| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355039 | A. BUILDING _____ B. WING _____ | 08/09/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GRIGGS COUNTY CARE CENTER | 1200 ROBERTS AVE NE COOPERSTOWN, ND 58425 |

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 08/06/18 and concluded on 08/09/18. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the | F 578 | | 8/27/18 |

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

Electronically Signed | 08/31/2018

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| F 578 | Continued From page 1<br>individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure the medical record for 1 of 16 sampled residents (Resident #9) accurately reflected the resident's Advanced Directive regarding code status. Failure to ensure the resident's medical record accurately reflected her wishes may prevent emergency personnel from knowing the resident's choices in the event of a medical emergency.<br><br>Findings include:<br><br>Review of Resident #9's medical record occurred all days of survey. Resident #9's hard copy medical record had a section titled "Advance Directive." A document, dated 02/15/18, titled "HCP [Health Care Provider] ORDERS for Life-Sustaining Treatment" stated, "Cardiopulmonary Resuscitation[CPR]: Person has no pulse and is not breathing." Directions on the form indicated to check one of the boxes. The boxes included "Attempt Resuscitation/CPR" or "Do Not Attempt Resuscitation/DNR [Allow Natural Death]." The facility failed to choose one of these options. The electronic medical record indicated "Do Not Resuscitate."<br><br>During an interview on 08/09/18 at 9:45 a.m., two | F 578 | F 578<br>1. The code status of resident #9 was verified and entered consistently into all relevant locations within the electronic medical record and paper chart on 8/10/18. Resident Care Coordinator educated and completed Resident #9 HCP Orders for Life Sustaining Treatment with Physician on 8/10/18. Admission Healthcare Provider Orders, HCP Orders for Life Sustaining Treatment Form and EMAR consistently state resident wishes Do not Resuscitate. Facility policy on Communication of Code Status implemented on 8/24/18.<br>2. Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents at the Griggs County Care Center have the potential to be affected<br>3. Facility policy Communication of Code Status implemented on 8/24/18 to adhere to residents□ rights. The facility will follow policy to communicate resident□s code status to all individuals who need to be informed of this information. The Director of Nursing Services educated Social Services and | |

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| F 578 | Continued From page 2<br>administrative nurses (#1 and #2) indicated they would expect one of the boxes on the HCP Orders to be checked to indicate the resident's wishes regarding CPR. An administrative nurse (#1) provided another document, dated 02/14/18, titled "ADMISSION HEALTHCARE PROVIDER ORDERS." Under the section "CODE STATUS," the box for DNR (Do Not Resuscitate) was marked for Resident #9. The administrative nurse (#1) also stated she would expect both forms and the electronic medical record to all be consistent with the same information of code status. | F 578 | licensed nurses regarding the documentation procedures for Advance Directives/code status at in-service on 8/27/18. Policy was reviewed. A chart audit of all residents was completed on 8/28/18. No discrepant findings were found. Education was provided to nursing staff at an in-service on 8/27/18. Policy was reviewed by staff.<br>4. For a period of three months, the Director of Social Services or designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident□s Advance Directive/code status throughout the paper chart and electronic medical record. After three months, the Director of Social Services will complete a random medical record audit of at least 10 records for consistent documentation. Results of the audits will be reviewed at the facility QI Committee meetings until such time it is determined that substantial compliance is maintained. Any problems with the Quality Assurance checks will be reported immediately to the appropriate supervisors so that correction/education can be performed, if needed. | |
| F 657 SS=F | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that | F 657 | | 9/13/18 |

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| F 657 | Continued From page 3<br>includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 15 of 15 sampled residents (Resident #3, #9, #11, #12, #15, #16, #17, #22, #23, #25, #26, #31, #32, #33, #36). Failure to review and revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident.<br><br>Findings include:<br><br>Review of the facility policy titled "COMPREHENSIVE CARE PLANS" occurred on | F 657 | F657<br>1. A. MDS coordinator will update all care plans going forward from 8/13/18 including Resident #3, #9, #11, #12, #15, #16, #17, #22, #23, #25, #26, #31, #32, #33, #36□s to reflect the current targeted goal dates for each goal to allow facility to monitor progress for each resident to achieve their goals. The MDS Coordinator was provided education on the revision/updating the target dates 8/13/18.<br>B. 1. Upon review of observation noted 8/7/18 at 0941 with resident #9 care plans were current and accurate. Nursing staff | |

