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	355108	A. BUILDING _____ B. WING _____	11/23/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on November 21, 2016 and completed on November 23, 2016, the sample included two (2) residents for complete review, nine (8) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		12/28/16

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

Electronically Signed | 12/16/2016

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with	F 156		

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files, the facility failed to provide adequate written notices to 4 of 4 sampled residents (Resident #11, #13, #14, and #15) or their representatives before Medicare Part A coverage and/or services ended. Failure of the facility to assure provided Medicare notices contained the correct Medicare explanation for payment and current intermediary review information limited the residents' ability to exercise their rights related to Medicare Part A benefits. Findings include: The Medicare Part A notices "Medicare Denial" for Resident #11, #13, #14, and #15 reviewed on 11/19/16, showed all the forms lacked the following: - The required information explaining the coverage of payment from Medicare.	F 156	1. No residents or their representatives expressed an interest in a demand bill, so no one was affected by this practice, however a letter explaining the information that was lacking in the forms will be sent to the resident or representative for resident #11, #13, #14, and #15. 2. All residents receiving Medicare services had the potential to ber affected by this practice, so a letter explaining the information that was missing from our form will be sent to all current residents who received Medicare A services in the past six months (or their representative). 3. Our Medicare Denial forms will be revised to include the correct contact information for the intermediary review and the required information explaining the coverage of payment from Medicare.	

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F 156	Continued From page 3 - The correct contact information for the intermediary review.	F 156	The new form and information about the changes made to it will be shared with the MDS coordinator, Business Office Coordinator, Nursing Services Coordinator, and the MDS interdisciplinary team on 12/23/16. 4. A QA will be developed and completed on a monthly basis for the first three months and quarterly thereafter for a minimum of one year to ensure that the necessary information is on the forms used. This QA will be done by the Business Office Coordinator or her designee.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop and implement an individualized activity program for 4 of 9 sampled residents (Resident #3, #5, #7, and #9) dependent on staff for activities. Failure to implement an individualized activity program to respond to the interests and current capabilities of the residents has the potential to affect their physical, cognitive, and emotional health. Findings include:	F 248	1. a. A new activity assessment will be completed for the residents identified. b. An individualized activity box will be developed for each of these residents and put in their room so all staff can use the activities with them at any hours of the day. This box will include information about the residents' activity interests and preferences. c. an entry will be added to the CNA's ADL sheets indicating that these residents have a 1:1 activity box in their rooms.	12/28/16

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F 248	Continued From page 4 The facility lacked a policy on Activities. Review of the group activity calendar during the days of survey identified the following: * 11/21/16 - 10:00 a.m. Fall Craft, 2:00 p.m. Bingo * 11/22/16 - 10:00 a.m. Pumpkin Pie, 2:00 p.m. Church, 6:00 p.m. Trivia * 11/23/16 - 10:30 a.m. Mass, 2:00 p.m. Bingo, 6:00 p.m. Bowling A posting in the hallway outside of the dining room identified the activities for 11/22/16 as: * 9:00 a.m. Decorate cookies * 2:00 p.m. Church with Pastor [first name] * 2:30 p.m. Coffee Hour * 6:00 p.m. Trivia - Review of Resident #5's medical record occurred on all days of survey and diagnoses included severe dementia with psychosis, anxiety and depression. The current care plan stated, ". . . Focus: Psychosocial: . . . I used to enjoy watching TV. I used to play piano at church and I love music. I enjoy visits from my family who come almost daily. My daughter used to come up and play Bingo with me. Recently I have been declining activities more often. I rarely come out for activities any longer. At times I enjoy one to one interaction with staff. I prefer to be in my room and take naps at frequent intervals. It appears that at times being around crowds and increased noise increases res [resident] anxiety as noted by increased scratching and picking on her skin . . . Interventions . . . I enjoy watching TV and listening to music . . . I have a church hymn CD please put this in for me at times . . . I will be encouraged to attend activities of my choice such	F 248	2. All residents will be reviewed to determine other residents who are unable to clearly communicate their activity preferences and needs, and are dependent on staff to initiate activities. 3. a. The activity assessment for new residents will be revised and determine the residents who are dependent on staff for activities. b. The activity room will be redesigned to include stations that fit the individual needs of current residents with dependent upon staff for activities, i.e. a schoolteacher station, a woodworking-oriented station, and a baby station. c. An education session will be held with all CNA and Case Manager staff to review individualized activity needs and 1:1 activity box use on 12/15/16 and 12/16/16. 4. A QA will be developed and review documentation related to individualized one-to-one activities. This will be done weekly for four weeks, bi-weekly for two months,monthly for three months and quarterly thereafter for the first year. It will be completed by the Resident Care Coordinator or her designee.	

