int [interest] such as but not limited to: church, devotions, all types of music, coffee time, baking, gardening, folding clothes, washing dishes, feeling helpful. Family supportive. Visit occasionally. In-room activities of choice. Assist as needed. Resident enjoys reading, watching TV, phone visiting . . . Resident enjoys baking and cooking in activity room . . . Resident loves to clean and fold laundry. Has own bucket of laundry. Enjoys bird watching." Resident #6's computerized Activities Report identified the following: * 05/01/09 - 05/31/09: five days with no activity, three days with one activity, and twelve days with two activities * 06/01/09 - 06/16/09: one day with no activity, one day with one activity, and five days with two activities - Observations in the facility's A Wing Lounge identified the following: * 06/15/09 from 7:50 a.m. to 9:20 a.m. and from 1:00 p.m. to 4:35 p.m., Resident #10 sat in a recliner in the Resident Lounge on the resident's care unit. During these time periods, the resident participated in restorative therapy at 9:20 a.m. During these same periods, Resident #10 did not participate in any activities nor was offered any activities. At approximately 2:30 p.m., observation identified an Activities Department staff member	F 248	psychosocial ewll-being. This will be completed weekly x 1month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues. If concerns are identified, immediate corrective action will be implemented. The Activity Director will submit a report of the monitoring results to the QA committee during the scheduled monthly QA meeting.	

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(#5) going to each room on the resident unit to invite residents to the afternoon's activity "banana splits." The staff member (#5) failed to offer the activity to Resident #10.
* 06/16/09 at 9:35 a.m., 10:30 a.m., 11:25 a.m., 1:40 p.m., 2:30 p.m., 3:20 p.m., 4:00 p.m., and 4:25 p.m., Resident #10 slept in a recliner in the facility's A Wing Lounge.
* 06/17/09 at 9:30 a.m., Resident #10 sat in a recliner in the facility's A Wing Lounge.
* 06/17/09 at 10:20 a.m., Resident #10 slept in a recliner in the facility's A Wing Lounge.

During confidential interview, on 06/14/09 at 7:30 p.m., Family Member #1 reported Resident #10 spends much of the day sleeping in a recliner in the Resident Lounge on the resident's care unit.

Resident #10's medical record, reviewed June 14-17, 2009, identified the resident's current diagnoses included, in part, Alzheimer's disease, cerebral vascular accident, macular degeneration, osteoarthritis. The resident's quarterly Minimum Data Set, dated 03/17/09, identified short and long term memory problems, moderately impaired daily decision making, extensive-to-total assistance with transfers and locomotion on/off unit, awake evenings, involvement in activities 1/3 to 2/3 of the time. Specific activity preferences included: music, reading/writing, spiritual/religious activity, walking/wheeling outdoors, and TV.

Resident #10's care plan, dated 03/10/08 and reviewed by the facility on 03/18/09, stated, "Problem: Pot. Alt. in Mood . . . Approach: . . . Encourage participation with Activity program. Introduce to other residents and assist to activities of choice. . . . Problem: Alt. in Leisure

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Pursuits . . . Approach: . . . Remind, invite & escort as needed to, oor [out of room] act of int [activities of interest] such as but not limited to: special events, coffee time, outings, music and more. . . . Family supportive. Wife visits daily . . . In-room activity of choice: TV watching, paging thru [through] newspaper, theme books, bird watching and more . . . Offer spiritual support as needed or desires. . . ."

Resident #10's computerized Activities Report identified the following:
* 05/01/09 - 05/31/09: eighteen days with no activity, ten days with one activity, and two days with two activities
* 06/01/09 - 06/16/09: four days with no activity, nine days with one activity, and one day with two activities

- Observation, from 1:00 p.m. to approximately 3:30 p.m. on 06/15/09, identified Resident #15 seated in a recliner in the Resident Lounge on the resident's care unit. During this period Resident #15 did not participate in any activities nor was offered activities. At approximately 2:30 p.m., observation identified an Activities Department staff member (#5) went to each room on the resident care unit to invite residents to the afternoon's activity "banana splits." The staff member (#5) failed to offer the activity to Resident #15.

Resident #15's medical record, reviewed on June 15-16, 2009, identified current diagnoses included dementia, depression, and anxiety. The resident's quarterly Minimum Data Set (MDS), dated 05/07/09, identified short and long term memory problems, moderately impaired daily decision making, limited assistance with transfers and

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F 248	Continued From page 20 supervision/limited assistance with locomotion on/off unit, awake evenings, involved in activities 1/3 to 2/3 of the time. Specific activity preferences included: cards/other games, exercise/sports, music, reading/writing, spiritual/religious activity, walking/wheeling outdoors, TV, and talking or conversing. Resident #15's computerized Activities Report identified the following: * 05/01/09 - 05/31/09: four days with no activity, seven days with one activity, and eight days with two activities * 06/01/09 - 06/16/09: six days with one activity, and one day with two activities During interview, on 06/17/09 at 9:30 a.m., when asked how long a typical activity lasted, a facility management staff member (#9) indicated, "Twenty minutes on average." The facility failed to consistently provide an activities program for Residents #6, #10 and #15 from 05/01/09 - 06/16/09.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to ensure a safe and sanitary interior regarding accumulated dust and debris on circulating fans in 3 of 4 resident care wings (B wing, C wing, and ancillary services wing) on 3 of 4 days of survey. Failure to keep the	F 253	To ensure fans are free of dust and debris and to decrease the chance of airborne illness including resident # 3 and any other resident which may affected, the Policy and Procedure on cleaning fans was revised (see att. G). All housekeeping employees will be in-serviced during their mandatory meeting. Fans are to be cleaned weekly and as needed. The weekly fan cleaning log was revised (see att. H). A new housekeeping employee	07/16/09 07/20/09

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F 253	Continued From page 21 fans free of dust and debris placed residents at risk of airborne illness, including a resident with respiratory problems (Resident #3) who occupied a room with a dirty fan. Findings include: - During the initial tour, on 06/14/09 at approximately 2:30 p.m., observation identified Resident #3's room with accumulated dust and debris on the fan blades and grid of a large "box fan" in operation on the floor. Review of Resident #3's medical record identified a diagnosis of respiratory infection with Methicillin Resistant Staph Aureus (MRSA). - During observation of residents receiving services in the Restorativd Thapapt%@ard	F 253	orientation checklist will be initiated (see att. I), all current staff and any new employees will complete the Orientation Program. The Housekeeping Supervisor and the Lead Housekeeper will monitor weekly x1 month, monthly x3 months then quarterly there after x 1 year that fans are cleaned as per facility policy and procedure. The Administrator will be notified of any issues. If concerns are identified immediate corrective action will be implemented. The Housekeeping Supervisor will submit a report of the monitoring results to the QA committee during the scheduled monthly QA meeting.	07/25/09
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	Care Plans of resident #3 and #9 have been updated to be specific regarding signage and precautions in place to prevent the spread of infection. The facility policy and procedure guidelines for management of MRSA VRE infections was revised (see att. J). Resident #2, 4, and 21 will have an OT/and or PT eval completed to ensure proper bed and wc positioning. Care Plan will be updated accordingly upon completion of eval. Resident #2, 4 and 21 and any other resident	06/18/09 07/15/09

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	355087	A. BUILDING _____ B. WING _____	06/17/2009

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F 279	Continued From page 22 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to develop a comprehensive care plan for 1 of 1 sampled resident with suspected tuberculosis (TB) (Resident #9), 1 of 1 sampled resident with respiratory Methicillin Resistant Staff Aureus (MRSA) (Resident #3), and 2 of 4 sampled residents (Resident #2 and #4) and one supplemental resident (Resident #21) with wedges in bed. Failure to develop comprehensive care plans for these residents limited the staff's ability to provide appropriate, consistent care and to communicate changes in the care required for these residents. Findings include: The facility failed to develop the care plan for Resident #9 and #3 with specific interventions for the residents, staff, and visitors to follow to prevent the spread of infection in the facility. - The facility suspected Resident #9 was infected with TB on 06/03/09 as identified by an initial positive Mantoux test (TB skin test). On 06/11/09 an infectious disease specialist provided the local physician with direction regarding isolation of the resident until infection could be confirmed or ruled out. (Refer to F442 for detailed information.) Resident #9's care plan, dated 05/22/06 and reviewed by the facility staff on 03/25/09, and reviewed on June 14-17, 2009, identified	F 279	affected will have their care plan updated to reflect their individual needs with any changes, on admission, quarterly, annually, upon hospital return, and with any significant change in condition. MRSA care plan revised to add signage and further specifics of respiratory precautions as requested by facility infection control MD Care plan policy updated to be addressed with nursing staff and interdisciplinary team with mandatory meeting July 20 or 21, 2009 Monitoring will be completed to assess that care plans are being updated timely and appropriately based on assessments completed. QA will be completed by DON or designee weekly x 4 weeks, monthly x3 months and then quarterly x 1 year. The Administrator will be notified of any issues. If concerns are identified immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA committee during the scheduled monthly QA meeting.	07/15/09 07/15/09 07/25/09

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F 279	Continued From page 23 "Potential for infection . . . Approach, Standard Precautions, Monitor for s/sx [signs/symptoms] of infection . . ." The care plan included an undated handwritten entry, which stated, "Encourage resident to wear mask OOR [out of room] (resistive to same) until determination R/T [related to] Mantoux resolved . . .;" and dated 06/11/09, "Follow recommendations per infection control M.D. [physician] RPT [Repeat] Mantoux Private room Sputum culture x [times] 3 f/u [Follow up] chest film x 2 weeks Follow protocol as he [infection control physician] directed. . . ." The facility failed to include infection control practices for facility staff regarding Resident #9's suspected TB, as outlined in the Centers for Disease Control (CDC) Guidelines (Refer to F442.), including protective clothing and the protocol identified by the infectious disease physician. - Review of the care plan for Resident #3 on 06/15/09, identified a problem with potential for infection related to a history of pneumonia, respiratory MRSA, cellulitis and chronic fungal infection of the foot, and a history of acute sinusitis. The approaches included standard precautions, monitor for signs and symptoms of infection . . . follow MRSA care plan, MD (Medical Doctor) orders/facility MRSA P/P (policy and procedure) . . . During interview at 8:20 a.m. on 06/15/09, an administrative staff member (#2) stated the standard precautions are to follow the CDC guidelines and must have gotten pulled from the	F 279		