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| F 657 | Continued From page 4<br>08/09/18. This policy, implemented on 11/28/17, stated "POLICY: To develop and implement a comprehensive person-centered care plan for each resident . . . includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . . . the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set [MDS] . . . will include objectives and timeframe's to meet the resident's needs as identified in the resident's comprehensive assessment . . . the objectives will be utilized to monitor the resident's progress . . . alternative interventions will be documented . . . the physician or professional will inform resident of the risks and benefits of proposed care . . . the facility will attempt alternate methods for refusal of treatment and document such attempts in the clinical record . . . "<br><br>Review of the facility policy titled "CARE PLANNING AND RESIDENT ASSESSMENT INSTRUMENT [MDS] occurred on 08/09/18. This policy, revised 08/24/09, stated, "POLICY: After a change of status is determined . . . the comprehensive care plan must be reviewed and revised as necessary . . . all care plans need to be evaluated and revised as the residents condition changes . . . updates are done quarterly and as needed [PRN] . . . "<br><br>Review of Resident #3, #9, #11, #12, #15, #16, #17, #22, #23, #25, #26, #31, #32, #33, #36's care plan showed the facility failed to review and revise the targeted goal dates for identified problem-focused areas on the current care plans. | F 657 | education provided to follow care cards and to notify supervisor if any questions.<br>2. Upon review of observation noted 8/7/18 at 1152 with resident #9 care plans were current and accurate. Nursing staff education provided to follow care cards and to notify supervisor if any questions.<br>3. Upon review of observation noted on 8/6/18 and 8/7/18 with resident 22 care plans were current and accurate. Nursing staff education provided to follow care cards and to notify supervisor if any questions. Heel boots immediately placed on resident while in bed.<br>4. Upon review of observations noted 8/6/18 at 1144 and 1445 Resident #17 care plan updated to indicate oxygen continuous per physicians orders.<br>5. Upon review of resident #12 medical record review on 8/9/18 care plan was updated to reflect diagnosis not diuretic on 8/21/18. Noted to have a duplicate entry on care plan and 1 stated diuretic use and 1 stated parkinsonism. Incorrect duplicate removed from care plan.<br>2. All residents at the Griggs County Care Center have the potential to be affected by this.<br>3. A. The facility□s MDS Coordinator and Interdisciplinary Team were provided education at in-service 8/27/18.<br>B. CNA□s were immediately provided education on following care cards and also provided education at in-service on 8/27/18.<br>4. MDS coordinator will review care | |

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| F 657 | Continued From page 5<br>Failure to update the target date for specific goals does not allow the facility to monitor the progress made by the residents to achieve their goals.<br><br>- An observation on 08/07/18 at 9:41 a.m. showed two certified nursing assistants (CNA) (#6 and #8) toileted Resident #9. One CNA (#6) communicated with the resident, via white marker board, not to bear weight on her left foot and pivot on her right foot. The CNA reported Resident #9 had fallen and broken her left hip in the last couple of weeks. With several prompts and extensive assist of two, the resident transferred from the wheelchair to the toilet and back to the wheelchair by pivoting on her right foot.<br><br>An observation on 08/07/18 at 11:52 a.m. showed two CNAs (#6 and #9) toileted Resident #9. The CNAs used physical cues to remind the resident not to bear weight on her left foot and pivot on her right foot. With several prompts and extensive assist of two, the resident transferred from the wheelchair to the toilet and back to the wheelchair by pivoting on her right foot.<br><br>Record review for Resident #9 occurred all days of survey. The care plan indicated ". . . Extensive assist of 1 staff with transfers, weight bearing as tolerated to right foot, left foot may touch the floor with no weight bearing. Pivot transfer . . ." The CNA care card stated ". . . Locomotion: Ext [extensive] x 1 . . . PIVOT TRANSFER ON RIGHT LEG ONLY TO WHEEL CHAIR . . ."<br><br>During an interview on 08/09/18 at 9:45 a.m., two | F 657 | plans daily for (2) weeks for those residents experiencing a change in status to ensure new or modified interventions have been addressed and documented regarding the resident□s care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and every other week for (1) month to assure the review and revision of care plans.<br>Results will be reviewed by the facility Quality improvement Committee until such time consistent substantial compliance has been achieved as determined by the committee. | |

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| F 657 | Continued From page 6 | F 657 | | |

administrative nurses (#1 and #2) reported it was difficult to transfer Resident #9 as she did not always follow instructions to be non-weight bearing on the left leg. The administrative nurse (#2) further stated she transferred the resident alone, however, it was difficult. She confirmed staff sometimes used two people to transfer due to it being difficult with only one. The care plan was not revised to reflect Resident #9's current need of transfers by two staff.

