STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355080	A. BUILDING _____ B. WING _____	11/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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 11/08/09 and completed on 11/10/09 the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	F-Tag 241 #1 The w/c cushions for resident #2 & #8 have been cleaned. #2 All residents who use w/c's have the potential to be affected by this deficient practice. #3 Nursing staff will be inserviced on the changes in the Perineal Policy that requires that all w/c's be clean & dry when a resident is seated in it. The night cleaning schedule will include washing the w/c cushion along with the w/c. QA studies will be completed to ensure continued compliance. #4 This deficiency will be corrected by Dec. 11, 2009	
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 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 and staff interview, the facility failed to provide care in a manner which promotes resident dignity for 2 of 5 sampled residents (Resident #2 and #8) who were dependent on staff for personal hygiene. Findings include: - Observation on 11/09/09 at 8:35 a.m., showed a CNA (#5) donned a mask and gloves, entered Resident #2's room, and assisted her into the bathroom. Observation showed the resident's pajama bottoms visibly wet with urine. The CNA removed the wet clothing and the saturated brief while Resident #2 sat on the toilet. Observation showed Resident #2's removable wheelchair cushion and the chair pad alarm wet with urine. The CNA (#5) dressed Resident #2 in dry clothing and assisted her back to the wheelchair without first cleaning and drying the cushion.	F 241		

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

Gerald Brenna, Nursing Home Administrator | 12/7/09

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 241	Continued From page 1 - Observation on 11/09/09 at 4:20 p.m., showed two CNA's (#9 and #10) utilized a PAL lift (a sit to stand mechanical lift) and transferred Resident #8 from her wheelchair to the toilet. Observation showed the resident's pants visibly wet with urine and the CNA (#10) removed her dry brief and wet pants. Observation showed Resident #8's removable wheelchair cushion wet with urine and smelled of urine. CNA (#10) dressed the resident in a new brief and dry pants. The CNAs (#9 and #10) utilized the PAL lift and transferred Resident #8 back to the wheelchair without first cleaning and drying the cushion. These observations showed facility staff failed to treat Residents #2 and #8 as individuals who deserved the dignity and respect necessary to prevent them from sitting on wheelchair cushions that smelled of urine. An interview with an administrative nurse (#1) took place on the morning of 11/10/09 regarding the soiled wheelchair cushions. She stated her expectation would be that facility staff remove and clean the cushions prior to placing the residents back in their wheelchairs..	F 241	#5 Cna's will be observed doing peri-cares. They will be checked that the w/c cushion is clean & dry before allowing the resident to sit back down on it. The DON/ designee will check 4 different CNA's performing perineal care on a resident with a w/c cushion each week for 4 weeks and then weekly till 100% compliance is reached; then monthly till 100% compliance is reached for 2 months. These results will be reviewed at the regularly scheduled QA mtg. F-Tag #279	
F 279 SS=D	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.	F 279	#1 A comprehensive care plan and care card has been developed to address MRSA precautions for resident #2 and #7. #2 All Residents admitted to the facility or returning from a hospital stay have the potential to be affected by this deficient practice.	

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F 279	Continued From page 2 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 §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, facility policies and procedures, and staff interview, the facility failed to develop and review/revise the residents' comprehensive plans of care to address Methicillin Resistant Staphylococcus Aureus (MRSA) for 1 of 1 sampled resident (Resident #7). Failure to develop, and review/revise the resident's care plan limits the staffs' ability to communicate changes in the resident's status and care, and to ensure continuity of resident care. Findings include: Review of the facility policy titled "Infection Control Policies", occurred11/10/09. This policy, dated 1996, stated; "Documentation, education and follow-up: . . . 2. Document in chart that precautions were began [sic], patient's/resident's reaction, education provided, and other pertinent information." - Resident #7's medical record, reviewed November 09-10, 2009, indicated the resident returned from the hospital with MRSA identified	F 279	#3 The DRO Policy (see attached) has been revised to include updating the residents care plan and care card when there is a diagnosis of a DRO. Nursing Staff has been inserviced and QA studies implemented. #4 This deficiency will be corrected by Dec. 12, 2009. #5 DON or Infection Control Officer will monitor all new admissions to the facility and all residents returning from the hospital checking for #1) a diag. of a DRO. #2) and if so, that appropriate precautions are in place in their care plan and care card. QA studies will be done weekly until 100% compliance is obtained, and then monthly until compliance is met for 3 consecutive months. The results will be reviewed at the Regularly scheduled QA mtgs. Telephone interview 12/17/09 @ 10:35 am w Loraine Haas DON: QA will be completed by the DON or Infection Control Officer K Buchholz RN	

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on 07/17/09 in a right leg wound culture. In addition, previous sputum cultures conducted on 02/28/09 and 05/02/09 also tested positive for MRSA.

