STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 01/13/20 and concluded 01/16/20.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		2/20/20

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

Electronically Signed | 02/12/2020

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F 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy, and staff interview, the facility failed to provide the Office of the State Long Term Care (LTC) Ombudsman a written notice of transfer, including the destination, the reason for transfer, and the resident's right to appeal the action for 1 of 4 residents (Resident #285) transferred to the hospital. Failure to provide a notice of transfer or discharge does not allow the Ombudsman to know who is being transferred so assistance may be provided to the resident if needed. Findings include:	F 623	1. Resident #285 had an Ombudsman notification sent on 1/15/20. 2. All residents who have a transfer to the hospital can be affected by this deficiency and will be observed to ensure the Ombudsman receives a notice of transfer. 3. Education was provided by the Director of Nursing to all nurses at the 2/13/20 staff meeting, and Social Services and the staff in accounts payable/resident trust on 2/10/20 about the policy titled, Transfer and Discharge (Including AMA) to ensure the notice of	

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F 623	Continued From page 3 Review of the facility policy titled "Transfer and Discharge (including AMA [against medical advice])" occurred on 01/16/20. This policy, revised 01/02/17, stated, ". . . Emergency transfer procedures should include the following: . . . c. Nursing should complete and send with the resident the following forms: iii. Notice of Transfer to Hospital- authorizes transfer and provides resident rights information. . . . h. A copy of the notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman. . . ." Review of Resident #285's medical record occurred all days of the survey. The progress notes indicated Resident #285 was hospitalized from 11/14/19 to 11/17/19. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for this hospitalization. During an interview on 01/15/20, at 10:10 a.m., an administrative staff member (#5) verified a notice of transfer to hospital form was not sent to the State LTC Ombudsman. The facility failed to provide the State LTC Ombudsman with a written notice of transfer for Resident #285.	F 623	transfer documentation is completed and the business office□s involvement with notifying the Ombudsman of resident transfers. 4. Monitoring of notification to Ombudsman will be done by accounts payable/resident trust personnel or the Director of Nursing. This will include Resident #285 and all residents within a week look back from the monitor date. Auditing will start on 02/14/20, daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the Director of Nursing and quality assurance committee for review.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		2/20/20

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F 640	Continued From page 4 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,	F 640		

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F 640	Continued From page 5 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to complete and submit an Omnibus Budget Reconciliation Act of 1987 (OBRA) required tracking record for 1 of 2 residents (Resident #1) closed record review who died in the facility. Findings include: The Long-Term Care Facility RAI Manual, pages 2-10, 2-14, and 2-36, stated, ". . . Death In Facility refers to when the resident dies . . . The facility must complete a Death in Facility tracking record. . . . OBRA-Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes . . . Must be submitted within 14 days after the resident's death . . ." Review of Resident #1's medical record occurred on January 14, 2020. The medical record identified the resident died in the facility on 09/18/19. Review of the MDS records completed for Resident #1 showed the facility failed to complete a Death in Facility Tracking Record within seven days. Failure to complete the Death in Facility Tracking Record also resulted in a failure to submit the tracking form within 14 days. During an interview on 01/14/20 at 3:00 p.m., a	F 640	1. A death in facility MDS was done for Resident #1 on the 14th of January 2020. 2. All residents that have a death in the facility can be affected by this deficiency and will be observed to ensure a Death in Facility Tracking Record and Tracking Form were created. 3. Education was provided by the Director of Nursing to both MDS nurses on doing a Death in Facility MDS and Tracking Form by 2/13/20 by reviewing the RAI manual pages 2-10, 2-14, and 2-36. They will also receive a HealthCare Academy education course titled, MDS 3.0 Certificate Program: Section A: Identification Information which will be completed by 2/20/20. 4. Monitoring for ensuring MDS Death in Facility Tracking Record and Tracking Form are completed correctly prior to submission will be done on all residents who have a death in the facility with a look back from the audit date and done by the MDS nurse and then by the Director of Nursing starting 2/14/20 weekly for 4 weeks, then monthly for 3 months, then quarterly three times. All results will be taken to the Director of Nursing and the quality assurance committee for concerns.	