- Observations throughout the survey showed Resident #22 did not wear heel boots while in bed.

Observations on 08/06/18 and 08/07/18 showed staff checked and changed Resident #22 and failed to offer a urinal.

Record review for Resident #22 occurred all days of survey. The current care plan and CNA care card indicated "check and change every 2 hours. . . to offer urinal every 2 hours . . . Heel Protectors on in bed . . ."

During an interview on 08/09/18 at 9:45 a.m., two administrative nurses (#1 and #2) reported Resident #22 does not wear heel boots or use a urinal and the staff had not updated the care plan or CNA care card.

- Observation on 08/06/18 at 11:44 a.m. showed Resident #17 walking independently to the dining room with his walker. He received oxygen via NC from a Helios portable oxygen unit. The Helios unit was set to "CF" (continuous flow).

Observation on 08/06/18 at 2:45 p.m. showed

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| F 657 | Continued From page 7<br>Resident #17 in his room with the oxygen concentrator set at 3L. The resident stated he received 3L from the oxygen concentrator while in his room and set the Helios to CF while ambulating.<br><br>Review of Resident #17's medical record occured on all days of survey. A physician's order, dated 07/25/18, identified continuous O2 per NC at 3L. The care plan problem list included, ". . . at risk for decreased cardiac output . . . resident has shortness of breath . . ." Approaches listed on the care plan included ". . . administer oxygen at 2.5L/NC . . . administer oxygen at [sic] as ordered . . ."<br><br>During an interview on 08/09/18 at 9:45 a.m., two administrative nurses (#1 and #2) reported staff had not updated the care plan or CNA care card to reflect Resident #17 received 3L continuous oxygen via NC.<br><br>- Review of Resident #12's medical record occurred on 08/09/18. The current care plan stated, "Problem: . . . Risk for dehydration r/t [related to] diuretic [water pill] use . . ." Resident #12's physician's orders failed to include a diuretic. The facility failed to revise/update Resident #12's care plan to reflect current medications. | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure | F 684 | | 9/13/18 |

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| F 684 | Continued From page 8<br>that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 12 sampled resident (Resident #22) related to perineal skin care. Failure to provide skin care according to each resident's care plan has the potential to result in negative outcomes for residents.<br><br>Findings include:<br><br>Observation on 08/06/18 at 3:45 p.m. showed two Certified Nursing Assistants (CNA #3 and #4) used pre-moistened wipes to provide perineal care for Resident #22. The resident stated "ouch" multiple times during cares and observation showed no redness to the penis.<br><br>Observation on 08/07/18 at 11:09 a.m. showed a CNA (#6) and a licensed nurse (#5) used a cleanser with dry wipes to provide perineal care. Resident #22 said "ouch" multiple times during the cares and observation showed redness to the foreskin of the penis. The CNA (#6) reported Resident #22's care card stated staff should not use pre-moistened wipes because they cause irritation to the resident's skin.<br><br>Review of Resident #22's medical record occurred on all days of survey. The CNA care card stated "no tenna wipes/use dry wipes." Resident #22's care plan stated ". . . resident is at risk for skin breakdown . . . keep skin clean | F 684 | F684<br>1. Pre-moistened wipes were immediately removed from resident #22 bed side stand. CNA□s working 8/6/18, 8/7/18 and 8/9/18 caring for resident #22 were provided education on policy and to follow care cards/care plan.<br>2. All residents at the Griggs County Care Center have the potential to be affected by this.<br>3. All nursing staff were provided education during in-service by Director of Nursing on 8/27/18.<br>4. Quality Assurance monitoring will be done to ensure nursing staff are following care cards/care plans by randomly observing resident cares. CNA□s will be observed by DON, or designee. This QA monitoring will be done immediately upon competition of staff in-service randomly on each shift 5x week for 4 weeks then randomly on each shift 3x week for 4 weeks and then randomly on each shift weekly for 4 weeks. Results will be reviewed by the facility Quality improvement Committee until such time consistent substantial compliance has been achieved as determined by the committee. | |