The current care plan failed to address the MRSA and lacked infection control interventions for staff to follow when providing cares for Resident #7.

During an interview on 11/10/09 at 10:35 a.m., when asked how staff are informed of infections and the required infection control interventions, facility management staff member (#1) stated, "The precautions should be written on the care plan. They'll find that information on the care plan."

- Review of Resident #2's medical record occurred on November 08-10, 2009. Medical diagnoses included emphysema, hip fracture, and MRSA. Review of Resident #2's MDS, dated 10/08/09, identified an antibiotic resistant infection (MRSA).

Resident #2's current care plan stated, "8/10/09 Resident has tested positive for MRSA. Staff will observe standard as well as contact precautions when working with [resident name] . . . staff will assist her as needed with good handwashing and encourage her not to put her fingers in the stoma [an surgical opening in the trachea]. Provide her with stoma protector. . . ."

Review of Resident #2's "resident care card," an information sheet carried by direct care staff, failed to identify a diagnosis of MRSA and failed to indicate the implementation of contact precautions.

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F 279	Continued From page 4 Failure of facility staff to provide an accurate "resident care card" for direct care staff caring for Resident #2 has the potential to affect the health and safety of all facility residents, staff, and visitors.	F 279		
F 312 SS=D	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, record review, policy review, and staff interview, the facility failed to provide perineal care (Resident #1) or proper perineal care (Resident #2) for 2 of 4 sampled residents identified as requiring assistance with personal hygiene. Failure to provide perineal care or providing inappropriate perineal care placed residents at risk for skin irritation, skin breakdown, and infection. Findings include: Review of the facility policy titled "Perineal Cares" occurred on 11/10/09. This policy, dated 2007, stated, "Purpose: . . . 1. To keep the resident clean, dry, and odor free. 2. To observe and identify skin problems as soon as possible so treatment can be started. 3. To prevent skin breakdown 4. To prevent infections . . . Procedure: . . . 6 . . . remove soiled incontinence product . . . 7. Wash all soiled skin areas and dry well, especially between skin folds . . . For female residents: . . . 1. Wash and rinse between the	F 312	F-Tag 312 #1 Resident #1 & #2 are receiving perineal care using the proper technique. #2 All residents identified as needing assistance with perineal care have the potential to be affected by this deficient practice. #3 Nursing Staff will be inserviced on the facilities revised Policy for Perineal Cares and Daily Cares (see attached). QA studies will be done to ensure continued compliance. #4 This deficiency will be corrected by Dec. 14, 2009	

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F 312	Continued From page 5 inner labia front to back. 2. Wash and rinse the outside of the labia front to back. 3. Wash the groins and upper thighs front to back . . . 5. Wash and rinse the suprapubic area . . .7. Wash and rinse the upper buttocks 8. Wash and rinse the rectal area front to back . . ." - Review of Resident #1's medical record occurred on November 08-10, 2009. Medical diagnoses for Resident #1 included neurogenic bladder. Resident #1's quarterly Minimum Data Set (MDS), dated 09/30/09, indicated problems with short and long term memory loss, moderately impaired daily decision making skills, incontinent of bladder, and required total assistance with toilet use and personal hygiene. Observation, on 11/09/09 at 4:00 p.m., showed two Certified Nursing Assistants (CNAs) (#9 and #10) transferred Resident #1 to the bathroom. The staff members removed the resident's brief and assisted him to the toilet. The resident did not void or have a bowel movement. The staff members then placed a new brief on the resident and transferred him to his wheelchair. Neither staff member provided perineal care before placing the new brief on the resident. At the end of this observation, when asked, the CNA (#10) confirmed the removed brief had been wet with urine. - Review of Resident #2's medical record occurred on November 08-10, 2009. Medical diagnoses included Methicillin Resistant Staphylococcus Aureus (MRSA), hip fracture, and history of a urinary tract infection. Resident #2's MDS, dated 10/08/09, identified no memory problems, moderately impaired in making daily decisions, incontinent of bowel and bladder, and	F 312	#5 The DON/designee will monitor 4 different Cna's weekly while providing perineal cares to ensure that cares are performed using proper technique. QA studies will be done weekly for 4 weeks, and continue weekly until 100% compliance is maintained and all Cna's have been monitored. This study will be continued every month until 100% compliance is reached for 2 months to ensure cares are performed using proper technique. QA studies will be reviewed at the regularly scheduled QA meeting.	