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F 279	Continued From page 24 care plan. The administrative staff member (#2) provided "VRE (vancomycin resistive enterococci) and MRSA infection care plan" based on the "Recommendations for the Prevention and Control of Antibiotic Resistant Organisms (MRSA/VRE in ND)." The VRE and MRSA infection care plan" stated, " . . . 15. MASKS AND FACE PROTECTION are not routinely required unless indicated by standard precautions where a splash or spray could be anticipated." During an interview at 8:30 a.m. on 06/15/09, Resident #3 stated he has MRSA in the lungs. He further stated he received a course of antibiotics which didn't work so he wears a mask when he is out of the room in the facility. The facility failed to develop the care plans for Resident #2, #4, and #21 regarding use of wedges in bed restricting the residents' ability to get out of bed independently. The facility staff applied wedges in bed after Resident #2, #4, and #21 attempted to get out of bed independently or had falls out bed. (Refer to F221.) The following resident's care plans, reviewed June 14-17, 2009, revealed the following: - Resident #2's and #4's care plans failed to address the wedge and how it affects mobility in/out of bed. The care plans failed to identify alternatives to be utilized prior to implementing this intervention. - Resident #21's care plan failed to address the wedge and how it affects his mobility in/out of bed. The care plan identified the wedge as a	F 279		

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F 279	Continued From page 25 positioning device and did not address other interventions for staff to attempt before using this method of positioning.	F 279		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide necessary services during mealtimes for 2 of 2 sampled residents (#6 and #10) and 2 supplemental residents (Resident #15 and #18) utilizing lap buddies while seated in their wheelchair at meals. Failure of the facility to assess the need for lap buddies at mealtimes, and to determine appropriate times to remove the lap buddies throughout the day restricted the residents from sitting close to the table and restricted their ability to eat. Findings include: - Random observations revealed the following: * On 06/14/09 at 4:55 p.m., during the evening meal, Resident #6 sat in a wheelchair, with lap buddy in place, at the dining room table. Resident #6 leaned forward in the wheelchair at a 45 degree angle. Resident #6's nose rested on the edge of the table and/or lip rested on the ridge of the tray throughout the meal. Resident #6 attempted to self feed, spooning ground meat onto her nose or pushing food directly off of the plate into her mouth.	F 312	To ensure Resident #6, 10, 15, and 18 and any other residents that may be affected receive necessary services to maintain good nutrition, grooming and personal oral hygiene, these Residents will be re-evaluated by OT and/or PT to ensure the least restrictive device is being used. If a lap buddy is necessary for Resident #6, 10, 15 and 18 or other residents, the lab buddies will be removed during ADL's such as meal time to ensure their highest level of function. The Mealtime Policy (see att. D) and the Restraint Use Policy (see att. A) was revised and will be inserviced to direct care employees during their mandatory inservice. Resident #6, 10, 15, and 18 and any other resident that may be affected will have their plan of care reviewed and updated to reflect their individual needs with any changes made and upon admission, quarterly, annually, and with any significant change in their condition. Monitoring will be completed by the Rehab Coordinator/Administrator weekly x 1	07/25/09 07/21/09 07/25/09

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F 312	Continued From page 26 * 06/15/09 at 4:50 p.m., Resident #6 sat in a wheelchair, with lap buddy in place, at a table in the Dining Room. Resident #6 leaned forward in the wheelchair at a 45 degree angle. Resident #6's chin rested near the edge of the table while she ate her meal. * On 06/15/09 at 5:05 p.m., during the evening meal, Resident #6 sat in a wheelchair, with lap buddy in place, at a dining room table. * 06/16/09 at 9:10 a.m., Resident #6 sat in a wheelchair, with lap buddy in place, at a table in the C Wing Lounge while staff fed her breakfast. * On 06/16/09 at 5:00 p.m., Resident #6 sat in a wheelchair, with lap buddy in place, at a dining room table. The resident sat, hunched over, feeding herself. Later in the observation, a staff member sat with Resident #6 and assisted her. Resident #6's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident on 04/14/05. The resident's quarterly Minimum Data Set, dated 05/07/09, identified short and long term memory problems, moderately impaired daily decision making, and limited assistance with eating. The resident's Resident Assessment Protocol (RAP), dated 03/16/09, identified, "Nutritional Status: . . . Her current weight is 117#, down 6 pounds in a month. She was started on supplements to encourage weight gain, and remains on ensure bid [twice daily] for weight maintenance. [Name] eats breakfast on unit, dinner and supper in the dining room. She sits at an assisted table with a can [CNA] to cue and assist as needed. She has a compartment plate and feeds herself after setup needing assist at times. . . ."	F 312	month, monthly x 3 months, and quarterly thereafter x 1 year. If any issues arise immediate corrective action will be implemented. The Rehab Coordinator will submit a report of the monitoring results to the QA committee during the scheduled monthly meeting.	07/25/09

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F 312	Continued From page 27 Resident #6's care plan, dated 04/14/05 and reviewed by the facility on 05/13/09, stated, "Problem: Self Care Deficit: . . . Approach: . . . Use lap buddy as allows . . . OT [occupational therapy] eval [evaluation] completed to assist with w/c [wheelchair] positioning for functional seated position . . . Pot. for Injury: . . . Approach: . . . May use lap buddy in w/c as needed/allows *Able to remove per self . . . Pot. [potential] Alt. [alterations] in nutrition . . . Meals served on C Wing Lounge, in room, or Dining Room depending on day. When in Dining Room or Lounge sits at a monitored table. Assist required as allows. Feeds self after set up. Dependent on cognition . . . Compartment plate . . . Offer high calorie foods/fluids. Encourage intake. . . . 2 scoops protein powder every day. 1.5 oz [ounce] Benecalorie daily." - Observations made during meals on 06/14/09 at 5:15 p.m., 06/15/09 at 5:05 p.m., and 06/16/09 at 5:00 p.m., revealed Resident #18 seated in a wheelchair with a lap buddy in place at a dining room table. At some point during all three meals, staff assisted Resident #18 to eat. Resident #18's medical record, reviewed 06/17/09, revealed an Occupational Therapy Inpatient Plan of Treatment, dated 01/30/09. This Plan of Treatment indicated ". . . W/C [wheelchair] positioning assessed as well: lap buddy to remain in place. . . lap buddy provides support needed for res [resident] to maint [maintain] a fxnl [functional] 90,90,90 [proper alignment while seated in a wheelchair]". This Plan of Treatment failed to address Resident #18's ability to remove the lap buddy or how often staff are to remove the lap buddy. The Plan of Treatment also failed to address use of the lap	F 312		

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F 312	Continued From page 28 buddy during mealtimes. Resident #18's current Comprehensive Care Plan, with a facility run date of 04/04/09, identified a problem with potential for skin integrity. One approach under this problem is "Lap buddy for support. Remove - reposition every 2 [hours] and as needed." - Observations made during meals on 06/15/09 at 5:05 p.m. and 06/16/09 at 5:00 p.m., revealed Resident #15 seated in a wheelchair with a lap buddy in place at a dining room table. At some point during both observations, an unknown staff member assisted the resident to eat. During the 06/16/09 observation, Resident #15 sat away from the table. The arms of the wheelchair/lap buddy hindered his ability to sit as close to the table as possible. Resident #15's medical record, reviewed on 06/17/09, revealed an OT (Occupational Therapy) Inpatient Weekly Summary, dated 08/21/08. This Weekly Summary indicated staff began using the lap buddy in Resident #15's wheelchair on 08/21/08. This Weekly Summary does not address Resident #15's ability to remove the lap buddy or how often staff are to remove the lap buddy. The Weekly Summary also failed to address use of the lap buddy during mealtimes and Resident #15's ability to eat with the lap buddy in place. Resident #15's current Comprehensive Care Plan, with a facility run date of 05/14/09, identified a problem of potential for injury. One approach under this problem is "Lap buddy for support in W/C [wheelchair]." The care plan fails to address how often or when the lap buddy should be	F 312		

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F 312	Continued From page 29 removed. - Random observations revealed the following: *On 06/14/09 at 5:15 p.m. and on 06/15/09 at 5:05 p.m., (during the evening meal), Resident #10 sat in a wheelchair, with lap buddy in place, at a dining room table. * On 06/16/09 at 11:25 a.m., The CNA (certified nursing assistant) (#12) placed Resident #10's lap buddy in position and then pushed him in his wheelchair from the Bathing Room to the Dining Room. * On 06/16/09 at 5:00 p.m., Resident #10 sat in his wheelchair, with his lap buddy in place, at a dining room table. Resident #10 sat away from the table. The arms of the wheelchair/lap buddy hindered his ability to sit as close to the table as possible. A CNA (#8) provided assistance to Resident #10 during the meal. Resident #10's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident on 03/07/08. The resident's quarterly Minimum Data Set, dated 03/17/09, identified short and long term memory problems, moderately impaired daily decision making, and limited assistance with eating. Resident #10's significant change Resident Assessment Protocol (RAP), dated 11/23/08, stated, ". . . [Name] is being monitored by LRD (licensed registered dietician) due to a significant weight loss since admission . . . Resident is alert but not able to express needs at all times; dependent on staff to provide extensive assist with eating and drinking . . ." Resident #10's care plan, dated 03/10/08 and reviewed by facility staff on 03/18/09, stated,	F 312		

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F 312	Continued From page 30 "Problem: Pot. [potential] Alt. [alterations] Nutrition: . . . Approach: . . . Meals served: x 3 [three times daily in] dining room as tolerated . . . Assist required: dependent on staff for fluid/food intake . . . Problem: Pot. for Injury: . . . Approach: . . . Full lap tray or lap buddy as needed for support . . ." Resident #10's Outreach Occupational Therapy Inpatient Plan of Treatment, dated 12/24/08, stated, "Cont. [continue] [with] use of lap buddy." During all above meal observations, facility staff members present in the dining room or seated at the residents' tables and assisting these residents failed to offer or attempt to assist to reposition the residents or remove the lap buddies. Failure of the facility to provide necessary services during mealtimes has the potential to affect residents abilities to eat as independently as possible.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to ensure 1 of 1	F 314	Coding was changed in the Dietmaster System, and diet card verified to be printing correctly with supercal potatoes for resident #2, immediately on being brought to our attention. All resident cards were printed and reviewed for accuracy. A policy on Selective Menu Cards was developed (see att. K). All future changes to diets will be verified by the Dietary Manager or designee by printing a daily selection	06/19/09