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as church, Bingo and musical events but I rarely come out any longer . . . I will enjoy one to one interaction with staff. At times I will refuse to participate and not respond at all . . ."

Review of the most recent Activity Assessment/Summary, dated 08/25/16, stated, ". . . Interaction/response to activities: [Resident #5] enjoys to be in her room. She enjoys frequent visits from her daughters as two of them are employed here. Due to her diagnosis [Resident #5] no longer participates in daily activities as large groups of people tend to make her more anxious. She does however enjoy watching her shirley temple movies and listening to music played on her dvds . . ."

Review of Resident #5's activity logs from November 01-22, 2016 identified the following:
* 21 entries of "Not Applicable"
* 22 entries of "Independent"
* 2 entries of "1:1"
* 1 entry of "Group"

During an interview on 11/23/16 at 10:18 a.m., regarding Resident #5's November 2016 activity logs, two activity/social service staff members (#15 and #16) stated "not applicable" identified when the resident did not participate in an activity, "independent" activities included TV or music in her room, and stated the resident does not leave her room or participate in group activities, so they are unsure why a staff member charted "Group" as an activity on the evening of 11/10/16. The staff members (#15 and #16) stated Resident #5 received one-to-one staff visits twice a week, lasting approximately 10-15 minutes each [documentation identified only two

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visits in 22 days], which included movies, hand massages, reading her mail or the paper to her, or talking to her. The staff (#15 and #16) also indicated Resident #5's family visits often.

Observation on all days of survey identified Resident #5 remained in bed at all times (except for her whirlpool bath) with her TV on. The resident's eyes remained closed during the majority of observations and the only interactions with staff occurred during cares and meals.

- Review of Resident #9's medical record occurred on 11/23/16 while observations of Resident #9 occurred on all days of survey. Diagnoses included Down's Syndrome and non-Alzheimer's dementia.

A progress note, dated 10/12/16, summarizing Resident #9's activities and social services, stated: ". . . His hearing is adequate. . . . usually understands what is being communicated to him. . . . is non-verbal. He does however understand what is being said. [Resident] will communicate by sounds, expressions, and actions. . . . vision is adequate without glasses. . . . will try to participate in activities if he is able. Other times he will participate by observing, laughing, and smiling. . . . prefers to watch tv [television] and look at magazines in the dining area. He will enjoy interactions with staff, and participate in activities of his choice. . . . will enjoy frequent visits and outings with his family. . . ."

Resident #9's care plan identified the problem of "Psychosocial: . . . does not belong to any religion at this time . . . enjoys looking at a magazine. He enjoys having his stuffed animals

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around. . . . will come out to watch the activities that are going on but can't always participate . . . not able to speak . . ." Interventions included the same except also, ". . . I enjoy visits from staff. Staff will encourage and remind me of activities going on for the day." The care plan identified the problem of "usually able to express his wants and needs. At times he hums which can be distracting for others." Interventions included: ". . . Staff will assist to move res [resident] in a quieter area if his humming becomes distractive [sic] to others."

On the afternoon of 11/22/16, between 2:10 p.m. and 6:00 p.m., Resident #9 sat on a love seat in the TV and sitting area adjacent to the dining room. The resident paged through magazines and made continuous humming/moaning-like sounds. Observation on 11/22/16 revealed Resident #9 did not attend cookie decorating at 9:00 a.m., church at 2:00 p.m., or coffee hour at 2:30 p.m.

Review of Resident #9's activity logs from November 01-22, 2016 identified the following:
* 22 entries of "Independent"
* 6 entries of "1:1"
* 2 entries of "Group"
The activities log showed primarily the resident's activities were watching television or a movie.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) of the right dominant side, anxiety disorder, aphasia (difficulty expressing oneself), and dementia with behavioral disturbance.