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F 312	Continued From page 6 required extensive assistance with toilet use and personal hygiene. Observation on 11/09/09 at 8:35 a.m., showed a CNA (#5) donned a mask and gloves, entered Resident #2's room, and assisted her into the bathroom. The CNA removed this resident's brief and pajamas saturated with urine. The CNA (#5) obtained a hygiene wipe and cleansed Resident #2's perineal area wiping from the anal area to the front labia area. Observation on 11/09/09 at 10:45 a.m., showed a CNA (#5) assisted Resident #2 to her room via wheelchair. This CNA donned a mask and gloves and assisted this resident to the toilet. After Resident #2 voided, the CNA (#5) obtained a hygiene wipe and cleansed her from the anal area to the front labia area. During an interview the morning of 11/10/09, an administrative nurse (#1) stated she expected facility staff to follow proper procedure for perineal care for residents.	F 312		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 7 Based on observation, review of professional reference, policy review, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen, and in 1 of 1 Activity room, on 2 of 3 days of survey. These practices have the potential to increase the risk of food borne illness and can affect all residents who eat food stored and prepared in these areas. Findings include: Review of the facility policy titled "Storage of Foods" occurred on 11/09/09. This policy, dated 11/96, stated, ". . . Purpose: To assure food is stored in sanitary conditions . . . 2. All staple food items are stored on shelves 6 inches above the floor . . . 3. All perishable items are stored in either refrigerators or freezers . . . ." Review of the facility policy titled "Sanitization" occurred on 11/09/09. This policy, undated, stated, ". . . Dry Food Storage: Store at least 6" [inches] off floor to prevent contamination by germs and rodents and to prevent food from getting wet when floor is washed . . . For opened containers [ex. brown sugar, jello, etc.] close package tight . . . Refrigeration: . . . Cover all food . . . Refrigerate left overs right away . . . Food Preparation and Serving: . . . Food kept out of danger zone [45 degrees to 140 degrees] . . . Cleaning: Clean and sanitize food-contact surfaces of equipment after every use . . . Keep floor clear of boxes, etc. so all of floor can be washed. . . ." The 2005 Food Code, Public Health Reasons, section 4-202.11 Food-Contact Surfaces, pages 424-425 states, "The purpose of the requirements	F 371	F 371 #1. No specific residents identified. #2. All residents are potentially affected by this deficient practice. #3. The Dietary Area has been cleaned. The Dietary Manager has revised the Cleaning Schedule to incorporate areas of concern. The Dietary Manager will in-service Dietary and Activity Staff on the importance of storing, preparing, and serving food under sanitary conditions. This includes cleaning Dietary area so that it is free of dust, walls are cleaned with no food on them, floors and equipment are clean and free of food and dust, and baked goods are covered so that dust or other unwanted materials cannot get to food. She will also in-service staff on keeping back door entrance to kitchen closed, storing food 6" off of floor and assuring food is packaged so contents are not exposed. The countertop with chipped edging has been replaced. The Maintenance Supervisor has cleaned the fans, vents, pipes, kitchen hood and rolling window. He replaced the ceiling tile in the dry storage area. He will add these items to his Preventative Maintenance List and complete every month.	