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F 314	Continued From page 31 sampled resident with a pressure sore (Resident #2) received the necessary care and services to promote healing regarding recommended dietary interventions. Failure to provide dietary interventions as recommended may have delayed the healing of Resident #2's Stage II pressure sore. Findings include: Resident #2's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident in February 2009. Current diagnoses included Methicillin Resistant Staph Aureus (MRSA) urinary tract infection, supra pubic catheter, renal failure, left foot ulcer (present on admission), and peripheral vascular disease. The resident's current Minimum Data Set, dated 05/19/09, identified short term memory problems, moderately impaired daily decision making, independent eating with set up help, leaves 25% or more at meals, and one stage II pressure ulcer. The resident's Pressure Ulcer Resident Assessment Protocol Summary (RAPS), dated 03/02/09, identified podiatry consults and limited blood flow to the resident's feet. The medical record identified continued podiatry consults approximately every three weeks with recommendations and physician orders for daily wet to dry dressings to the left heel. Resident #2's dietary progress notes, on 02/24/09, recommended Arginaid (a protein supplement) eight ounces, two times each day to promote healing of the left heel ulcer. The dietary progress note, dated 05/05/09, stated ". . . Current weight down to 142.4 # [pounds] . . . Meal	F 314	card to verify that the correct choices are being offered. The Dietary Manager and staff who access the computer program were trained on the Dietmaster system by the president of Dietmaster Systems, Inc., training included a review of entering new orders to the diet/tray card. Monitoring on resident #2 and a sampling of at least 6 additional residents, to verify that cards are accurate, will occur weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The Dietary Manager will submit a report of the monitoring results to the QA committee during scheduled monthly meetings.	07/10/09 07/25/09

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intakes average 72%. Continues to receive Arginaid 240 cc [cubic centimeters] BID [two times each day] and MVI [multivitamin] daily d/t [due to] chronic heel ulcer. . . . Will start whole milk, special cereal, and supercal potatoes with meals d/t weight loss. Goals are for: 1) wound healing, 2) weight to remain between 140-150#. . . ." The medical record identified the resident weighed 143.4# on 06/09/09.

Observation of Resident #2's left heel dressing change, on 06/15/09 at 10:30 a.m., by a licensed nursing staff member (#3), identified a stage II area on the left heel approximately one centimeter in diameter. Review of the weekly skin monitoring and measurement record identified the left heel area showed very slow reduction in size.

During interview, on 06/16/09 at 2:05 p.m., a supervisory dietary staff member (#23) reported the resident's dietary supplements, such as Resident #2's special cereal and supercal potatoes print from the computer program on the meal ticket for each meal. This staff member provided the resident's meal tickets for the previous noon meal and breakfast meals which failed to identify either the special cereal or supercal potatoes as menu items or options. This staff member reported a dietary management staff member (#24), who was not in the facility, would have to provide additional information.

On 06/16/09 at 4:05 p.m., dietary management staff member (#24) reported she would check on Resident #2's special cereal and supercal potatoes. At 5:10 p.m. this staff member reported the special cereal and supercal potatoes did not print on the meal tickets so Resident #2 "probably didn't get them" since the recommendation on

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F 314	Continued From page 33 05/05/09. On 06/17/09 at approximately 9:30 a.m., a dietary staff member (#24) reported the consultant dietitian's recommendations for Resident #2 to receive the special cereal and supercal potatoes failed to be entered into the dietary department computer system from which the diet tickets are printed, confirming her interview from 06/16/09 at 4:05 p.m. Failure to ensure Resident #2 received the special cereal and supercal potatoes since 05/05/09 (six weeks) limited the facility's ability to ensure the resident received the nutritional care and services necessary to promote healing of the stage II pressure ulcer on the left heel.	F 314		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION 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: 1. Based on observation, resident interview, and record review, the facility failed to ensure 2 of 2 sampled residents (Resident #4 and #9) with a diagnosis of dysphagia and history of aspiration received adequate supervision during meals and/or did not receive and use straws, on 4 of 4 days of survey. Failure to provide supervision during meals for residents with a diagnosis of dysphagia and history of aspiration placed these	F 323	To ensure the facility maintains an environment that assures the residents #4 And # 9 and any other resident that may be affected will be as free of accidental hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents, the "Mealtime Policy" for assisting with meals was revised see (att. D and L). Direct care employees that assist with or supervise meal time, will be in-serviced during the mandatory meetings. Dietary cards will reflect for each resident if they have dysphagia and need to be supervised with their meal to ensure their needs are met to prevent any	07/16/09 07/21/09

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F 323	Continued From page 34 residents at risk of choking, recurrent aspiration, and pneumonia. Findings include: - Observation throughout the survey identified Resident #9 in a private room and facility staff brought all his meals to his room. Observations failed to indicate facility staff members stayed in the resident's room to assist or remind him during his meals. On 06/15/09 at 9:20 a.m., a certified nursing assistant (CNA) (#15) identified the facility placed Resident #9 in isolation due to suspected tuberculosis (TB). Observation during medication pass, on 06/15/09 at 8:55 a.m., identified a licensed nurse (#3) offered and gave Resident #9 water from the sink, the resident coughed, and the licensed nurse (#3) gave the resident thickened water from the medication cart. Resident #9's medical record, reviewed June 15-17, 2009, identified the facility initially admitted the resident on 05/22/06. On 03/02/09 the facility discharged the resident to an acute care facility and re-admitted the resident on 03/07/09. Current diagnoses included renal failure, diabetes mellitus, dementia, and difficulty swallowing. The resident's current significant change Minimum Data Set, dated 03/14/09, identified short and long term memory problems, moderately impaired daily decision making, supervision and set up help with eating, swallowing problems, and a mechanically altered diet. Resident #9's Discharge Summary from the acute care facility, dated 03/07/09, stated, "PRINCIPLE DIAGNOSIS . . . 2. Difficulty Swallowing . . .	F 323	accidental hazards from occurring. Resident # 4 and # 9 and any other resident that may be affected, this information is also reflected on their individual plan of care. A CNA will be assigned to those residents who need help and/or supervision with their meals. A list of all residents who needs supervision and/or assistance will be placed in the staff wing books. Resident's #9 , #4 and a random sample of appropriate residents will be monitored during meal time by the CNA Coordinator and other Nursing staff to ensure the "Mealtime Policy" is followed. The CNA Coordinator shall monitor weekly x1 month, monthly x3 months and quarterly there after x 1 year. Any issues will be reported to the Administrator. If concerns are identified immediate corrective action will be implemented. The CNA Coordinator will submit a report of the monitoring results to the QA committee during the scheduled monthly QA meeting. To ensure Resident #10 and # 18 and any other residents which may be affected by this practice are assisted appropriately with wc mobility a policy on "Wheelchair Transportation" was developed (see	07/25/09

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F 323	Continued From page 35 Swallowing study was done on 03/04/09. This was questionable for some problems. . . . The swallowing study was repeated on 03/06/09. At that time it was felt that the patient should be on spoon thick liquids and a pureed diet. . . ." Resident #9's care plan, dated 05/22/06 and reviewed by facility staff on 03/25/09, stated "Problem, Potential altered nutrition . . . *Dysphagia . . . Approach . . . Level 2 Diet, Mechanical Soft with ground meats, nectar thick liquids, breads OK. . . . Eats all 3 meals in dining room, or in room as desires. Feeds self after set up. . . ." Resident #9's Occupational Therapy (O.T.) Dysphagia Plan of Treatment Progress Report/Summary, dated 04/02/09, stated ". . . O.T. will have res [resident] eat @ [at] level 2/mechanical soft diet, ground meats, nectar liquids, breads okay. Dietary has been following this diet since 03/19/09, [no] overt s/s [signs/symptoms] of aspiration." The O.T. Dysphagia Plan of Treatment form included The Dysphagia Outcome and Severity Scale which stated "Level 2: Moderately Severe Dysphagia: Maximum Assistance or Maximum Use of Strategies with Partial PO [by mouth] Only. May exhibit one or more of the following: Severe retention on pharynx, unable to clear or needs multiple cough. Severe oral stage bolus loss or retention, unable to clear or needs multiple cues. Aspiration with two or more consistencies, no reflexive cough, weak volitional cough or aspiration with one or more consistencies, no cough and airway penetration to cords with one or more consistencies, no cough. . . ."	F 323	att. L),which addresses safe practices for wc transportation and the need to place wheel chair leg rests for dependent residents when transporting/assisting resident's with wc mobility to decrease the risk of injury. Direct care employees will be in-serviced during the mandatory meetings. A list of residents who have leg rests in place shall be placed in the CNA wings books to ensure that the resident needs are met to prevent any accidental injuries from occurring. Resident #10, #12 and other appropriate residents will be monitored by the CNA coordinator and other nursing staff. The CRA Coordinator shall monitor weekly x1 month, monthly x3 months and quarterly thereafter x 1 year. The Administrator shall be notified of any issues. If concerns are identified immediate corrective action will be implemented. The CNA Coordinator will submit a report of the monitoring results to the QA committee during the scheduled monthly QA meeting.	07/16/09 07/21/09 07/25/09

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The facility staff did not provide supervision to ensure Resident #9 did not experience difficulty swallowing during meals.

- Resident #4's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident on 09/05/08 following a stroke, discharged the resident to an acute care facility due to "pneumonia" on 03/12/09, and re-admitted the resident on 03/16/09. Current diagnoses included post stroke, dysphagia, chronic obstructive pulmonary disease (COPD), and a feeding tube in the stomach (PEG tube). The resident's current Minimum Data Set, dated 03/23/09, identified no short or long term memory problems, modified independence in daily decision making, independent with set up help for eating, and swallow problems.

The resident's Resident Assessment Protocol Summary (RAPS) regarding the PEG tube, dated 09/16/08, identified the resident experienced dysphagia, aspiration pneumonia, and "failed" several swallowing evaluations. Therefore, the acute care facility inserted the PEG tube. The medical record identified the resident began oral feedings on 09/29/08, has been taking adequate nutrition, and the resident has not used the PEG tube for nutrition since 09/30/08.