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Resident #3's care plan identified the problem of "Psychosocial: I am a member of . . . church, I enjoy visits from my family, friends and a former pastor. My wife comes almost daily. I enjoy brief one to one interaction with staff. . . . I rarely attend activities." Interventions included ". . . other times I wheel myself away. I enjoy children I sleep often during the day because I have been up a lot during the night. I sometimes sleep in my wheelchair because I become agitated in my bed and won't sleep in my bed. I used to enjoy attending church with my wife. I will be encouraged to attend activities of my choice. I sometimes have difficulties staying on task and being able to participate in complete activity, and I will be reminded when I am awake if there are activities of my interest, including music, animals, the outdoors, and religion."

An activities/social services summary progress note, dated 11/16/16, stated: ". . . hearing adequate . . . limited speech and is rarely understood due to his stroke and dementia . . . At times [resident] will spend time by the bird avery [sic]. He will enjoy short interactions with staff. Due to his stroke and dementia, [resident] rarely attends activities as he is not able to participate or always understand them. . . . Due to [resident's] cognitive condition, he has reduced social interactions and loss of interest. Staff will have one on one interaction with [resident] and look through his Alaska photo album or have short visits with him . . . wife comes up almost daily to visit." A summary progress note, dated 08/17/16, stated: ". . . [Resident] does not attend many activities due to his short attention span. . . . does not enjoy large crowds . . ."

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Observation on all days of survey showed Resident #3 in his room, in his bed or a rock-and-go chair with his eyes closed. Observation revealed he left his room to eat one meal (of three meals observed). Observation revealed no TV (television) present in the room. Observation showed his wife present in the resident's room on the evening of 11/22/16, just before the supper meal.

Review of Resident #3's November 01-22 activity log identified the following activities:
* Family/Friend visit: 20 times (nearly daily)
* Special event on one occasion
* TV or Movie on eight occasions always occurring between 10:00 p.m. and 11:00 p.m.
* One "Special" and two "Other" activities
The log identified the resident actively participated in all of the activities; was independent or 1:1 in all activities, except one group activity

On 11/23/16 at 10:30 a.m., a staff member (#17) confirmed Resident #3 does not have a TV in his room, and stated she has seen staff bring him to the nurse's station to "mingle."

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) (stroke) with hemiplegia (paralysis of one side of the body) on the right side of her body, and aphasia (loss of ability to understand or express speech).

Resident #7's annual MDS, dated 09/30/16, identified unclear speech, usually makes self understood, able to understand others, and

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unable to interview for an assessment of cognitive status. The MDS identified the resident required extensive assistance for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing.

A progress note, dated 10/12/16, summarizing Resident #7's activities and social services, stated: ". . . [Resident's] hearing is adequate . . . She is able to understand communication and what is communicated to her. . . . isn't always able to verbally communicate her needs or wants due to a past CVA. . . . Does understand what is being communicated to her. . . . Interaction/response to activities: [resident] usually likes to be in the hallway resting in her wheelchair by the main nurses station. She also likes to watch the price is right and rest in her room . . . comes to Mass and bingo weekly. . . . will enjoy weekly card games in her room with family and friends. . . . prefers to sit in the hallway and watch the people and rest. . . . will enjoy daily visits from family and friends that come in to play bingo and cards with her. . . ."

Resident #7's care plan identified the problem of "Psychosocial . . . I am catholic . . I like seeing and visiting with family and friends. I enjoy phone calls. I enjoy coming out for Bingo. I attend mass on Thursday at 10:30 a.m. I enjoy playing cards with family and friends. Occasionally I enjoy going on outings with family. I sit in the hallway by the central nurses station watching the comings and goings. I fall asleep in my chair at times but prefer to stay there . . ." Interventions included the same "I enjoy playing Bingo. Please encourage me to come to group activities. . . . I