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F 371	Continued From page 8 for multi-use food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned . . . Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. . . ." A main tour of the kitchen, nourishment centers, and activity room occurred on 11/08/09 at 11:55 a.m. with a dietary staff member (#11). Observations showed the following in the kitchen: * Back door entrance to the kitchen opened approximately half an inch. Posted signage on the door stated, "Please make sure the door is either pulled or pushed shut." * In the dish washing room, a build-up of dust/debris and/or food particles around the edges of the ceiling vent, on the piping and on the top of the dish washer, and on the floor underneath the dish washer. A fan, with a build-up of dust on the blades, sat on a shelf and faced the clean end of the dish washing area. * Underneath the two compartment sink, a build-up of dust and debris on the floor and on the piping of the sink. The wall underneath the sink showed dried food/liquid splashes. * A preparation area, located across from the two compartment sink, showed a countertop with chipped edging on one side, and five small pitted areas on the surface. One of the five pitted areas showed a dried food particle lodged inside. The ceiling light above this preparation area showed a build-up of dust. * A standing fan, with a build-up of dust on the	F 371	#4. This deficiency will be corrected by 12-14-09 #5. The Dietary Manager will monitor the Dietary and Activity Area to assure food is stored, prepared, and served under sanitary conditions 1 time a week for 2 weeks until compliance is met at 100% for 2 consecutive weeks. She will then monitor 1 time a month until 100% compliance is met for 2 consecutive months. The Maintenance Supervisor will monitor that ceiling tiles, fans, vents, pipes, the rolling window and the kitchen hood is cleaned 1 time a month for 2 months until compliance is met at 100% for 2 consecutive months. He will then monitor 1 time every 2 months until compliance is met at 100% for 2 consecutive months. Results of the Dietary Manager and Maintenance Supervisor monitoring will be reviewed at the Quality Assurance Mtg.	

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blades and the base, sat on the floor and faced the preparation area.
* In the dry storage area, a box holding two bottles of vinegar sat on the floor. A ceiling tile contained a crack approximately one foot in length and half an inch in width. A ceiling vent, located above stored paper products and food items, showed five clumps of dust build-up in its grates.
* In the walk-in cooler, two working fans showed dust build-up. On a shelf, below these fans, sat a bag of whole green peppers and a bag of whole onions. Both bags had an approximately three inch wide hole in them exposing the contents of the bags.
* In the walk-in freezer, a box of hash browns, a box of chocolate ice cream cups, and a bucket of vanilla ice cream sat directly on the floor.
* A preparation area, containing a microwave, showed a build-up of dried food residue on the inside of the handle of the microwave. A food processor sat in the preparation area, and showed a dried/crusty film of food on the blades. The ceiling above this preparation area showed a build-up of dust on the tiles.
* A second preparation area containing drawers, showed a build-up of dried food residue on the handles of three drawers. The wall behind this preparation area revealed dried food/liquid splashes on the wall.
* On an open shelved cart, directly below a juice machine, sat an uncovered 9 x 13 inch pan of prepared lemon meringue bars.
* Visible splashes of dried food/liquid on the wall behind and on the sides of the cooking range.
* Directly above the steam table/serving area, a rolling window showed a build-up of dust on the sleeves, wheels, and hinges.
* Throughout the kitchen, the ceiling pipes

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showed a build-up of dust.
Review of the facility policy titled "Sanitization" occurred on 11/09/09. This policy, undated, stated, ". . . Freezer: Keep clean, wipe up spills right away . . ." Observation in a separate dry storage area located in the basement of the facility showed the following:
*A reach-in freezer containing seven bags of vegetables showed food particles scattered on the floor of the freezer.

Observation showed the following in the Activity Room:
*Visible splashes of dried food/liquid on the handles of the oven door and the knobs of the stove.

A final dietary tour of the main kitchen, nourishment centers, and activity room occurred on 11/09/09 at 8:00 a.m. with an administrative dietary staff member (#10).
Observations showed the following items remained unchanged:

* Dust/food/debris build-up in the dish room, under the two compartment sink, on the piping and ceiling throughout the kitchen, on vents in the walk-in cooler and dry storage, on the standing fan in the preparation area, on the rolling window above the steam table, and on the wall near the cooking range.
* Dried food/liquid splashes on the handles of the drawers and microwave in the kitchen and on the cooking range in the Activity Room, the chipped edging and five pitted areas on the countertop of a preparation area, and in dry storage the box of vinegar sat on the floor, and cracked ceiling tile remained.

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F 371	Continued From page 11 An interview and review of the above findings occurred on 11/09/09 at 8:30 a.m. with an administrative dietary staff member (#10). This staff member agreed the above findings should be addressed and corrected.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, contract review, and review of professional reference, the facility's consultant pharmacist failed to ensure each resident's drug regimen remained free from unnecessary drugs, including monitoring for gradual dose reductions (GDR), for 4 of 6 sampled residents (Resident #1, #8, and #9) receiving scheduled antipsychotic, antianxiety, and/or antidepressant medications. An unnecessary drug includes any drug used for excessive duration, without adequate monitoring, or without adequate indications for its use. Failure of the pharmacist to report drug irregularities, including monitoring of GDR, may result in residents receiving unnecessary medications and has the potential to affect residents' highest level of functioning.	F 428	F-Tag #428 #1 The Consulting Pharmacist has reviewed the medications for resident's # 1, #8, and #9 monitoring for any drug irregularities including possible Gradual Dose Reductions. #2. All residents receiving medications are at risk for this deficient practice. #3. The Consulting Pharmacist will include monitoring for drug irregularities including monitoring of GDR on her monthly mediation review. The DON will review these reports and notify the attending physician of any concerns. QA studies will be completed to ensure continued compliance. #4. This deficiency will be corrected by Dec. 14, 2009.	