Resident #4's care plan, dated 04/01/09, stated "Problem, Pot [Potential] Alt [Altered] Nutrition, Related to: . . . *Swallowing problem . . . *Dysphagia . . . Approaches . . . *Diet: level 3 Dysphagia, advanced, cut up meats, may have breads, no straws, follow dysphagia techniques . . . Problem, Potential for infection, Related to *H/O [history of] Pneumonia (aspiration) . . . *Recent

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F 323	Continued From page 37 COPD/Pneumonia . . ." Resident #4's Dysphagia Plan of Treatment, dated 05/11/09, stated "Reason for Referral, Family noticed [increased] coughing [with] liquids. . . . Progress Report/Summary, Res. [Resident] maint. [maintained] safe swallowing on current/previous diet. [No] [changes] needed. D/C [Discontinue] res. Level 3 diet, thin liquids." The O.T. Dysphagia Plan of Treatment form included The Dysphagia Outcome and Severity Scale which stated "Level 3: Moderate Dysphagia: Total Assist, Supervision, or Strategies; Two or More Diet Consistencies Restricted May exhibit one or more of the following: Moderate retention in pharynx that is cleared with cue. Moderate retention on oral cavity that is cleared with cue. Airway penetration to the level of the vocal cords without cough with two or more consistencies or aspiration with two consistencies, with weak or no reflexive cough, or aspiration with one consistency, no cough and airway penetration to cords with one consistency, no cough." Observation of Resident #4 during meals identified the following: *06/14/09, 5:05 p.m. - Seated at the edge of his bed, coughing, received evening meal tray with ground hamburger, noodles, beets, apple sauce. Ate independently without supervision. When questioned regarding eating by himself in his room, Resident #4 stated this occurs "a lot" and "O.K., I guess." *06/15/09, 9:10 a.m. - Finished breakfast in dining room, hot cereal, juice, toast, milk, coffee. Straw	F 323		

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F 323	Continued From page 38 present in juice. *06/15/09, 5:00 p.m. - Seated in wheelchair in room, received evening meal tray, cut up chicken, mixed vegetables, cookie, milk, coffee, and water. Ate independently without supervision, straw in the water. *06/16/09, 8:05 a.m. - Seated at a dining room table, eating breakfast of hot cereal, juice, water, and coffee. Straws in the juice and water. Resident #9 and #4 each have a history of swallowing problems. Facility staff provided thickened water to Resident #9 after he coughed while drinking regular water. Facility staff provided Resident #4 with straws during meals and in his room despite his recent swallow evaluation and care plan indicating "no straws." Resident #9 and #4 have a history of pneumonia and swallow problems. The facility staff's actions placed these residents at risk of choking, aspiration, and possible pneumonia while eating unsupervised. 2. Based on observation, staff interview, and record review, the facility staff failed to provide adequate supervision and assistive devices regarding foot/leg supports for 2 of 12 sampled residents (Resident #10 and #18) who required assistance with wheelchair transportation. Failure to use wheelchair lower extremity supports (foot pedals) places residents at risk of injury during transport. Findings include: Random observations revealed the following: * On 05/14/09 at 5:20 p.m., a staff member pushed Resident #10 in his wheelchair from the Dining Room to the A Wing Lounge with the soles of his shoes sliding along the floor.	F 323		

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F 323	Continued From page 39 * On 06/16/09 at 11:25 a.m., a certified nursing assistant (CNA #12) pushed Resident #10 in his wheelchair from the Bathing Room to the Dining Room with the soles of his shoes sliding and at times dragging on the floor. The CNA stopped to cue Resident #10 to pick up his feet. * On 06/16/09 at 1:00 p.m., one staff member pushed Resident #10 in a wheelchair toward the therapy room while another staff member held the resident's feet off the floor. Just outside the therapy room, they stopped and the staff member holding Resident #10's feet up, placed them on the floor. The staff then verbally encouraged Resident #10 to hold his feet up off the floor while being pushed into the therapy room. - Resident #10's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident on 03/07/08. The resident's quarterly Minimum Data Set, dated 03/17/09, identified short and long term memory problems, moderately impaired daily decision making, extensive-to-total assistance with transfers and locomotion on/off unit. Resident #10's significant change Resident Assessment Protocol (RAP), dated 11/23/08, stated, ". . . Once in wheelchair self propels aimlessly on and off the unit, needs staff to push to any destination. . . ." Resident #10's care plan, dated 03/10/08 and reviewed by the facility on 03/18/09, stated, "Problem: Self Care Deficit . . . Approach: . . . Mobility: w/c [wheelchair] primary mode of transport . . . " - Observation on 06/16/09 at 1:00 p.m. revealed an activity staff member (#9) push Resident #18	F 323		

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F 323	Continued From page 40 in a wheelchair from the activity room to the lounge area on Birch Lane. The resident alternated between lifting her feet as though walking while being pushed and skimming her feet across the floor as the staff member pushed the wheelchair. Observation on 06/16/09 at 5:15 p.m. revealed a certified nursing assistant (CNA #8) push Resident #18 in a wheelchair from the dining room to the resident's room at the far end of Birch Lane. The resident alternated between lifting her feet as though walking while being pushed and skimming her feet across the floor as the CNA pushed the wheelchair. The annual Minimum Data Set (MDS), dated 04/02/09 and reviewed 06/17/09, revealed Resident #18 required limited assistance of one person for locomotion on the unit. The ADL [activities of daily living] functional Resident Assessment Protocol (RAP) completed with the annual MDS, stated, ". . . Once in w/c [wheelchair] is pushed by staff on and off the unit, does self propel but unable is (sic) to get to any location. . ." During interview with three administrative staff members (#1, #2, and #6) on 06/17/09 at 11:00 a.m., the above observations were shared. These staff members offered no disagreement that transporting residents in their wheelchairs without proper lower extremity supports is not a safe practice.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328	**A log (see attachment #M) will be maintained and kept at the nurse's station to identify any resident who**	7/15/09

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F 328	Continued From page 41 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 by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 2 residents (Resident #4) using continuous oxygen received proper respiratory care regarding the availability of oxygen. Failure to ensure the availability of oxygen for Resident #4 placed the resident at risk of injury and anxiety related to low oxygen saturation levels. Findings include: - Resident #4's medical record, reviewed June 14-17, 2009, identified the facility admitted the resident in September 2008 after a stroke, discharged the resident to an acute care facility on 03/12/09 due to pneumonia and re-admitted the resident on 03/16/09. Current diagnoses included dysphagia, chronic obstructive pulmonary disease (COPD), hypertension, and urinary retention. The current Minimum Data Set, dated 03/23/09, identified the resident required limited or extensive assistance with all activities of daily living (ADLs) and used oxygen in the previous 14 days. Resident #4's physician orders included oxygen at two to eight liters per minute every shift as	F 328	**is currently receiving oxygen including resident #4. Oxygen tanks will be checked nightly by night nurse to assure that tanks have adequate oxygen supply available and tanks will be changed at that time as needed. This duty was added to the nurse's nightly duty checklist on 7/15/09. Mandatory in-service regarding revised P/P on oxygen use (see attachment #N), will be provided regarding proper procedure for oxygen use to include checking oxygen gauges and changing of oxygen tanks. Monitoring of oxygen usage will be completed, including proper level of oxygen available in tank, and to assess adequate SAO2 levels of residents requiring oxygen therapy as documented on treatment sheets. QA will be completed on resident #4 and a random sample of residents by the DON or appropriate designee weekly x 4 weeks, monthly x3 months and then quarterly for 1 year. The administrator will be notified of any issues. If concerns are identified immediate corrective action will be implemented. DON will submit a**	07/21/09 07/25/09

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F 328	Continued From page 42 necessary and oxygen saturation levels every shift. Resident #4's current care plan, dated 04/01/09, stated "Problem, Pot [Potential] altered comfort, Related to: *Fatigue/weakness, *Dyspnea, *Low O2 [oxygen] sats [saturation level] - O2 dependent . . . *Chronic COPD exac/ [exacerbation] Pneumonia . . . Approaches . . . *Assess for nonpharmalogical [sic] interventions . . ." Resident #4's O2 saturation levels for the period May 16 to June 16, 2009 identified values from 85% on 05/27/09 at 1:06 a.m. and 87% on 05/22/09 at 4:01 p.m. to 97% on numerous occasions. Observations throughout the survey identified the resident using oxygen from a tank attached to his wheelchair or from an oxygen concentrator in his room. On 06/15/09 at 8:45 a.m., after a certified nursing assistant (CNA #25) completed Resident #4's shower and assisted him in dressing, the CNA stated "See if you got some air in this tank." referring to the oxygen tank attached to the resident's wheelchair. The CNA opened the valve on the tank and stated, "Wheezing a bit, takes a lot out of you." referring to the resident's breathing, the effects of the humidity in the tub room, and the effort expended by the resident in dressing. Observation identified Resident #4 demonstrated some labored breathing and audible wheezes. Observation also identified the gauge on the oxygen tank indicated "0" that the oxygen tank was empty and Resident #4 did not receive oxygen from the tank. The CNA (#25) wheeled Resident #4 into the hall	F 328	**report of the monitoring results to the QA committee during the scheduled monthly QA meeting.**	

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in the wheelchair with the empty oxygen tank. The resident's breathing and wheezes improved out of the tub room, but continued to be present. The CNA sanitized the shower chair and wheeled Resident #4 to his room approximately 50 feet from the tub room. The CNA assisted the resident with hair care. A licensed nurse (#3) arrived with Resident #4's scheduled medications. The nurse (#3) asked the CNA (#25) "Did you check the oxygen tank?" and the CNA (#25) replied "I put it on because he was wheezing, humidity in [the] shower." The licensed nurse (#3) provided Resident #4 his medications and left the room along with the CNA (#25). Neither staff member re-checked Resident #4's oxygen tank to ensure the resident received oxygen. The resident continued to sit in the wheelchair with the oxygen tubing in his nose, attached to the empty oxygen tank, and demonstrated some labored breathing with wheezing.

When questioned, after the licensed nurse (#3) and the CNA (#25) left the room, Resident #4 reported he did not receive any air flow (oxygen) from the tubing in his nose. At this time, the licensed nurse (#3) and the CNA (#25) returned to the room and were informed the resident did not receive oxygen from the tank. The CNA (#25) wheeled the resident to the oxygen storage room, removed the empty tank, and attached a full oxygen tank to Resident #4's wheelchair. The CNA then wheeled the resident to the dining room for breakfast.