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F 248	Continued From page 11 enjoy playing cards with family and friends. I like to attend Mass on Thursdays at 10:30 am. . . ." except "Please stop and greet me as you pass by." Observations of all days of survey showed the following: * 11/21/16 at 3:20 p.m.: sitting in room in her wheelchair engaged with son and daughter-in-law playing cards * 11/21/16 at 5:45 p.m.: sat in her wheelchair in the hallway near the nurse's station, asleep * 11/22/16 at 9:15 a.m.; 9:45 a.m. and 3:20 p.m.: sat in her wheelchair in the hallway near the nurse's station, with her eyes closed. Did not attend any of activities for the day: cookie decorating at 9:00 a.m., church activity scheduled at 2:00 p.m., coffee hour at 2:30 p.m. and did not attend Trivia at 6:00 p.m. * 11/23/16 at 10:00 a.m., sat in her wheelchair in the hallway near the nurse's station	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the	F 280		12/28/16

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F 280	Continued From page 12 participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 1 of 10 sampled residents (Resident #5). Failure to revise the care plan limited staffs' ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of Resident #5's medical record occurred on all days of survey and identified diagnoses of severe dementia with psychosis, anxiety and depression. The current care plan stated, ". . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Alzheimer's . . . Interventions: . . . EATING: I am usually independent with eating; but sometimes need extensive assistance to complete the task. I like to use my fingers when eating; so staff will provide finger foods as much as possible. I have been letting staff assist when needed to finish the task of eating . . . Staff will provide tray service when I chose [sic] to stay in my room . . ."	F 280	1. The care plan for Resident #5 will be updated to accurately reflect her current needs and plan of care. 2. All residents have the potential to be affected by this practice. 3. a. Education will be provided to all CNA and nursing staff to review each person's role in keeping the resident care plans up to date as changes occur pm 12/15/16 and 12/16/16. b. A new system will be put into place. Whenever an ADL sheet is updated, it will be given back to the nurse to ensure the care plan matches the ADL sheet. The nurse will initial the change on the ADL sheet and turn this in to the Nursing Services Coordinator. 4. QA will be completed weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter. The QA will include a complete care audit in which the care given is compared to the care plan and the ADL sheet.	

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Review of the quarterly Minimum Data Set (MDS), dated 08/18/16, identified total assistance of one staff member for eating. Observation and staff interviews during the survey identified the resident always ate in her room and rarely, if ever, ate independently.

The current care plan stated, ". . . Usually once in bed I am able to reposition myself . . ."

During an interview on the morning of 11/22/16, a certified nursing assistant (CNA) (#3) identified Resident #5 was unable to reposition herself in bed.

During all days of survey, observation identified Resident #5 remained on her back in bed.

Observation on all days of survey identified an abductor pillow in between Resident #5's legs.

Review of a progress note, dated 09/13/16, identified therapy initiated the abductor pillow to improve lower extremity range of motion for more ease when performing perineal cares.

Resident #5's current care plan failed to identify the use of the abductor pillow.

During observation of personal cares on 11/22/16 at 10:30 a.m. and 5:40 p.m., all three CNAs (#3, #4, and #5) who assisted Resident #5 used a folded disposable linen protector pulled up near her abdomen as an incontinence product. All CNAs (#3, #4, and #5) also tucked the resident's top sheet around the resident's abdomen and thighs to deter the resident from scratching her lower body (the resident was still able to access

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F 280	Continued From page 14 these parts of her body independently). The facility failed to include both individualized interventions on Resident #5's current care plan.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: IMPROPER FEEDING/HYDRATION 1. Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 4 sampled residents (Resident #5) observed being fed received the care and services necessary to attain the highest degree of safety possible. Failure to ensure proper positioning while feeding residents may result in choking and/or aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, identified, ". . . Coughing and choking are very obvious symptoms of dysphagia . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle . . . The 90 degree position allows the patient to control material in the oral cavity with a minimal	F 309	1. CNA's were instructed regarding mealtime assistance positioning for Resident #5 and the importance of following the re-weigh policy at shift-to-shift report beginning on 11/24/16 through 12/1/16. Weights and meal plan for Resident #3 were reviewed by the Dietary Coordinator immediately and she has been reviewing the weights and the re-weigh policy with the C.N.A.'s taking the weights whenever a weight is taken. The Dietitian also reviewed the weights and meal plan for Resident #3 on 12/6/16 and 12/13/16. 2. a. No other residents are being fed while in bed at this time. b. All residents have the potential to be affected by weight re-weigh practices. 3. a. Education will be provided on 12/15/16 and 12/16/16 to all CNA and nursing staff regarding proper positioning	12/28/16