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| F 684 | Continued From page 9<br>and dry as possible . . . observe skin with cares and report any signs of skin break down [sore, tender, red, or broken areas]. Weekly skin assessment by nurse . . . provide incontinence care after each incontinent episode . . . use moisture barrier product to perineal area PRN . . ."<br><br>During an interview with a staff nurse (#7) on 08/08/18 at 10:22 a.m., she stated CNAs are not to use pre-moistened wipes on Resident #22 and she expected the pre-moistened wipes to be removed from the resident's room. An observation at this same time showed pre-moistened wipes in the resident's bedside drawer.<br><br>During an interview on 08/09/18 at 9:45 a.m., two administrative nurses (#1 and #2) stated they expected the care plan and the CNA care card to match and CNAs perform cares based on the CNA care card. They expected staff to not use pre-moistened wipes and to remove the wipes from Resident #22's room. | F 684 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by: | F 695 | | 9/13/18 |

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| F 695 | Continued From page 10<br>Based on observation, record review, staff interview, and review of professional reference, the facility failed to provide the necessary care and services for 2 of 2 sampled residents (Resident #17 and #25) with orders for continuous oxygen. Failure to provide Resident #17 and #25 with continuous oxygen per physician's orders may result in increased shortness of breath and other respiratory conditions.<br><br>Findings include:<br><br>Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like many medications, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ."<br><br>- Review of Resident #25's medical record occurred on all days of survey. Diagnoses included: chronic obstructive pulmonary disease (COPD), history of pneumonia and shortness of breath. The current care plan stated "resident has shortness of breath R/T [related to] COPD, administer oxygen as ordered, monitor oxygen saturation via pulse oximetry as ordered, monitor and report signs of respiratory distress, monitor lung sounds PRN [as needed]." The physician order stated, "O2 [oxygen] 3L [liters] per NC [nasal cannula] continuous." The medical record lacked evidence of nursing assessments of lung | F 695 | F695<br>1. Resident oxygen flow rates immediately adjusted to correct flow rate ordered on resident #17 and #25. Respiratory therapy consulted re: Resident #17 and ordered a different portable tank Marathon to meet needs of resident.<br>2. All residents requiring oxygen at the Griggs County Care Center have the potential to be affected by this.<br>3. All nursing staff were provided education during in-service by Director of Nursing on 8/27/18.<br>4. Quality Assurance monitoring will be done to ensure nursing staff are following orders and Oxygen is administered at the correct flow rate. This QA monitoring will begin upon completion of staff in-service randomly on each shift 5x week for 4 weeks then randomly on each shift 3x week for 4 weeks and then randomly on each shift weekly for 4 weeks. Results will be reviewed by the facility Quality improvement Committee until such time consistent substantial compliance has been achieved as determined by the committee. | |

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| F 695 | Continued From page 11<br>sounds and oxygen saturations.<br><br>Observation on 08/07/18 at 10:19 a.m. showed Resident #25 in his room with oxygen at 3.5L per NC. A staff nurse (#7) entered Resident #25's room and stated she was unsure how many liters of oxygen the resident should be on. The staff nurse (#7) left the room, checked the physician's orders, and returned to change the oxygen to 3L.<br><br>Observation on 8/08/18 at 9:10 a.m. showed Resident #25 in his wheelchair. A staff nurse (#7) entered Resident #25 room, noticed the flow set at 2L and changed the rate to 3L.<br><br>During an interview on 8/07/08 at 10:19 a.m., a staff nurse (#7) stated Resident #25 is on "Three liters per nasal cannula continuous flow."<br><br>During an interview on 08/09/18 11:57 a.m., an administrative nurse (#1) stated Resident #25 should be on 3L of oxygen per NC continuous flow per physician orders.<br><br>The facility failed to consistently provide Resident #25 with oxygen at the ordered flow rate of 3L.<br><br>- Observation on 08/06/18 at 11:44 a.m. showed Resident #17 walking independently to the dining room with his walker. He received oxygen via NC from a Helios portable oxygen unit. The Helios unit was set to "CF" (continuous flow). The resident gasped for air and leaned on furniture and his walker. He stopped at the door to the dining room to ask for a chair to be brought to him as he struggled to go further.<br><br>Observation on 08/06/18 at 2:45 p.m. showed | F 695 | | |