Resident #4's medical record identified the resident had a history of breathing related diagnoses including COPD and recent pneumonia. O2 saturation levels showed a wide range indicating a need for O2. Observation

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F 328	Continued From page 44 throughout the survey indicated Resident #4 used oxygen on a continuous basis. The CNA and licensed nurse observed wheezing and labored breathing as signs of needing oxygen and failed to identify the gauge on the tank showing "0" or empty. Failure to accurately read the oxygen tank gauge, failure to identify the resident's continued wheezing and labored breathing after the CNA turned on the oxygen tank as possible indications of oxygen tank malfunction, and failure to ensure availability of oxygen for an oxygen dependent resident, placed Resident #4 at risk of continued breathing difficulties, limited functional status, and at risk of increased anxiety related to the breathing difficulties.	F 328		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	On 7-14-09 the pharmacy in question was again notified of the need to include the lot number and expiration date on medication cassette for resident #9, #23, as well as any resident they provide medication to. A letter notifying the pharmacy provider was sent on 7/17/09 and a copy was also sent to the State Pharmacist (see Exhibit A). The pharmacist was notified that they had to incorporate the required expiration dates and lot numbers or Wedgewood Manor would be unable to accept medications from them. Monitoring that the appropriate expiration dates and lot numbers are on Rx's will occur weekly by the DON or appropriate designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year and	07/14/09 07/17/09 07/15/09 07/25/09

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F 431	Continued From page 45 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure medication was labeled in accordance with currently accepted professional principles to include the lot number and expiration date for 2 residents (Resident #9 and #23) during 1 of 2 medication pass and eleven additional residents. Failure to include the lot number and expiration date does not provide information required to track the medication and creates the potential for residents to receive expired medication. Findings include: - During observation of facility staff dispensing medications for Resident #9 at 8:55 a.m. and Resident #23 at 9:25 a.m. on 06/16/09, the area on the label for recording the medication lot number and expiration date on the medication cassette remained blank. A staff nurse (#3) who passed the medications at 8:55 a.m. and 9:25 a.m., agreed the medication cassettes lacked the lot number and expiration date.	F 431	reviewed by the consulting pharmacist monthly. If any issues arise the Administrator will be notified and immediate corrective action will occur. The DON will submit a review of the monitoring results to the QA Committee during the regularly scheduled monthly meeting.	07/25/09

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F 431	Continued From page 46 Review of the medication cassettes in the medication carts on 06/15/09, revealed thirteen residents had medication cassettes which lacked the medication lot number and expiration date. Review of the facility "Medication Administration guidelines" policy and procedure with an original date of 12/96 and a revision date of 03/02, occurred on 06/16/09. The policy and procedure identified the purpose as, "Medications are administered as prescribed, in accordance with good nursing principles and practices and only by Licensed Nurse/Medication Aides as ordered by Physician." The Procedure stated, "1. Medications are prepared, administered, and recorded by authorized personnel according to state and federal laws. . ." On 06/17/09 at 9:20 a.m., an administrative staff member (#2) provided information the consulting pharmacist faxed to the facility. The information included, "Guidelines on prepackaging of medications" approved by the ASCP (American Society of Consultant Pharmacists) Board of Directors, November 10,1998. The preamble stated, "Certain precautions must be taken if the quality of prepackaged medication is to be maintained. The guidelines presented herein will assist the pharmacist in developing procedures for prepackaging drugs from the original manufacturer's container without compromising the quality of the product." "Current federal and state label requirement, whichever is more stringent, must be adhered to. The desired components are as follows: . . . 5. Beyond-use date 6. Control number (lot number) . . ."	F 431		

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F 431	Continued From page 47 During an interview at 10:15 a.m. on 06/17/09, the consulting pharmacist (#4) concurred the medication lot number and expiration date are information which are required to be included on the medication label.	F 431		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of professional standards and staff interview, the facility failed to follow infection control practices on 4 of 4 days (June 14-17, 2009) of survey. Failure to follow infection control practices places residents, staff, and visitors at risk for infection. Findings include: - Observations on all days of survey identified facility staff members inconsistently following standard infection control practices related to residents with airborne and contact isolation. (Refer to F442.) During interviews, housekeeping staff members identified cleaning approaches and techniques inconsistent with standard precautions and with one another related to resident rooms	F 441	The facility will educate all current housekeeping employees and any new employees will be required to complete an orientation program (see att. I), which includes infection control. The meeting minutes will include names of staff in attendance. Any staff not in attendance will have to follow-up with the lead housekeeper or housekeeping supervisor to review any training that was held at the meeting to ensure they stay current in their practice. The housekeeping supervisor or lead housekeeper will monitor that infection control practices are followed diligently by housekeeping staff and their carts are equipped with appropriate cleaning agents. This will be monitored weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. Visitors identified with resident #3 will be in-serviced on how to wash hands appropriately, gown, glove, and mask if they enter a room with contact isolation. It is encouraged they do not enter these rooms unless necessary. "Infectious	7/20/09 7/25/09 7/25/09

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F 441	Continued From page 48 occupied by residents with known or suspected infections. During interview, on 06/15/09 at 11:10 a.m., a housekeeping management staff member (#6) reported the facility does not have an orientation and training program for housekeeping staff members. New staff members work with an experienced staff member for approximately one week before working independently. This staff member reported the facility instructs housekeeping staff in special cleaning approaches for rooms occupied by residents with infections; including use of certain cleaners, contact times, and protective apparel. The staff member identified "Cavi" cleaner is used specifically for one room occupied by a resident with suspected tuberculosis (TB). This staff member (#6) was uncertain in what sequence rooms occupied by residents with infections should be cleaned, including last. At the conclusion of the interview, observation of the facility's three housekeeping carts, with a staff member (#6), identified only the "Cavi" wipes on one cart, only the "Cavi" spray on the second cart, and no "Cavi" product on the third cart. The staff member (#6) reported the "Cavi" wipes and spray products should be on all three carts. On 06/16/09 at 5:20 p.m., a housekeeping management staff member (#6) provided a list of current housekeeping staff and copies of department meeting minutes and attendance rosters of housekeeping staff training for the past year related to infection control. This information is as follows: Current staff list - five individuals; two hired since 10/08.	F 441	Prevention Education" will be provided to residents, visitors and family members as indicated. The DON and nursing staff will be responsible to ensure appropriate education is received by visitors. Resident# 3 and any residents that may have an infectious illness will have signage on the door indicating that they need to contact nursing staff for further instructions: The DON or licensed nursing staff in charge will be responsible to educate and monitor that visitors are following necessary precautions to help prevent the spread of infection. A Biohazard Waste Policy Was developed (see att. Q). Hazardous waste was removed to an outside facility/garage area where there is no chance of contact with clean linen or other items. Monitoring that infectious waste is removed in a timely manner will be completed by Maintenance, any issues will be bought to the attention of the Administrator and immediate corrective action will occur. Monitoring will occur weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The Maintenance employee will submit a review of the monitoring to the QA committee during the regularly T.C. 7-27-09 Adm stated staff will be education on Biohazard Waste Policy in conjunction 07/17/09 Inf. Control 07/25/09	

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F 441	Continued From page 49 Department Meetings: *02/13/08 - attendees - one of five current staff. Agenda - Clean environment, different types of germs and how to clean them, questions and answers. *03/13/08 - attendees - none identified. Agenda - Infection control, proper cleaning for Methicillin Resistant Staph Aureus (MRSA), precautions for respiratory, wound, and urinary infections. *12/08 - attendees - none identified. Agenda - Minutes stated "Over the past few months we have discussed the following issues: 1. Weekly cleaning means you are to pull out furniture, dust, scrub, clean the entire resident area." *06/11/09 - attendees - four of five current staff. Agenda - Protective clothing for room of resident with suspected TB, isolation precautions, sterilize mop handle, change mop head . *06/16/09 at 10:30 a.m. (held on request) - attendees - four of five current staff present, remaining person scheduled 06/17/09. Agenda - Proper cleaning procedure for isolation rooms. It is unknown which staff members attended the department meetings of 03/13/08, 12/08, and the meetings referenced in 12/08. The facility failed to ensure housekeeping staff members were trained and knowledgeable in appropriate cleaning techniques and approaches for rooms occupied by residents with known or suspected infections requiring contact and airborne precautions. The facility did not employ two of five current housekeepers at the time of the department meeting regarding infection control on 03/13/08. During interviews, on June 15-16, 2009, (Refer to F442.) four of four	F 441	scheduled monthly meeting. The Infection Control Program is being revised using the latest edition of the Infection Control Manual specifically for Long- Term Care 2009. This edition provides a comprehensive resource for policies and procedures reflecting the most current standards for infection prevention (refer to table of contents att. O). The policies are written for compliance with OBRA regulations, CDC recommendations, JCAHCO standards for long-term care and current national standards of practice. The facility's infection control system will have a system to monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. The facility will maintain a separate record on infection that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of the infection, and describes what cautionary measures were taken to prevent the spread of infection within the facility. The new system will aide the facility in analyzing clusters, changes in prevalent organisms, and monitoring	7/25/09

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F 441	Continued From page 50 housekeepers (three who attended the department meeting on 06/11/09) provided information inconsistent with facility policy and contact and airborne precautions. The facility failed to provide an orientation and training program, including infection control, for newly hired housekeeping staff members; failed to provide an ongoing training program, including infection control, for housekeeping staff members; failed to ensure documentation of attendance for training provided; and, failed to ensure housekeeping staff members consistently implemented appropriate infection control practices. These failures placed all facility residents, staff, and visitors at risk of infection related to residents requiring contact and airborne precautions. - At 11:05 a.m. on 06/15/09, a visitor put a mask on, entered Resident #3's room to deliver the mail, exited the room and handed the mask to another visitor who walked down the hall and disposed of the mask. Neither visitor washed their hands. The "VRE and MRSA infection care plan" provided by an administrative staff member (#2) at 8:20 a.m. on 06/15/09 stated, ". . . VISITORS 8. Educate visitors of need to wash hands and need to follow same precautions as staff [observation showed staff utilizing a gown, gloves, and mask]. 9. Direct contact with other patients should be discouraged." - The National Institute for Occupational Safety and Health "Guidelines for Protecting the Safety and Health of Health Care Workers" stated the	F 441	rates of infection in a timely manner. Nurses will be inserviced on new Infection Control Policy and Procedures. Surveillance data will be reviewed monthly and as needed to assist in prevention and control of additional cases. The infection control manual will be reviewed periodically, revised as needed, and signed by the Infection Control Committee. Monitoring that the facility is following infection control practices will be completed by the DON and Administrator weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. If problems are identified immediate corrective action will occur. A report will be submitted to the QA Committee monthly and Infection Control Committee quarterly.	7/21/09 7/25/09