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F 309	Continued From page 15 impact of gravity. This position must be maintained during and following the meal. Repositioning is frequently required during the meal. . . . Pillows may need to be placed . . . to achieve the correct position. . . ." Review of Resident #5's medical record occurred on all days of survey and diagnoses included severe dementia. The quarterly Minimum Data Set (MDS), dated 08/18/16, identified severely impaired daily decision making, total assistance for eating, and no symptoms of a swallow disorder. The current care plan stated, ". . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Alzheimer's . . . Interventions: . . . EATING: I am usually independent with eating; but sometimes need extensive assistance to complete the task. I like to use my fingers when eating; so staff will provide finger foods as much as possible. I have been letting staff assist when needed to finish the task of eating . . . Staff will provide tray service when I chose [sic] to stay in my room . . ." Observations during cares and meals identified the following: * 11/22/16 at 10:50 a.m., a CNA (#3) raised the head of the resident's bed to an approximate 30 degree angle and offered the resident a drink of water. Resident #5 drank from the straw and finished half the glass of water. * 11/22/16 at 11:50 a.m., a CNA (#7) stood on the right side of the resident's bed and raised the head of bed to approximately 45 degrees to feed her her noon meal. The resident's torso leaned to the right, her head turned to the right side, chin	F 309	while feeding in bed and the proper documentation of re-weights. As part of this education, staff will be required to demonstrate the proper techniques for positioning while feeding and documentation of re-weights. 4. QA will be conducted weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year. A QA will be completed by the Nursing Services Coordinator or designee to include the observation of positioning for mealtime assistance while a resident is in bed. A QA on the re-weight documentation will be completed by the Dietary Coordinator or her designee weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year.	

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down, and her right cheek touched her right shoulder. Resident #5 remained in this position while the CNA (#7) fed her all food and beverage items. The resident began coughing after she finished her chocolate milk. The CNA (#7) failed to reposition the resident to ensure safety during the meal.
* 11/22/16 at 5:40 p.m., a CNA (#4) raised the head of the resident's bed to an approximate 45 degree angle and offered the resident a drink of water. Resident #5 took a drink of water from the straw.
* 11/22/16 at 6:30 p.m., a CNA (#6) stood on the right side of the resident's bed and raised the head of bed to approximately 80 degrees to feed her her noon meal. The resident's torso leaned to the right, her head turned to the right side, chin down, and her right cheek touched her right shoulder. Resident (#5) remained in this position while the CNA (#6) fed her all food and beverage items. At 6:40 p.m., two administrative staff members (#1 and #13) observed the CNA (#6) feeding Resident #5 her evening meal. The staff members (#1 and #13) assisted the CNA (#6) to correct the resident's position.

During an interview on 11/23/16 at 12:00 p.m., an administrative nurse (#1) confirmed the CNA (#6) fed Resident #5 while she remained in an unsafe position.

ACCURACY OF WEIGHTS

2. Based on record review, review of a guide/policy, and staff interview, the facility failed to ensure accurate weights for 1 of 3 sampled residents (Resident #3) identified with weight loss. Failure to assess and evaluate the accuracy

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of weights may result in an inaccurate assessment of the resident's status and failure to address significant weight changes in relation to.

Findings include:

Review of a facility form titled "Bath Aide Daily Sheet" occurred on 11/22/16. The form, undated, provided a sequence for cares for direct care staff providing residents' baths including checking resident's previous weights, weighing the resident and direction to do a reweigh for changes of five pounds more or less.

Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) of the right dominant side, anxiety disorder, aphasia (difficulty expressing oneself), and dementia with behavioral disturbance.