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F 428	Continued From page 12 Findings include: The Centers for Medicare and Medicaid has outlined the standards of practice regarding the tapering of a medication dose (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For hypnotic medication for as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. Review of the facility contract between the consultant pharmacist and the facility occurred on the morning of 11/10/09. This contract, dated 10/22/92, stated, "This is an agreement between Dunseith Community Nursing Home and [name of pharmacist] to provide certain services. . . which includes, but is not necessarily limited to the following: . . . The drug regimen of each resident must be reviewed at least once a month. . . . Report any irregularities to the attending physician and the director of nursing. . . ." - Resident #1's medical record reviewed on November 08-10, 2009, showed the facility admitted the resident on 02/27/2002. Resident #1's medications included, Geodon (an antipsychotic) 60 mg (milligrams) at bedtime,	F 428	#5. The DON//Designee will complete a QA study reviewing the monthly Pharmacy report for monitoring of drug irregularities and GDR recommendations and that these concerns have been reported to the attending physician. This QA study will be done monthly for 6 months and continue monthly until 100% compliance is reached for 1 month. The results will be reviewed at the regularly scheduled QA meeting.	

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started 08/07/07, Ativan (an antianxiety) 0.5 mg twice daily, started 09/20/04, and Ativan 1 mg at noon, started 05/23/05.

Review of the monthly "Pharmacy Consulting Reports" from December of 2008 to September of 2009 for Resident #1 indicated the following:
* From 12/2008 - 03/2009, "Nothing to report."
* On 04/01/09, documented on behaviors related to seizures.
* From 05/2009 - 08/2009, "Nothing to report."
* On 09/2009, missed several medications on 09/19/09.
The consultant pharmacist failed to address possible GDR's for Resident #1.

- Resident #9's medical record reviewed on November 09-10, 2009, identified the facility admitted the resident on 04/25/1986. Resident #9's medications included, Buspar (an antianxiety)15 mg twice daily, started 11/12/95, Desipramine (an antidepressant)100 mg at bedtime, started 12/09/03, Risperdal (an antipsychotic) 0.5 mg every morning, and Risperdal 1 mg every evening, started 01/19/06, and Remeron (an antidepressant) 30 mg at bedtime, started 07/31/06.

Review of the monthly "Pharmacy Consulting Reports" from December of 2008 to September of 2009 for Resident #9 stated, "Nothing to report." The consultant pharmacist failed to address possible GDR's for Resident #9.

- Resident #8's medical record reviewed on November 09-10, 2009, showed the facility admitted the resident in January 2007. Resident

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F 428	Continued From page 14 #8's medications included, Cymbalta (an antidepressant) 60 mg daily, started 01/31/07, and Risperdal 0.5 mg twice daily, started 03/19/09. Review of the monthly "Pharmacy Consulting Reports" from December of 2008 to September of 2009 for Resident #8 stated, "Nothing to report." During an interview on 11/09/09 at 10:30 a.m., when asked where GDR recommendations were located, facility management staff member (#1) stated, "Pharmacy would document GDR recommendations on the consult report." The pharmacy consultant failed to address possible GDRs for Resident #8. An interview occurred on 11/10/09 at 10:10 a.m. with the facility's consultant pharmacist (#2). When asked where documentation of GDR recommendations could be located in the medical record, the pharmacist stated she does not address GDR's. The physician addresses GDR's. Another interview occurred on 11/10/09 at 10:20 a.m. with the facility's physician (#3) and Physician's Assistant Certified (PAC) (#4). When asked where and when they address GDR's, the physician stated he would review a medication if the facility's consultant pharmacist had concerns with a medication. Otherwise, if no current concerns existed with the residents' behaviors or medications, there would be no documentation regarding GDR's in the medical record.	F 428		
F 441 SS=E	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	F 441		