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F 441	Continued From page 51 following regarding the storage of hazardous waste; "Infectious waste should be stored for a minimum amount of time and should be packaged securely enough to ensure containment of the waste and to prevent penetration by rodents and vermin. Limited access to the storage area is recommended. The universal biological hazard symbol should be posted on the storage area door, waste containers, freezers, or refrigerators. Containers for biohazardous material should be a distinctive red or orange color." On 06/15/09 at 11:00 a.m., observation in the facility's garage identified 22 cardboard boxes labeled "Biohazardous" in six stacks immediately inside the garage roll-up door, one of the stacks on a wooden pallet and the remaining five stacks on the concrete floor. A maintenance department staff member (#11) reported the facility routinely stores the biohazardous material in this area and it is picked up every two weeks by a contractor. The anticipated pick up date was 06/16/09. Observation also identified the staff member moving a covered cart from a van and the staff member identified the cart contained clean linen from an off-site laundry. The garage also contained a variety of boxes and stored items. The staff member reported the garage does have water on the floor at times due to inclement weather and the floor is lower than the surrounding area. Observation identified the garage floor approximately two inches lower than the exterior driveway. The garage door was open at this time and random observations during the survey identified the garage door open during the day and the boxes containing the biohazard material exposed.	F 441		

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F 441	Continued From page 52 On 06/16/09 at 10:40 a.m., observation in the facility's garage identified 24 cardboard boxes labeled "Biohazardous" in seven stacks, six on the floor and one on a wooden pallet immediately inside the garage door as identified on 06/15/09. During the environmental tour, on 06/16/09 at approximately 2:30 p.m., observation no longer identified the cardboard boxes labeled "Biohazardous" in the garage. A maintenance department staff member (#11) reported the contractor picked up the boxes "about noon" that day. This staff member further stated the contractor extended the period between the last pick up and this one to three weeks due to a personal illness. During discussion regarding the storage of the biohazardous materials, an administrative staff member (#1), also present during the tour, agreed the boxes were exposed to the elements and could become wet when the garage experienced water on the floor. The maintenance staff member (#11) reported the facility did not consider scheduling more frequent pick ups to reduce the amount of material accumulated. This staff member agreed the biohazardous material should be stored in an enclosed, more secure area. Storage of the biohazardous materials in the open garage placed the materials at risk of exposure to the elements, potential insect or vermin infestation, and deterioration of the boxes between pick-ups. The facility staff use the garage for a variety of purposes including unloading clean linen and storage of other items. Storage of the biohazardous materials in this area created the potential for the spread of infection to these items.	F 441		

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Failure to store the biohazardous material in a safe, secure manner in an area of limited access placed all the facility's residents, staff, and visitors at risk of infections and failed to provide a safe and secure environment.

2. Based on review of the facility's infection control program and staff interview, the facility failed to maintain an infection control program designed to ensure the prevention, control and spread of infection within the facility for 14 of 14 months reviewed (April 2008 to June of 2009). Failure to implement an active infection control program has the potential to affect the health of all facility residents, staff, and visitors.

Findings include:

The Centers for Medicare and Medicaid Services (CMS) has outlined the requirements for an Infection Control Program as follows: "The facility's infection control program must have a system to monitor and investigate causes of infection (nosocomial and community acquired) and manner of spread. A facility should, for example, maintain a separate record on infection that identifies each resident with an infection, states the date of infection, the causative agent, the origin or site of infection, and describes what cautionary measures were taken to prevent the spread of the infection within the facility. The system must enable the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. Surveillance data should be routinely reviewed and recommendations made for the prevention and control of additional cases. The written infection control program should be periodically reviewed by the facility and revised as

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F 441	Continued From page 54 indicated." Observation during the initial tour of the facility at 2:30 p.m. on 06/14/09, showed seven rooms (Room #1, #4, #14, #18, #26, #28, and #32) with containers for the disposal of biohazardous waste material (which indicated infectious material). The resident roster provided by facility staff identified eight residents (Resident #1, #3, #4, #9, #12, #15, #20, and #22) with an infection or on an antibiotic. * The infection control log failed to include each resident with an infection, failed to identify the causative agent, and failed to describe what cautionary measures were taken. Review of the June Infection Control Log occurred at 5:50 p.m. on 06/15/09. The Infection Control Log identified 4 residents with upper respiratory infection, 1 resident with lower respiratory infection, and 1 resident with a urinary tract infection. The infection control log failed to include Resident #3, #4, #9, #15, #16, and #17. The infection control log failed to identify the organism/causative agent for any of the residents listed on the log. Residents from six of the seven rooms with containers for the disposal of biohazardous waste material were not identified on the infection control log as resident's with infections. The infection control logs for March, April, and May also lacked the organism/causative agent and specific cautionary measures implemented to prevent the spread of infection. None of the infections were identified as nosocomial.	F 441		

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* The Infection Control Committee cannot analyze clusters, changes in prevalent organisms, or increases in the rate of infection when the infection control log failed to include each resident with an infection, failed to identify the causative agent, and failed to describe what cautionary measures were taken. The Infection Control Committee cannot make recommendations for the prevention of infections and control the spread of infections with incomplete information.

Review of the Infection Control Meeting minutes for the 2nd quarter of 2008 identified the infection control rate as 35% in April, 24% in May, and 11% in June. The minutes lack evidence of how the committee analyzed the information and what recommendations were made by the committee.

The Infection Control Meeting minutes for the 3rd quarter of 2008 identified the infection control rate as 29% in July, 16% in August, and 15% in September. The minutes lack evidence of how the facility completed the tracking and analysis without the identification of the organism and if the committee made any recommendations.

The Infection Control Meeting minutes for the 4th quarter of 2008 identified the infection control rate as 18% in October, 27% in November, and 16% in December. The minutes lack evidence of how the facility completed the tracking and analysis without the identification of the organism and if the committee made any recommendations.

The Infection Control Meeting minutes for the 1st quarter of 2009 identified 12 infections in January, 8 infections in February, and 27 infections in March. In March, 16 of the 27 infections were gastrointestinal. The minutes lack evidence the

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F 441	Continued From page 56 facility attempted to investigate the cause of the gastrointestinal outbreak to identify the organism; whether viral or bacterial. The minutes also failed to identify the measures implemented to prevent the spread of the infection and discussion/ recommendations to prevent future gastrointestinal outbreaks. The Infection Control Log for the month of March lacked the names of the resident's who suffered the gastrointestinal infection. On 06/16/09 at 9:30 a.m., an administrative staff member (#1) provided a list of sixteen residents who suffered gastrointestinal symptoms from March 24, 2009 - April 7, 2009. The administrative staff member (#1) stated the facility had reviewed the food items served for supper on 03/23/09, but felt the residents did not all consume a common food. During interview with an administrative dietary staff member (#13) following the dietary tour at 10:00 a.m. on 06/16/09 and at 4:00 p.m. on 06/16/09, the surveyor requested, but did not receive information regarding dietary involvement in the investigation of the gastrointestinal outbreak in March. During an interview at 4:15 p.m. on 06/15/09, an administrative staff member (#1) stated the facility had not contacted the state epidemiologist regarding the gastrointestinal outbreak.	F 441		
F 442 SS=F	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 442	To ensure that the facility initiates and implements necessary isolation precautions for resident# 9 and any other resident that may be affected, the	07/25/09

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F 442	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, review of professional reference, and staff interview, the facility failed to ensure initiation and implementation of isolation precautions for 1 of 1 facility resident suspected of having tuberculosis (TB) (Resident #9), for 4 of 4 days of survey. Failure of facility staff to initiate and consistently follow appropriate infection control practices for this resident placed all facility residents, staff, and visitors at risk for infection related to airborne transmission of this infectious organism. Findings include: The CDC (Centers for Diease Control) Infection Control in Health-Care Setting stated the following regarding TB (tuberculosis) elimination. "All health-care settings need an infection-control program designed to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed tuberculosis (TB) disease (or prompt referral of persons who have suspected TB disease for settings where persons with TB disease are not expected to be encountered). In order to be effective, the primary emphasis of the TB infection-control program should be on achieving these three goals. In all health-care settings, particularly those in which persons who are at high risk for exposure to Mycobacterium tuberculosis work or receive care, policies and procedures for TB control should be developed, reviewed periodically, and evaluated for effectiveness to determine the actions necessary to minimize the risk for transmission of M. tuberculosis.	F 442	facility is revising their TB exposure control plan using the latest 2009 edition of the "Infection Prevention Manual for Long Term Care" (see att. O). Employees will be in-serviced on the new policy and will review appropriate precautions to be implemented if this were to occur again. The housekeeping training program was revised to ensure appropriate orientation for required sanitation measures of the environment occurs (see att. I). Resident #9's care plan was updated to reflect appropriate interventions in the prevention of spread of infection to others. Signage was placed on resident #9's door to notify staff and visitors to check with nursing before entering so they could be instructed on necessary precautions to take to prevent the spread of infection. Resident #9 did complete appropriate follow-up as recommended by the facility Infection Control Practitioner and also an Infectious Disease Specialist of Altru Health Systems. Resident #9 had an Enhanced Chest CT scan on 6-25-09 and findings concluded there was no specific evidence for TB. On 7-8-09 resident	07/25/09 07/21/09 06/18/09 06/18/09 06/25/09 07/08/09

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F 442	Continued From page 58 The facility's policy, TUBERCULOSIS EXPOSURE CONTROL PLAN, dated 05/95 and reviewed on 06/15/09, stated, "I. PURPOSE: The purpose of this document is to review the mode and risk of tuberculosis (TB) transmission in our health-care facility and to reduce the risk of transmission to healthcare workers (HCW), patients, volunteers, visitors and other persons within our setting. II. GOAL: The goal of our program is to prevent the spread of tuberculosis by protecting susceptible people from inhaling airborne particles generated by infectious individuals. III. OBJECTIVES: (1). To follow recommended measures for early identification and management of patients with Tuberculosis . . . . IV. AUTHORITY AND RESPONSIBILITY: 1. Administration: The administrator is responsible for ensuring that exposure control standards are carried out as identified in the facility-wide policies and in the final rule and regulation. 2. Infection Control Coordinator [ICC]: The facility [ICC] is responsible for the implementation of the TB exposure control standard. In collaboration with administration, management and the employees, the ICC will provide direction and training relative to the implementation of the standard. The ICC will be responsible for: a. reviewing and updating the standard at least annually. . . . d. conducting on-going training with staff regarding the standard. 3. Infection Control Committee: The Infection Control Committee will be responsible for . . . recommending the implementation of the plan assisted by the ICC.	F 442	#9's PCP recommended the facility contact the State Health Department for further guidelines for treatment of TB prophylactically, the appropriate representative of the North Dakota Health Department was contacted and the following recommendations were received: given the fact this resident has not traveled outside of the country, has had prior negative tests and given his advanced age the ND Dept. of Health has chosen not to treat with INH because of the possible toxic side effects to the liver. No respiratory isolation is needed and it is ok for resident #9 to be in the general population, need to continue to monitor health with an annual x-ray, complete additional testing if we are suspicious of any further sx's that might suggest TB-the facility would then f-u with the North Dakota Department of Health for further guidance. Monitoring that these practices are followed will be completed by the DON and the CRA Coordinator /Housekeeping Supervisor weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The Administrator will be notified of any issues and	07/08/09 07/25/09