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F 640	Continued From page 6 nurse manager (#2) confirmed staff failed to complete the MDS for Death in Facility for Resident #1.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 01/04/19 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 19 sampled residents (Resident #35 and #41). Failure to accurately complete Section J (Health Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: - The Long-Term Care Facility RAI User's Manual, revised October 2019, page J-2, stated, ". . . Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen . . . Code 0, no: if the medical record does not contain documentation that a scheduled pain medication was received. Code 1, yes: if the medical record	F 641	1. Resident #35 J0100C quarterly MDS dated 11/09/19 was changed to code no on 2/10/20. Resident #41 on J0100A quarterly MDS dated 11/19/19 had corrections done to J0100A coded yes on 1/16/20. 2. All residents with pain have the possibility to be affected by this deficiency. 3. Education will be provided individually to the two MDS nurses on reading the RAI manual pages J-2 and J-3 by 2/13/20. The two MDS nurses will also be provided education from HealthCare Academy modules titled, MDS 3.0 Certificate Program: Section J: Health Conditions with completion by 2/20/20. 4. Monitoring for ensuring MDSs sections J0100A and J0100C are completed correctly prior to submission will be done on Resident #35 and Resident #41 and four other residents in a week look back period by the MDS nurse and then by the Director of Nursing starting 2/14/20. These audits will be done weekly for 4 weeks, monthly for 3 months, then quarterly three times. All	2/20/20

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F 641	Continued From page 7 contains documentation that a scheduled pain medication was received. . . ." Review of Resident #41's medical record occurred on all days of survey. Section J0100A on the quarterly MDS, dated 11/19/19, indicated no scheduled pain medications given to the resident; however, the resident's electronic medication administration record (eMAR) indicated the Resident #41 received scheduled Tramadol (pain medication) for pain four times a day on each day of the look back period - November 15-19, 2019. During an interview on 01/16/20 at 9:17 a.m., an MDS Coordinator (#3) confirmed Resident #41 received scheduled Tramadol on all days during the look- back period of the 11/19/19 quarterly MDS, and also confirmed staff coded section J0100A inaccurately on this MDS. - The Long-Term Care Facility RAI User's Manual, revised October 2019, pages J-2 and J-3 stated, ". . . J0100: Pain Management . . . There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted. . . . Coding Instructions for J0100C, Received Non-medication Intervention for Pain. Code 0, no: if the medical record does not contain documentation that a non- medication pain intervention was received. Code 1, yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy. . . ."	F 641	results will be taken to the Director of Nursing and QA committee for concerns.	

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F 641	Continued From page 8 Review of Resident #35's medical record occurred on all days of survey. The quarterly MDS, dated 11/09/19, showed staff coded section J0100C for receiving a non-pharmacological pain intervention within the 5-day look-back period. The current care plan stated, ". . . Pain . . . Attempt to redirect resident's focus on pain and offer activity services and other tasks to keep preoccupied. . . . Evaluate effectiveness of pain management interventions. . . ." A Nursing Rehab Time Log showed Resident #35 received 15 minutes of rehab activity on 11/07/19 at 1:32 p.m. Documentation showed staff failed to evaluate the effectiveness of the 15 minute non-pharmacological pain intervention. A Progress Note, dated 11/07/19 at 3:50 p.m., identified the resident complained of a headache during an activity, staff administered an as needed (PRN) medication, sent the resident back to the activity, and evaluated the effectiveness of the PRN medication, but failed to evaluate the effectiveness of the activity intervention. Review of the Point of Care History Report showed various activities the resident attended but failed to identify the activities' effectiveness on the resident's pain. The facility failed to evaluate the effectiveness specifically related to non-pharmacological interventions in order to correctly code J0100C.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		2/20/20

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F 658	Continued From page 9 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice regarding medication administration for 1 of 2 residents (Resident #18) who received insulin. Failure to follow physician's orders and correctly document insulin administration, may result in an adverse reaction and/or ineffective management of a resident's condition. Findings include: Review of the facility policy titled "Administering Medications" occurred on 01/16/20. This policy, revised April 2019, stated, ". . . Medications are administered in accordance with prescriber orders . . . As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medications was administered; b. The dosage . . . ." Review of Resident #18's medical record occurred on all days of the survey. The medical record identified a diagnosis of Type 2 diabetes mellitus and physician's orders for the following: * "Novolog Per Sliding Scale TID [three times a day] with meals. . ." * "Novolog 10 units scheduled with meals (hold if blood sugar less than 80 [mg/dl] . . ."	F 658	Part 1 1. Resident #18 did not have observed side effects from insulin administration. 2. All diabetic residents have the possibility to be affected by this deficiency. 3. All nursing staff was educated at the 2/13/20 nurses meeting on manufacture guidelines of Novolog insulin sliding scale administration, review policy titled Administering Medications, and how to document sliding scale administration. 4. Audits on insulin documentation in relationship to residents blood sugars will start 2/14/20 and be done by the nurse managers or Director of Nursing on Resident□s #18 and five other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All results will be taken to the QA committee for concern review. Part 2 1. Resident #41□s Colestipol was reviewed by the consulting pharmacist on 1/17/20 and the physician ordered on 1/23/20 to give Colestipol one hour prior to other medications. 2. All residents have the possibility to be affected by this deficiency if they are on	