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F 441	Continued From page 15 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: Based on observation, record review, professional literature review, facility policy review, and staff interview, the facility failed to implement infection control policies and procedures for 2 of 5 sampled residents (Resident #2 and #7) requiring assistance with personal cares and/or requiring contact precautions for Methicillin Resistant Staphylococcus Aureus (MRSA). Failure of the facility to implement policies and procedures for staff to follow when caring for residents diagnosed with MRSA placed residents, staff, and visitors at risk for contacting or spreading an infection. Findings include: The Recommendations for the Prevention and Control of Multi-Drug Resistant Organisms (MDRO) in North Dakota, developed April 2008, stated the following regarding Long Term Care Facilities Guidelines for Management of MRSA . . . Infections: * ". . . Implementing Contact Precautions (gowns & gloves) for all residents known to be colonized or infected with targeted MDRO provides the best protection against transmission . . ."	F 441	F-Tag 441 #1 Appropriate Infection Control Procedures have been implemented for staff to follow on residents #2 and #7 to decrease the potential of spreading MRSA to other residents, staff, and visitors. #2 All residents who have been diagnosed with MRSA have the potential to be affected by this deficient practice. #3 The facility policy for DRO's has been revised and Nursing Staff inserviced on appropriate precautions to be used when providing cares for a resident with a DRO (see attached). QA studies will be completed to assure continued compliance. The DRO Policy will be included with the annual and new employee training sessions. #4 This deficiency will be corrected by Dec. 14th, 2009.	

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F 441	Continued From page 16 * ". . . Employee: Perform hand hygiene before and after all patient contact, after contact with environmental surfaces, equipment in the room or used by the patient. Hands must be decontaminated after glove removal . . ." * ". . . Gloves: . . . should be worn upon entering the patient room. Gloves should be changed between multiple procedures on the same person if they become contaminated . . . Hands must be washed/decontaminated immediately after removing gloves and prior to exiting the room . . ." * ". . . Gowns: . . . should be worn if anticipated clothing contact with the person, environmental surfaces of equipment in the direct care environment . . ." * ". . . Masks: . . . They are indicated according to standard precautions where a splash or spray could be anticipated (i.e., suctioning, wound irrigation, tracheostomy care, or actively coughing person with respiratory infection.) . . ." * ". . . Visitors: Visitors should wash or decontaminate hands with an antimicrobial soap and water or a waterless alcohol-based hand rub on room entry and exit . . ." * ". . . Termination of Precautions/Isolation: . . . Three or more surveillance cultures for the target MDRO must be repeatedly negative over the course of weeks . . ." Review of the facility's policy titled "Infection Control Policies" occurred on 11/10/09. This policy, dated 1996, stated: * "Policy: All patients/residents infected or colonized with DRO ' s [drug resistant organisms] will be assessed for possible placement in Contact Precautions in order to minimize the risk of transmission to others . . ." * "Room Identification: Place the isolation cart for supplies outside of the room for "Contact	F 441	#5. DON/designee will monitor 4 different CNA's weekly for 4 weeks and then continue to monitor weekly until 100% compliance has been reached. This study will then be done monthly until 100% compliance is reached for 2 months to ensure that staff understands the interventions identified on the care plan and that correct procedure is followed when completing resident cares. The results of this study will be reviewed at the regularly scheduled QA meeting. See Attached Addendum	

F441

Addendum to #3.

The facility Policy for DRO's has been revised to include:

PROCEDURE:

2) Identification of residents with resistant organisms.

The resident's chart and the name plaque on their door will be labeled with a green dot sticker to identify the presence of a resistant organism. This will alert staff to review the care plan/care card for use of appropriate precautions. A stop sign will be placed on the door of the resident identified as having a DRO. The stop sign will instruct visitors to report to the nurses station prior to entering the residents room. Nursing staff will educate them on appropriate handwashing & PPE precautions to be followed.

received 12/17/09 by fax KBeachie

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Precautions. Place STOP sign on the door."
* "Providing Cares: Hand Hygiene: MOST IMPORTANT! 1. Staff: Wash hands with soap and water or use alcohol based waterless hand cleaner . . . Masks are rarely needed with contact precautions, except with uncontrolled coughing of sputum. during trach cares, or with wound irrigation."
* "Visitors: Instruct and/or assist with hand hygiene - - hand hygiene should be performed when entering and leaving the room."
* "Documentation . . . and follow-up: 1. Note precautions on Kardex or Resident Care Cards., 2. Document in chart that precautions were began, patient ' s/resident's reaction, education provided, and other pertinent information., 3. For LTC [long term care]: Make entry on the MAR [medication administration record]., . . . 5. Complete Isolation Checklist and return to Health Services Coordinator . . ."
* "Discontinuing Isolation: . . .
Isolation/precautions may be discontinued when three sets of cultures are completed and shown to be negative . . ."