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F 442	Continued From page 59 4. Physicians and providers: The physician caring for the patient is responsible for communicating to the appropriate persons, (i.e., . . . nursing . . .) when he/she suspects or has confirmed the patient has an active M. tuberculosis disease. . . . 5. Department Managers, Directors, and Supervisors: Individuals functioning in these positions are responsible for ensuring the components identified in the TB Exposure Control Plan are in place and that the identified policies and procedures of the plan are being adhered to by employees. 6. Employees: The employees of [acute care facility] and Wedgewood Manor have the ultimate responsibility to participate in, comply with, and support the identified policies, principles, and procedures in this TB Exposure Control Plan. Employees have a right to have access to this information, education, and training programs. V. EXPOSURE CONTROL PLAN: . . . B. IDENTIFICATION, EVALUATION, AND TREATMENT OF PATIENTS WITH M. TUBERCULOSIS DISEASE: *The most important factors in preventing transmission of M. Tuberculosis are early identification of patients who may have infectious TB, prompt implementation of TB precautions for such patients, and prompt initiation of effective treatment for those who are likely to have TB. 1. Identifying patients who may have active TB: . . . b. Appropriate TB precautions and diagnostic measures should be instituted for patients in whom active TB is suspected. . . . a. INITIATION OF ISOLATION FOR TB: 1. Any patient suspected of having or known to have infectious TB (TB disease) will be placed	F 442	immediate corrective action will occur. A report will be submitted to the QA committee during the regularly scheduled monthly meeting.	

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F 442	Continued From page 60 in the TB Isolation room . . . and AIRBORNE PRECAUTIONS will be instituted. . . . b. TB ISOLATION (AIRBORNE PRECAUTIONS) PRACTICES: . . . 2. Patients placed in isolation should remain in their isolation rooms with the door closed at all times. . . . 4. The number of persons entering the isolation room should be minimal. 5. All persons entering the TB isolation room must wear respiratory protection. . . ." The facility's policy, Standard Precautions For All Patients, dated 05/96 and reviewed on 06/17/09, stated ". . . 3. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated equipment, mucous membranes and/or not-intact skin. 4. Wear face protections when spraying or splashing of blood, body fluids, excretions or secretions is likely. 5. Wear a gown when spraying or splashing of blood, body fluids, excretions or secretions is likely to contaminate work clothes. . . ." The facility's policy, Contact Isolation, undated, reviewed on 06/17/09, stated "Universal Precautions plus: . . . 7. Dedicate mopheads. . . ." The facility's policy, Airborne Isolation, undated, reviewed on 06/17/09, stated "Includes: 1. Tuberculosis, suspected or confirmed . . . *Requires Contact Isolation in addition to Respiratory Isolation. . . . Airborne Isolation, Standard Precautions plus: . . . 2. Close patient's door and anteroom door. . . . 7. Some staff and visitors may be restricted . Check with nurse before entering the room."	F 442		

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F 442	Continued From page 61 - During the initial tour, on 06/14/09 at 2:20 p.m., observation identified Resident #9's room on the resident care wing nearest to the nurse's station. All residents, staff, and visitors accessing the wing had to pass by Resident #9's room. Resident #9's room door was open to the hallway and without signage restricting entry or advising residents, staff, or visitors to contact the facility staff before entering. The surveyor, unaccompanied by facility staff, entered the room and observed the resident in bed. The resident was awake and his eyes followed the surveyor, but the resident did not verbally respond to the surveyor's greeting or introduction. Observation also identified two red covered containers in the room identified as "Linen" and "Garbage." The bathroom for the resident's room also included a separate door without a lock that allowed passage into an adjacent conference room. During interview following the initial tour, on 06/14/09 at approximately 3:30 p.m., a supervisory nursing staff member (#3) reported Resident #9 was hospitalized in 03/09 with a diagnosis of "pneumonia" and attributed the red covered containers, used for potentially infectious material, to the "pneumonia." This staff member also reported the resident required total assistance with personal cares, fed himself, and had no recent falls. This staff member failed to identify any current or suspected TB infection or infection control practices for Resident #9. On 06/15/09 at 9:20 a.m., random observation identified a certified nursing assistant (CNA) (#15) donned a protective gown, mask, and gloves and carried a meal tray containing disposable dishes into Resident #9's room. When the CNA emerged	F 442		

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from the room, during interview, she stated "Found out a couple weeks ago he [Resident #9] might have TB." The door to Resident #9's room remained open to the hallway and did not have signage restricting entry or advising anyone to contact the facility staff before entering.

During interview on 06/15/09 at 10:55 a.m., a supervisory nursing staff member (#3) reported Resident #9 had a positive "Mantoux" (TB skin test), the facility was working with an infectious disease specialist, and was going "through the motions" regarding further investigation of the TB diagnosis. The staff member (#3) reported a repeat Mantoux test was done "yesterday," (06/14/09).

Resident #9's medical record, reviewed June 15-17, 2009, identified the facility initially admitted the resident on 05/22/06. On 03/02/09 the facility discharged the resident to an acute care facility and re-admitted the resident on 03/07/09. The resident's significant change Minimum Data Set, dated 03/14/09, identified short and long term memory problems, moderately impaired daily decision making, and required extensive assistance of two or more persons for transfers, walk in room, and toilet use.

Resident #9's care plan, included a handwritten modification, undated, which stated "Problem . . . Questionable Mantoux results vs. sensitivity to preservative in shot. . . . Approach . . . Encourage resident to wear mask OOR [out of room] (resistive to same) until determination RT [related to] Mantoux resolved. Infectious disease M.D. being consulted RT Mantoux.;" and, handwritten dated 06/11/09, "Follow recommendations per infection control M.D.

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RPT [Repeat] Mantoux
Private room
Sputum culture x [times] 3
f/u [Follow up] chest film x 2 wks [weeks]
Follow protocol as he directed. . . ."

The resident's medical record included the facility's Immunization Consent/Record which identified a Mantoux test on 06/01/09 and read as "(+) Reaction" on 06/03/09; and a Mantoux test on 06/11/09 and read as "(+) Reaction" on 06/13/09.

The medical record included a handwritten communication to the physician, dated 06/13/09, signed by a supervisory nursing staff member (#3), which stated ". . . REASON FOR CONSULT: [Question mark] Positive repeat Mantoux. . . . I feel he has another questionable (+) reaction to (R) [right] inner forearm, 1 cm [centimeter] x [by] 0.75 cm Erythema/Induration. . . . Continues [with] moist non-productive cough. Has an order to obtain 3 sputum specimens for culture, but resident does not understand the steps to take to obtain an accurate sample. . . . [Physician] was called . . . Keep alone in room (resident), et [and] f/u [follow up] [with] [local physician] et [infectious disease specialist] on Monday [06/16/09]."

The resident's medical record included the following clinic note, dated 06/03/09: ". . . He had a recent chest x-ray on March 9th, which was normal. . . .;" Another clinic note, dated 06/04/09, identified a repeat chest x-ray and stated ". . . No evidence for tuberculosis as I read this; however, I will await the Radiologist's over read and we will behave in accordance with their findings. . . .;" and a Physician's letter, dated 06/16/09,

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F 442	Continued From page 64 summarizing the events from the initial positive Mantoux test, which stated ". . . Chest x-ray report . . . showed density in both bases . . . an infiltrate could not be excluded. . . . the 11th of June I did talk with [infectious disease physician specialist] and he recommended that since the question of tuberculosis has been raised and that it is possible in an elderly person that they could have a negative test by Mantoux and yet we should still be obligated with a patient that occasionally has a cough and has had questionable Mantoux and chest x-ray that we go ahead and err on the side of caution and try to obtain 3 acid fast bacilli sputum samples as well as keep the person in a private room. The nursing home was made aware of this on Thursday, the 11th of June and precautions have been taken. . . ." During interview, on 06/15/09 at 10:15 a.m., a housekeeping staff member (#16) working on Resident #9's care unit reported resident rooms are not cleaned in any sequence, but Resident #9's room is "usually last;" mopheads for Resident #9's room are bagged as contaminated isolation linen; and, gown, gloves, and mask are worn when cleaning Resident #9's room. This staff member reported the housekeeping staff does not use special cleaning sprays or solutions in Resident #9's room. During interview, on 06/15/09 at 11:10 a.m., a housekeeping management staff member (#6) reported the facility has instructed all housekeepers in special cleaning approaches required for Resident #9's room, including wearing gown, gloves, and mask and the use of "Cavi" cleaner specifically for TB. This staff member was uncertain if Resident #9's room should be cleaned last.	F 442		

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F 442	Continued From page 65 Observation, on 06/15/09 at 1:50 p.m., identified a CNA (#17) entered Resident #9's room to assist with cares. On entering the room, this staff member donned a protective mask, but failed to don a gown or gloves from the cart in the hallway outside the resident's room. Observation, on 06/15/09 at 3:45 p.m., identified a CNA (#8) entered Resident #9's room to respond to a bed alarm and provide cares. On entering the room, this staff member donned a protective mask and gloves and approximately three minutes later returned to the hall cart, donned a gown, and returned to the room. During interview, on 06/16/09 at 9:25 a.m., a housekeeping department staff member (#18) cleaning resident rooms on Resident #9's unit reported resident rooms are not cleaned in any sequence or order; cleaned depending on when residents are out of the rooms; gown, mask, and gloves are worn in Resident #9's room; separate mophead is not used in Resident #9's room; and a special cleaner is not used in Resident #9's room. The staff member was not aware of any recommended contact time for effectiveness of any cleaning product used and the staff member's training consisted of working with an experienced housekeeping department staff member. During interview, on 06/16/09 at 10:00 a.m., a housekeeping department staff member (#19) cleaning resident rooms not on Resident #9's unit reported she does clean resident rooms on Resident #9's unit; resident rooms are cleaned when residents are out of the rooms and not in any order or sequence; and a specific cleaner is not used in Resident #9's room. This staff	F 442		