Review of progress notes identified variations of weight greater than five pounds from week to week. The weight summary report identified no reweighs done for the following readings:
* 8 pound (lb) difference from 01/05/16 to 01/13/16
* 6.5 lb difference from 05/17/16 to 05/23/16
* 5 lb difference from 05/31/16 to 06/08/16.
* 5.5 lb difference from 08/24/16 to 08/31/16
* 7 lb difference from 11/10/16 to 11/18/16

During interview on 11/22/16 at 4 p.m. a supervisory staff member (#10) stated re-weighs are done when a weight difference of 5 lbs is identified. The weight summary report identified staff weighed Resident #3 with a tub scale prior to 11/18/16, and beginning on 11/18/16 staff used

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F 309	Continued From page 18 a Hoyer Scale lift.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to prevent skin breakdown and minimize the potential for the development of pressure ulcers for 2 of 5 sampled residents (Resident #5 and #7) at risk for pressure ulcers who required assistance with repositioning. Failure to consistently reposition residents and implement interventions for pressure relief may result in the development of pressure ulcers. Findings include: Review of the facility policy titled "Standard of Care Policy" occurred on 11/23/16. This policy, revised December 2014, stated, ". . . Skin Standards . . . Reposition all chair and bed bound residents every 2 hours . . ." - Review of Resident #5's medical record	F 314	1. a. Staff were instructed at shift-to-shift report beginning on 11/24/16 through 12/1/16 to elevate the heels of Resident #5 at all times when in bed. One-to-one staff instruction was also provided on 11/24/16, 11/26/16 and 11/27/16 by the Nursing Services Coordinator. b. The Nursing Services Coordinator consulted with the Restorative Care Assistant on 11/26/16 to extend the foot pedal further for resident #7. 2. Any resident requiring assistance to reposition could potentially be affected by this practice. 3. Education will be provided on 12/15/16 and 12/16/16 to all CNA and nursing staff regarding proper positioning of feet while in bed and on foot pedals of wheelchairs. As part of this education, staff will be required to demonstrate the proper	12/28/16

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F 314	Continued From page 19 occurred on all days of survey and diagnoses included severe dementia. A quarterly Minimum Data Set (MDS), dated 08/18/16, identified severely impaired daily decision making, extensive assistance of two staff members for bed mobility, and at risk of pressure ulcers. Information provided by the facility identified Resident #5 was bedfast. The current care plan stated, ". . . I have a heel that is reddened . . . Interventions . . . Please place the Gel Cushion so it is at the foot of the bed and underneath my heels . . . Please position me so I do not have my heels in contact with the footboard . . . Please stack two pillows underneath both of my lower legs just above the heels to elevate my heels above the mattress and Gel Cushion . . . I have an ADL [activities of daily living] Self Performance Deficit r/t [related to] Alzheimer's . . . Bed Mobility . . . Usually once in bed I am able to reposition myself . . ." During an interview on the morning of 11/22/16, a certified nursing assistant (CNA) (#3) identified Resident #5 was unable to reposition herself in bed. During all days of survey, observation identified Resident #5 remained on her back in bed. The resident received all meals in bed. Pressure-reducing devices included a gel cushion under the resident's heels. Observation showed staff failed to elevate Resident #5's heels/legs with pillows on all days of survey and failed to reposition the resident every two hours as per facility policy for bedfast residents.	F 314	techniques to elevate residents heels while in bed. 4. QA will be conducted weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year. This QA will be completed by the Nursing Services Coordinator or designee to include the observation of positioning of feet while in bed and in wheelchairs for residents who are dependent on staff for repositioning.	

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- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) (stroke) with hemiplegia (paralysis of one side of the body) of the right side of her body, aphasia (loss of ability to understand or express speech), congestive heart failure, non-insulin dependent type 2 diabetes mellitus, and peripheral vascular disease (PVD).

Resident #7's annual MDS, dated 09/30/16, identified unclear speech, usually makes self understood, able to understand others, and unable to interview for an assessment of cognitive status. The MDS identified extensive assistance for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The MDS identified the resident with functional limitation in range of motion bilaterally.

Observation of Resident #7 on all days of survey showed the resident seated in a wheelchair, except when toileted by staff. During observation the resident's right arm and hand were in a contracted position, and right ankle and foot were in an involuntary extension position, and a marked foot drop (inability to move the front part of the foot) was present. The foot rest for the resident's right foot had a thin padding. Observations included the following:
* 11/21/16 at 3:55 p.m. the resident sat in a wheelchair in the dining room table. The resident's right heel rested on the front edge of the foot pedal.
* 11/21/16 at 5:00 p.m. two CNAs (#11 and #12) transferred Resident #7 from her wheelchair to

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the toilet, and back to her wheelchair. The CNAs attached the foot pedal on the right side of the wheelchair, and placed the back of the heel and instep onto the foot plate. The forefoot extended off the end of the foot plate.
* 11/22/16 at 7:40 a.m., while the resident sat in her wheelchair, observation showed both of her feet and lower legs with marked edema.
* 11/23/16 at 10:00 a.m., the resident sat in her wheelchair in the hallway near the nurse's station with her back heel and instep resting onto the foot plate and the forefoot extended off the end of the foot plate.