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| F 695 | Continued From page 12<br>Resident #17's oxygen concentrator set at 3L while in his room. The resident stated he received 3L from the oxygen concentrator while in his room and set the Helios to CF while ambulating.<br><br>Record review occurred all days of survey for Resident #17. A physician's order for 3L continuous O2 per NC was dated 07/25/18. The CNA care card stated "O2 @ 3L cont. [continuous]."<br><br>In an interview on 08/09/18 at 9:45 a.m., two administrative nurses (#1 and #2) confirmed Resident #17 received 3L continuous oxygen via NC while in his room and while ambulating. They stated Resident #17 had the Helios unit set to CF when ambulating, however, they could not confirm how much oxygen the unit delivered at this setting. After a call to respiratory therapy, an administrative nurse (#1) reported the Helios unit Resident #17 used delivered 2L of oxygen when set to CF.<br><br>Failure to deliver oxygen as ordered may have resulted in Resident #17 experiencing increased shortness of breath. | F 695 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. | F 880 | | 9/13/18 |

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| F 880 | Continued From page 13<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility | F 880 | | |

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| F 880 | Continued From page 14<br>must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>HAND HYGIENE/GLOVE USAGE<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/20/17.<br><br>1. Based on observation, review of facility policy, and staff interview, the facility failed to follow proper hand hygiene and glove usage for 3 of 15 sampled residents (Resident #22, #26, and #36) observed during personal cares and 3 random observations of water distribution. Failure to practice infection control related to hand hygiene/glove usage has the potential for transmission of communicable diseases and infections to residents and staff.<br><br>Finding include: | F 880 | F880<br>1. A. CNA□s # 4 and #12 were provided immediate education by the facility DON and Infection Control Nurse re: proper hand hygiene and proper glove use per Griggs County Care Center Policy. CNA #11 was also provided immediate education to prompt/remind resident to wash hands after toileting and doing perineal hygiene per self. Staff were immediately provided education by Infection Control Nurse regarding proper hand hygiene while doing fresh water pass.<br>B. Fan was immediately removed and cleaned and Maintenance department staff was immediately provided education | |

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| F 880 | Continued From page 15<br>Review of the facility policy titled "Handwashing" occurred on 08/09/18. This policy, revised on 01/26/18, stated, ". . . recommended to use hand sanitizer . . . before and after assisting a resident/patient with toileting . . . after performing personal hygiene actions . . . after removing gloves . . ."<br><br>- Observation on 08/06/18 at 3:45 p.m. showed a Certified Nursing Assistant (CNA) (#4) provided perineal care to Resident #22 after an incontinent bowel movement. The CNA (#4) removed her gloves after perineal care, transferred the resident to his wheelchair, and placed hearing aid in ear. The CNA (#4) failed to perform hand hygiene after removing her gloves and prior to completing other tasks.<br><br>- Observation on 08/08/18 at 2:15 p.m. showed a CNA (#12) provided perineal care after Resident #26 had a bowel movement. The CNA (#12) removed her gloves and assisted another CNA (#11) to transfer the resident with a mechanical sit-to-stand lift to her wheelchair. The CNA (#12) adjusted Resident #26's clothes, applied foot pedals to the wheelchair, and then performed hand hygiene. The CNA (#12) failed to perform hand hygiene after removing her gloves and prior to completing other tasks.<br><br>- Observation on 08/08/18 at 2:30 p.m. showed Resident #36 provided her own perineal cares after going to the bathroom. A CNA (#11) assisted the resident off the toilet and into her wheelchair. The CNA failed to prompt or encourage Resident #36 to wash her hands after the resident provided her own perineal cares. | F 880 | on proper procedure for fan cleaning by Maintenance supervisor and Infection Control Nurse. Lint was immediately cleaned from dryer and Laundry staff was provided education on proper procedure and daily schedule for removing lint from dryer. Education also provided on proper fan use near clean laundry by Laundry Supervisor.<br>2. A. All residents at the Griggs County Care Center have the potential to be affected by this.<br>3. A. All staff were informed of findings and provided education at an in-service on 8/27/18 regarding the proper procedure of hand hygiene/ handwashing and proper glove use. This was provided by reviewing the policy, demonstration and providing staff with a brochure resource Hand Hygiene When and How from the World Health Organization.<br>B. All staff were informed of findings at staff inservice on 8/27/18. Education provided by Infection Control nurse and DON on proper procedure for fan cleaning/schedule, on proper procedure and daily schedule for removing lint from dryer. Education also provided on regulations and proper fan use near clean laundry. Policies were reviewed.<br>4. A. Quality Assurance monitoring will be done to ensure proper handwashing/hand hygiene techniques are being followed by CNA□s by randomly observing CNA□s providing cares by the facility DON or designee. This monitoring will be done upon completion of staff in-service and will be | |