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F 442	Continued From page 66 member identified cleaning products used in resident rooms, but not "Cavi;" and, a separate mophead is used in Resident #9's room. During interview, on 06/16/09 at 10:05 a.m., a housekeeping department staff member (#20) cleaning resident rooms not on Resident #9's unit reported she does clean resident rooms on Resident #9's unit; resident rooms are cleaned when residents are out of the rooms and not in any order or sequence; a specific cleaner is not used in Resident #9's room; and a separate mophead is used in Resident #9's room. On 06/16/09 at 10:15 a.m., two surveyors met with an administrative staff member (#1) and housekeeping management staff member (#6) to inform them of a lack of signage on Resident #9's room door advising anyone wishing to enter the room to contact the nursing staff. Also discussed were the inconsistencies in the interviews with housekeeping staff members #16, #18, #19, and #20 and #6 regarding the following: * failure to consistently clean Resident #9's room last; * keep the mopheads separate and handle as contaminated linen; * use "Cavi" cleaner for Resident #9's room; * awareness of contact time required for effectiveness of any cleaners used. The staff members (#1 and #6) agreed the above inconsistencies placed facility residents at risk for infection. At this time, as requested, these staff members agreed to provide immediate training to the housekeeping and other support staff on duty that may have contact with Resident #9; agreed to arrange training for housekeeping and other support staff having contact with Resident #9	F 442		

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F 442	Continued From page 67 before those staff came on duty; provide a list of all housekeeping staff employed by the facility; provide an orientation and training schedule for all future housekeeping staff hired by the facility; and provide copies of all agenda items, attendance rosters, and training materials used by the facility for the housekeeping staff in the past year. On 06/16/09 at 11:15 a.m., observation identified a facility staff member (#22) entering Resident #9's room with clean personal linen. This staff member failed to don a gown, a mask, or gloves. The facility staff did post a sign on the room door advising anyone entering the room to stop at the nurse's station. During interview, this staff member reported facility staff told her she did not need to use protective equipment to take the clean laundry into Resident #9's room. When questioned, the housekeeping management staff member (#6) reported this staff member (#22) returned to work that day after being off work for a period of time and she "didn't get to her yet" (regarding support staff education). The staff member (#6) agreed education of all facility staff and volunteers is important to reduce the risk for infection. On 06/16/09 at 5:20 p.m., a staff member (#6) provided a list of five housekeepers and their dates of hire. The list included staff member #16, #18, #19, and #20. The staff member also provided an agenda for a department meeting at 10:30 a.m. on 06/16/09 attended by the five housekeeping department staff members. At this time the staff member (#6) reported she was working on the orientation and training schedule for future hires which would be completed the next morning.	F 442		

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F 442	Continued From page 68 On 06/16/09 at 5:20 p.m., the staff member (#6) also provided Housekeeping Department meeting minutes as requested. The minutes for a meeting, dated 06/11/09 at 11:00 a.m., identified four housekeepers in attendance, including staff member #16, #18, and #19. The minutes stated: "1. Discussed room [Resident #9's] and the need to gown, glove and mask whenever entering the room until we know for sure. Follow isolation precautions. 2. Sterilizing mop handle with cavi-wipes [sic], change mop head and water when done in isolation room." The facility staff identified Resident #9 with a questionable positive Mantoux test on 06/03/09 and recommendations from the infectious disease specialist for management as a suspected case of TB on 06/11/09. The medical record identified the repeat Mantoux positive on 06/13/09. The facility staff failed to implement its Tuberculosis Exposure Control Plan on 06/11/09, including posting signage limiting access to Resident #9's room, keeping Resident #9's room door closed, ensuring facility nursing staff and housekeeping staff are aware of and consistently implemented specific restrictions and requirements of this Plan beyond Standard Precautions. Failure to implement its Plan, failure to follow its policies and procedures regarding Airborne Isolation, and failure to follow the CDC Guidelines placed all residents, staff, and visitors at risk for infection.	F 442		
F 445 SS=F	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 445	To ensure the facility is handling, processing, and transporting linen	

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	355087	A. BUILDING _____ B. WING _____	06/17/2009

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F 445	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, review of professional reference, and staff interview, the facility failed to ensure linens were handled, processed, and transported so as to prevent the spread of infection, on 4 of 4 days of survey. Failure to ensure soiled linens are handled with limited direct contact with facility staff clothing and collection bags are replaced when full increased the potential for spread of infection; failure to ensure the off site laundries launder and handle the linen properly, including linen from residents with known or suspected infections, placed all facility residents at risk for spread of infection; and failure to receive clean linen in an area without potential exposure to biohazardous waste placed all residents at risk of potential for spread of infection. Findings include: The National Institute for Occupational Safety and Health (NIOSH), Guidelines for Protecting the Safety and Health of Health Care Workers, dated September 1988 and reviewed on 06/17/09, stated, ". . . Hazardous Waste Disposal . . . Limited access to the storage area is recommended. . . ." The facility policy and procedure, Standard Precautions For All Patients, dated 05/96 and reviewed on 06/17/09, stated, ". . . 6. Handle contaminated patient care items and linen in a manner to prevent contamination of skin, mucous membranes, clothing, other patients and the environment. . . ."	F 445	appropriately to prevent the spread of infection an in-service will be held to instruct employees on the proper handling of linen and the need to empty linen hampers in a timely manner to prevent the spread of infection (see "Safe Handling Linen Policy" att. P). Bio-hazardous waste was moved to an isolated area where there will be no chance of contamination of linen (see Bio-hazardous Waste Policy att. Q). The CRA Coordinator/Housekeeping Supervisor and Maintenance will monitor that these interventions are being followed weekly x 1 month, monthly x 3 months and quarterly thereafter x 1 year. The Administrator will be notified of any issues and immediate corrective action will occur. A report will be submitted to the QA Committee monthly during the regularly scheduled monthly meeting.	07/21/09 07/17/09 07/25/09

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F 445	Continued From page 70 - During observation of resident cares in the facility's resident care A wing tub room, on 06/15/09 from 8:13 a.m. to approximately 8:35 a.m., the following were identified: * soiled linen hampers full and overflowing. * an unidentified staff member entered the tub room with soiled linen carried directly against her clothing and placed on top of the already overflowing hamper. * a certified nursing assistant (#10) entered the tub room with soiled linen carried directly against her clothing and placed it on top of the already overflowing hamper. - Review of Resident #2's medical record, on June 14-17, 2009, identified a urine culture positive for Methicillin Resistant Staph Aureus (MRSA) on 05/13/09. The facility placed the resident on Contact Isolation Precautions, which included separate handling of linen. Observation, on 06/16/09 at 9:05 a.m., identified the covered isolated contaminated linen hamper in Resident #2's room was overflowing and the lid could not be closed. At 9:25 a.m. an unidentified staff member emptied the overflowing linen hamper and, while making the resident's bed, placed the resident's pillows on the hamper cover. - On 06/15/09 at 11:00 a.m., observation in the facility's attached garage identified 22 boxes labeled "Biohazardous Material" stacked in a corner and the garage door open. A maintenance department staff member (#11), present at that time identified the covered cart he was handling contained "clean linen" delivered from an off-site laundry.	F 445		

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F 445	Continued From page 71 - During interview, on 06/15/09 at 11:10 a.m., a management staff member (#6) responsible for the facility's housekeeping and linen services reported the facility sends its laundry to two area hospitals. This staff member reported the linen from residents in isolation receives "special handling" regarding laundry services, but the staff member did not know what type of handling. This staff member reported she did not receive information from either laundry such as water temperatures, cleaning products used, documentation of cleaning product concentrations, cleaning methods for the laundry carts used, or any other information to ensure appropriate laundering of soiled and contaminated linen and applicable to the facility's quality monitoring process. This staff member reported she is notified if one of the laundries receives a type of item it should not be receiving. The facility staff's practice of continuing to add linen to the tops of full soiled and contaminated linen hampers; failure to empty full soiled and contaminated linen hampers; the staff's practice of carrying soiled linen in direct contact with their clothing; placing clean linen items on top of contaminated linen hampers; and receiving clean linen in an area containing biohazardous waste placed all facility residents, staff, and visitors at risk of potential for infection. Failure to obtain and maintain information regarding the handling of laundry, including contaminated linen, limited the facility's ability to ensure adequate and appropriate laundry practices to minimize the risk of potential for infection are being carried out.	F 445		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	To ensure the facility maintains clinical records for Resident #9, and all residents	

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F 514	Continued From page 72 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and review of professional standards, the facility failed to maintain clinical records in accordance with accepted professional standards and practices when facility staff back dated an entry in the medical record (care plan) for 1 of 12 sampled residents (Resident #9). Findings include: The Fundamentals of Nursing: Concepts, Process, and Practice 8th Edition by Berman, Snyder, Kozier and Erb copyright 2008 Pearson Education, Inc. stated the following regarding documenting and reporting on page 258, 260, and 262; "Because the client's record is a legal document and may be used to provide evidence in court, many factors are considered in recording. Health care personnel not only must maintain the confidentiality of the client's record but also meet legal standards in the process of recording." . . . "Notations on records must be accurate and correct." . . . "Don't alter a record even if requested by a superior or a physician."	F 514	records are in accordance with accepted standards and practices that are complete; accurately documented; readily accessible and systematically organized, the facility revised their care plan policy (see att. R) and late entry policy (see att. S). The "Care Plan Policy" and "Late Entry Policy" will be reviewed with the interdisciplinary team and all licensed nursing staff during the mandatory meeting. Monitoring will be completed by the DON or appropriate designee that care plans are updated appropriately and late entries are correctly documented. Monitoring will occur weekly x 4 weeks, monthly x 3 months, and than quarterly x 1 year. The Administrator will be notified of any issues. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee during the scheduled monthly meeting.	07/15/09 07/21/09 07/21/09

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F 514	Continued From page 73 - A copy of the care plan for Resident #9 received at 10:30 a.m. on 06/17/09, included a hand written entry dated 06/11/09, which stated, "follow recommendation per infection control MD [Medical doctor] *rpt [repeat] mantoux (a tuberculosis skin test) *private room * sputum cultures x [times] 3 * f/u [follow-up] chest film x 2 wks [weeks]. The above entry, with a date of 06/11/09, was not present on the copy of the same page of Resident #9's care plan provided by facility staff on 06/15/09 at 9:15 a.m. The entry, dated 06/11/09, occurred after 9:15 a.m. on 06/15/09 and was not identified as a late entry.	F 514		