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F 658	Continued From page 10 Review of Resident #18's electronic medication administration record (eMAR) dated, 12/01/19 to 01/15/20, identified Resident #18 received 10 units of Novolog as scheduled with breakfast on two occasions when blood sugars were less than 80 mg/dl on two occasions. Documentation indicated nursing staff administered greater than 10 units of Novolog as scheduled with meals on nine separate occasions. During an interview on 01/16/20 at 12:30 p.m., a nurse (#10) confirmed she documented both the scheduled and sliding scale doses together in the same box on Resident #18's eMAR, because she thought this dose box was for the total Novolog dose given. During an interview on, 01/16/20 at 8:20 a.m., an administrative nurse (#11) stated she expected the nursing staff to document the sliding scale doses and scheduled doses separately on the eMAR. Administrative nurse (#11) also stated she expected nursing staff to follow Resident #18's physician orders and hold the scheduled Novolog for a blood sugar less than 80 mg/dl. The facility failed to follow Resident #18's physician ordered blood sugar parameters and failed to document the scheduled and sliding scale doses of Novolog separately on his eMAR. 2. Based on record review and staff interview, the facility failed to accurately transcribe the consultant pharmacist's recommendations for 1 of 5 sampled residents (Resident #41) reviewed for unnecessary medications. Failure to ensure the pharmacist's recommendations are accurately transcribed/followed may result in	F 658	Colestipol. No other residents in the facility are on Colestipol. 3. All nursing staff and medication aids were educated at the 2/13/20 nurse meeting by the Director of Nursing on the importance of Colestipol timing and the pharmacist medication regimen review involving Colestipol, with a focus on medication timing. 4. Audits on Colestipol administration given alone one hour to other medications will start on 2/14/20. This audit will be done by the nurse managers or Director of Nursing and include Resident #41 and any other resident□s on Colestipol. This will be done daily Monday through Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the Director of Nursing, consulting pharmacist, physician, and quality assurance committee.	

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F 658	Continued From page 11 adverse medication interactions and/or decreased effectiveness of the medications. Findings include: Review of Resident #41's medical record occurred on all days of survey. The consultant pharmacy medication regimen review (MRR), dated 11/11/19, stated, ". . . MEDICATION(S) INVOLVED: COLESTIPOL [to help decrease cholesterol] . . . IRREGULARITY OR COMMENT(S): To minimize drug interactions, administer other drugs at least 1 hour before or at least 4 hours after colestipol. . . . Nursing staff to address ASAP [as soon as possible] but no later than 30 days. . . ." The MRR contained a hand written notation which read, "updated in the eMAR 11/22/19". An administrative staff member (#1) signed/dated the form 11/25/19, indicating review of the MRR. Resident #41's eMARs dated 11/22/19 to 01/15/20, identified, ". . . colestipol . . . Special Instructions Medication must be administered one hour before or 4 hours after meals for best absorption. . . . Start . . . 11/22/2019 . . ." Observation on 01/16/20 at 7:16 a.m., showed a medication assistant (MA) (#4) administered all of Resident #41's scheduled morning medications, including the colestipol, at the same time. Facility staff failed to accurately transcribe the pharmacist's recommendation's on Resident #41's eMAR, which resulted in a medication error.	F 658		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		2/20/20

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	355063	A. BUILDING _____ B. WING _____	01/16/2020

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F 812 SS=E	Continued From page 12 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's labeling, review of facility policy and staff interview, the facility failed to properly store food, fluids, and supplements in 4 of 5 food service areas (Household Units 1, 2, 3, and 4 Kitchenettes). Failure to identify the expiration dates of protein based supplements, to label opened time sensitive fluids, to label/date prepared trays, and to dispose of expired food items has the potential to result in altered potency of the supplements and foodborne illnesses. Findings include:	F 812	1. All items found to be outdated or expired and not labeled or dated were removed from facility refrigerators on units 1, 2, 3, 4 on 1/16/20. Policy titled, “Food purchasing receiving and storage” reviewed thawing of custard and was enacted to serve frozen, per manufacturer labeling starting 1/16/20 date of survey. 2. All residents who use or receive items from facility refrigerators on units 1, 2, 3, and 4 have the possibility of being affected by this deficiency. 3. Education was provided to dietary personnel by the dietary manager on	