- Review of Resident #7's medical record occurred November 09-10, 2009. Resident #7's medical record identified the facility admitted the resident in August 2003. The medical record indicated the resident had returned from the hospital with MRSA identified on 07/17/09 in a right leg wound culture. In addition. previous sputum cultures conducted on 02/28/09 and 05/02/09 tested positive for MRSA.

Resident #7's quarterly Minimum Data Set (MDS), dated 10/29/09, indicated problems with short and long term memory, moderately impaired daily decision making skills, extensive

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assistance with mobility and activities of daily living (ADLs), and an antibiotic resistant infection.

The current care plan, reviewed by the facility on 10/29/09, failed to address the MRSA and lacked infection control interventions for staff to follow when providing cares for Resident #7. Resident #7's Care Card, undated, stated, "Contact precautions - lower right leg - sputum - MRSA, Staff - Good handwashing."

Random observations, on 11/10/09 at 7:55 a.m., identified a certified nurse assistant (CNA) (#5), wore a mask and gloves, and assisted Resident #7 into the restroom. Resident #7 coughed while the CNA (#5) provided cares. A nursing staff member (#6) entered the resident's room without mask or gloves. The facility did not provide an isolation cart outside of Resident #7's room or place a STOP sign on her door. When asked whether contact precautions were necessary, a nursing staff member (#6) stated, "Masks are used at our discretion. We wear them during cares." The CNA (#5) continued to provide cares while the nursing staff member (#6) retrieved additional masks from a storage area down the hall.

Random observations, on 11/10/09 at 9:00 a.m., identified Resident #7 sat in her wheelchair next to the nurses' station without a mask. Resident #7 began coughing, and requested a glass of ice water.

During an interview on 11/10/09 at 10:30 a.m., when asked to view Resident #7's MRSA documentation on the MAR as per facility policy, a nursing staff member (#7) stated, "I've never seen that [MRSA] documented on the MAR . . . in

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other areas of the chart, yes."

During an interview on 11/10/09 at 10:35 a.m., when asked how staff are informed of infections and the required infection control interventions, an administrative nurse (#1) stated, "The precautions should be written on the care plan. They'll find that information on the care plan. Everyone is on standard precautions." Regarding Resident #7's positive test results for MRSA in her sputum, she stated, "They [staff] can wear a mask if she has uncontrolled coughing."

During an interview on 11/10/09 at 11:00 a.m., when asked to view Resident #7's Isolation Checklist, a licensed staff member (#8) stated, "I don't have one for her." Regarding the location of Resident #7's MRSA, she stated, "She had MRSA in her leg and in her sputum a long time ago. I think her sore closed. I don't think she is positive anymore in her leg." The staff member confirmed if Resident #7's sputum still tested positive for MRSA, "Staff should wear a mask when working with her, especially if it makes them more comfortable. If coughing, she [Resident #7] should be wearing a mask when out of her room." When asked how the facility decided Resident #7 could be removed from isolation, she stated, "She should have had two more cultures first." Regarding the unavailability of an isolation cart, she stated, "I don't like leaving a cart in the hallway. I don't want others to think she's different." Finally, when asked what interventions the facility had in place to protect staff/visitors, she stated, "I didn't think she was positive for MRSA any longer."

- Review of Resident #2's medical record occurred on November 08-10, 2009. Medical

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diagnoses included MRSA and history of a urinary tract infection. Resident #2's MDS, dated 10/08/09, identified no memory problems, moderately impaired in making daily decisions, incontinent of bowel and bladder, required extensive assistance with toilet use and personal hygiene, and an antibiotic resistant infection (MRSA).

Review of a nurse's note, dated 08/11/09 at 10:00 a.m., stated, "[Resident's name] is positive for MRSA and nurse contacted 6th floor [hospital name] to try to determine where MRSA is colonized. They [hospital staff] do not know as they just swabbed the nares. We will use contact precautions and observe good handwashing. Red bag linens and clothing."