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| F 880 | Continued From page 16<br>During an interview on 08/09/18 at 12:00 p.m., an administrative nurse (#2) stated she expected staff to use hand sanitizer after removing their gloves.<br><br>- Observations throughout the day on 08/08/18 and 08/09/18 showed three unidentified staff members entered multiple resident rooms with fresh water mugs and exited with the old water mug. The staff failed to sanitize their hands between the handling of clean and dirty water mugs.<br><br>During an interview on 08/09/18 at 9:45 a.m., an administrative nurse (#2) reported she expected staff members to gather all the dirty water mugs from a wing, sanitize their hands, and then deliver clean water mugs. The administrative nurse (#2) confirmed the staff failed to follow the process of delivering water and proper infection control.<br><br>ENVIRONMENT<br><br>2. Based on observation, review of facility policy, and staff interview, the facility failed to maintain a clean, safe, and sanitary environment in 1 of 1 laundry room. Failure to clean oscillating fans and maintain facility dryers per manufacture's instructions has the potential to result in an unsafe and unsanitary environment.<br><br>Review of a facility policy titled "Maintenance of Alliance Laundry Dryers" occurred on 08/09/18. This policy, dated 07/31/17, stated, ". . . follow the attached instructions for maintaining the Alliance Laundry Systems dryers and will follow the instructions in the Alliance Laundry Systems | F 880 | done randomly on each shift 5x/week for 2 weeks, then randomly 3x/week for 2 weeks, then weekly for 4 weeks and then monthly for 2 months. If any problems are found with the QA audits the CNA will be educated immediately and the process with be corrected at that time. Appropriate supervisors will be notified of problem so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed by the facility Quality Improvement Committee and determination of further monitoring will be made by the Committee.<br>B. Quality Assurance audits will be completed by the Laundry department supervisor, or designee to ensure that dryer lint compartment/screen is cleaned appropriately on a daily basis and that documentation indicates completion each day. Quality Assurance audits will also be completed to ensure fans are being cleaned weekly and documentation indicates completion. This QA monitoring will begin immediately following the in-service 8/27/18 and will be done 5x/week for 2 weeks, then 3x a week for 2 weeks, then weekly for 4 weeks and monthly for 2 months. If any problems are found with the QA audits staff will be educated immediately and the process with be corrected at that time. Appropriate supervisors will be notified of problem so that additional correction/education can be performed, if needed. Results of all monitoring will be reviewed by the facility Quality | |

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| F 880 | Continued From page 17<br>Operations/Maintenance Manual for recommended routine maintenance. These instructions include guidelines for daily removal of lint from the lint compartments. . . . required to sign off on the appropriate daily check off sheets in the department to indicate the lint removal has been done for the day."<br><br>A tour of the laundry room occurred on 08/09/18 at 12:30 p.m. with a staff member (#10) and an administrative nurse (#2). Observation showed two large dryers and, upon removal of the vent covers, a thick layer of lint laid on the floor of both dryers. When asked how often staff removed the lint from the dryer vents, the staff member (#10) stated it should be done daily. The staff member (#10) referenced the "Alliance Drier Daily Check List" hanging above each dryer. He stated staff members initial the check list each day the dryers are cleaned. The check list failed to show staff members removed the lint daily.<br><br>Observation showed a dirty oscillating fan blowing over the clean laundry area. When asked how often the fan was cleaned, the staff member (#10) stated the fan is only cleaned when laundry staff submit a request for cleaning. | F 880 | Improvement Committee and determination of further monitoring will be made by the Committee. | |