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F 812	Continued From page 13 * Review of the facility policy titled "Food Purchasing, Receiving and Storage" occurred on 01/16/20. This policy, dated 12/19/19, stated, ". . . Refrigeration and Frozen Storage: . . . 10. Frozen supplements will have the date that they are taken out of the freezer on the item. . . . If there is no discard date, staff should follow the 5 day rule for discarding items. . . . Food Storage on Households: . . . c. Open food and beverages must be labeled, dated and placed in the refrigerator after opening or preparing and should be discarded after 5 days. e. (sic) Food items found in the refrigerator without a label or date will be discarded to prevent potential foodborne illness from occurring. e. Supplements should be labeled and dated after opening and discarded according to package specifications as they are varied. f. other opened containers must be dated, covered and labeled during storage. . . ." * The manufacturers' label for Hormel Solutions a custard supplement stated, "keep frozen." * Review of the manufacturers' label for the thickened beverages stated, "Discard if not used within 10 days of opening." Observations during the dietary tour on 01/16/20 at 9:35 a.m. with a dietary staff member (#6) showed the following thawed, undated, unlabeled, and expired items: - Unit One: three containers of Hormel Solutions Custard not dated when thawed. - Unit Two: tray of food in the refrigerator undated and unlabeled. - Unit Three: three prepackaged hard-boiled eggs dated "1/10", two yogurts expiration date 12/03/19 (44 days past), and two yogurts	F 812	1/20/2020 with a review of CMS regulation F812- 483.60(i)(2) to Store, prepare, distribute and serve food in accordance with professional food service safety. Dietary Employees will again receive education on 2/17/2020 by the dietary manager on the CMS regulation F812-483.60(i)(2) and policy titled, “Food Purchasing Receiving and Storage”. 4. Audits to ensure foods/fluids are labeled and dated after opening and foods/fluids are disposed of by their use by/expiration dates and supplements are used/stored according to manufacturer’s guidelines will be started 2/14/20 daily Monday to Friday for 2 weeks, 2 times weekly for 1 month, 1 time weekly for 2 months, monthly for two months, and 6 times quarterly for 3 quarters. These audits will be performed by the Certified Dietary Manager, Dietitian or designee. All information gathered during these monitors will be shared and discussed during our monthly quality meetings, with Dietary Employees at monthly meetings, and quality assurance as needed.	

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F 812	Continued From page 14 expiration date 12/30/19 (17 days past). - Unit Four: One undated thickened water and one undated thickened orange juice. During the tour, the dietary staff member (#6) identified she expected staff to label the thaw date on the Hormel Solutions Custard, to label the tray with a date and resident's name, to have discarded the hard boiled eggs on 01/15/20, to have discarded the expired yogurts, and to label the thickened beverages when opened. The staff member (#6) identified unless specified by the manufacturers' label opened foods/fluids should be discarded after five days.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880		2/20/20

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F 880	Continued From page 15 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 16 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview, the facility failed to ensure staff followed standard infection control practices regarding care of a urinary drainage system for 1 of 2 residents (Resident #57) with catheters observed during cares. Failure to maintain the connection of the catheter with the leg drainage bag may contribute to development of a urinary tract infection (UTI), for this resident with a history of UTIs. Findings include: Review of the facility policy titled "Catheter Care, Urinary" occurred on 01/15/20. This policy, dated September 2014, stated, ". . . General Guidelines . . . If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. . . . Changing Catheters 1. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. . . ." Review of the facility policy titled "Urinary Leg Drainage Bags" occurred on 01/15/20. This policy, dated October 2010, stated ". . . Wipe the	F 880	1. Resident #57 was reviewed on 1/27/20 and the Foley catheter was intact and remains free of signs and symptoms of a urinary infection. Resident #57 was ordered a one-piece catheter bag and coude that reduces the chance for disconnection. 2. All residents have the possibility to be affected by this deficiency who have a Foley catheter. 3. All nursing staff was educated at the 2/13/20 nurse meeting by the Director of Nursing on the policy titled, Urinary Leg Drainage Bags with a focus on areas of sanitizing the Foley connection ports prior to re-connecting. 4. Audits on needs for Foley catheter handling will start on 2/14/20. This audit will be done by the nurse managers or Director of Nursing and include Resident #57 and all other resident□s with catheters daily Monday through Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the director of nursing, infection control nurse, and quality assurance committee.	

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F 880	Continued From page 17 Foley catheter/drainage tubing junction with alcohol before disconnecting. . . .Wipe the connection tip of straight drainage tubing with alcohol wipe. If there is reason to believe the integrity of the system has not been maintained, obtain new drainage bag. . . . Reconnect system. . . ." While observing cares for Resident #57 on 01/13/20 at 1:50 p.m. the catheter drainage system became discontinued three times. The first time the system came apart with the drainage bag in the bed, the certified nurse aide (CNA) (#8) reconnected the drainage bag with out cleansing of the port. The second time it came apart the drainage bag fell to the floor and the CNA (#8) was going to reattach at the connection, and this surveyor stopped the CNA (#8). The nurse (#7) obtained a new drainage bag and connected it per policy. The two staff members (#7 and #8) continued care, for the third time, the system came apart with the drainage bag falling on the floor again. The nurse (#7) obtained a bag and connected it per policy. During an interview on 01/15/20 at 12:22 p.m., an administrative nurse (#1) stated "the sterility of the system should be maintained."	F 880		