Resident #2's current care plan stated, "8/10/09 Resident has tested positive for MRSA. Staff will observe standard as well as contact precautions when working with [resident name] . . . staff will assist her as needed with good handwashing and encourage her not to put her fingers in the stoma [an surgical opening in the trachea]. Provide her with stoma protector. . . ." Review of Resident #2's "resident care card," an information sheet carried by direct care staff, failed to identify a diagnosis of MRSA and failed to indicate the implementation of contact precautions. Resident #2's MAR failed to indicate MRSA precautions.

* Observation 11/08/09 at 5:40 p.m., showed a CNA (#13) entered Resident #2's room to assist her to the bathroom. The CNA stated, "Normally I wear a mask when I'm in here. She's MRSA positive." The CNA could not identify the location of MRSA. Observation revealed no stop sign on the door to alert staff or visitors of possible

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precautions and no isolation cart outside the door as per facility policy.

* Observation on 11/09/09 at 8:35 a.m., showed a CNA (#5) donned a mask and gloves, entered Resident #2's room, and assisted her into the bathroom. While this resident sat on the toilet, the CNA removed her brief and pajamas saturated with urine and dressed her in clean clothes, socks, and shoes. Resident #2 coughed and the CNA adjusted the resident's tracheostomy cover and stated, "this looks good." The CNA (#5) assisted Resident #2 to an upright position and proceeded to cleanse her perineal area, apply a clean brief, and pulled up her pants. The CNA assisted this resident back to her wheelchair, combed her hair, applied her jacket and glasses, fastened her safety seat belt, and opened the door with her gloved hand to allow her to exit the room. Only after the CNA (#5) completed all Resident #2's morning cares, did she remove the gloves and mask she donned upon entering the room. When asked why she wore a mask, the CNA (#5) stated Resident #5 has MRSA but could not identify the location.

* Observation on 11/09/09 at 10:45 a.m., showed a CNA (#5) assisted Resident #2 to her room via wheelchair. The CNA donned a mask and gloves and assisted this resident to the toilet. After Resident #2 voided, the CNA (#5) cleansed her perineal area, applied a clean brief, and pulled her pants up. The CNA assisted Resident #2 back to the wheelchair, applied her jacket, fastened her safety seat belt, and opened the door with her gloved hand to allow the resident to exit the room. The CNA (#5) remained in Resident #2's room. The CNA opened a dresser drawer and placed the package of perineal wipes,

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used during Resident #2's cares, back in the drawer and removed her mask and gloves. Observation showed the CNA (#5) wore the same pair of gloves throughout Resident #2's cares.

* Observation on 11/09/09 at 1:35 p.m., showed a CNA (#5) donned a mask and gloves and entered Resident #2's room and assisted her to the toilet. After Resident #2 voided, the CNA cleansed the resident's perineal area, applied a new brief, pulled her pants up, and assisted her to the wheelchair. The CNA wheeled Resident #2 to the door with her gloved hands on the hand grips of the wheelchair, opened the door to allow the resident to exit the room, then removed her mask and gloves. Observation showed the CNA (#5) wore the same pair of gloves throughout Resident #2's cares.

* Observation on the morning of 11/10/09 showed a CNA (#14) donned gloves but no mask prior to entering Resident #2's room. The CNA removed this resident's stoma cover, washed the stoma area, washed the rest of her body, and dressed her. Observation showed Resident #2 coughed and sputum came out of her stoma. CNA (#14) cleaned the area with a tissue and re-applied the stoma cover. A CNA (#14) failed to don a mask even after Resident #2 coughed sputum through her stoma.

During an interview the morning of 11/10/09, a licensed staff member (#8) stated Resident #2's sputum tested positive for MRSA. When asked if she expected facility staff to wear a mask, she stated "only if she's [Resident #2] coughing." When asked how direct care staff learn of a resident with MRSA, she stated each resident's "care card" contained the information.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNSEITH COM NURSING HOME	15 1ST ST NE DUNSEITH, ND 58329

(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
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Failure of the CNA (#5) to change gloves after she touched Resident #2's stoma site/sputum and before she continued perineal cares has the potential to spread MRSA. Failure of the CNA (#14) to don a mask during personal cares when Resident #2 coughed has the potential for this staff member to spread MRSA. Failure of the CNA (#5) to remove her gloves before she touched Resident #2's wheelchair, door knob, and dresser drawer, has the potential to spread MRSA to other residents, vistors, and staff members.