The care plan identified the resident with communication problems as well as the problems of:
* ADLs with an intervention of "SKIN INSPECTION: I am at risk for skin breakdown do [sic] to my immobility from my stroke. I have weakness on my RT [right] side and I am unable to reposition myself. Please check my skin every shift for redness, open areas, scratches, cuts, bruises and report changes to the Nurse."
* "potential for skin breakdown and pressure ulcers . . . I have increased edema in LE's [lower extremities] and DX [diagnosis] of PVD. 9-26-16 Pink skin tissue of instep of R [right] foot with several tiny firm white bumps top of R foot et [and] base of 2nd, 3rd et 4th R toes."
Interventions included the resident refusing to wear blue heel lift boots when she is in bed or in the recliner and "I do not have to wear them if I am up in the wc [wheelchair]." The care plan identified the resident preferred to sleep in her recliner at night verses in her bed, and sit in wheelchair when awake. The care plan did not address the resident's foot drop and measures to

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F 314	Continued From page 22 relieve/prevent pressure to the right foot when seated in the wheelchair and recliner. On 11/23/16 at 10:10 a.m., a physical therapist (#13) stated staff attempted different interventions other than the resident placing her right foot onto just part of the foot pedal. The most current therapy assessment, completed on 09/30/15, (over a year ago) stated, "UPDATE: Pt [patient] has increased edema in right leg, restorative aide and OTR [registered occupational therapist] spoke with pt re [regarding] leg placement on leg rest. Pt wants her foot to fit all the was [sic] back of pedal, which isnt [sic] possible due to edema in leg, knee cannot bend to fit foot on the plate. Put an elevating leg rest on and adjusted length, concern is that her foot will develop pressure from foot plate, restorative and OTR padded the plate with a foot support in order to decrease pressure to foot. Discussed this with pt, who did agree to try this option." Resident #7's marked edema of the feet, medical diagnoses including paralysis and decreased sensation of her right side, PVD, diabetes, communication difficulties, and need for extensive assistance/dependence from facility staff, placed her at risk of pressure ulcer development. The facility failed to ensure no unnecessary pressure occurred to Resident #7 right heel and instep.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		12/28/16

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F 323	Continued From page 23 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 3 of 10 sampled residents (Resident #3, #4, and #5) who required extensive assistance with cares. Failure to assess and ensure the safety of side rails (Resident #3), assess and determine resident assistance needs required with cares (Resident #5), provide the required staff assistance during cares (Resident #5), and utilize a gait belt for safe transfers (Resident #4) placed residents at risk for injury, including entrapment and falls. Findings include: An internet website http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications/ucm062884.htm, dated August 23, 1995, stated "This Safety Alert concerns entrapment hazards associated with the use of hospital bed side rails in a small, identifiable patient population, and recommends certain actions to prevent such hazards. The Alert is not specific to any manufacturer or product; it is part of a cooperative effort between FDA, the healthcare industry, and manufacturers to resolve the problem. Currently, no universal standards exist for design of hospital bed side	F 323	1. a. The bedrail for Resident #3 was removed. b. CNA staff were instructed in shift-to-shift report beginning on 11/24/16 through 12/1/16 the importance of following the care plan (specifically for Resident #5) and using gait belts for any resident who requires weight bearing assistance and, specifically, for Resident #4.. 2. a. All residents using bedrails have the potential to be affected. b. All residents are affected by staff members consistency in following the care plan and using gait belts when needed. 3. a. Education will be provided on 12/15/16 and 12/16/16 to all Housekeeping, Bedmaker, CNA and nursing staff regarding the entrapment potential between the gap of a mattress and bedrail, and the proper way to position and secure mattresses to prevent movement that could potentially create a gap between the mattress and the bedrail. Staff will also be required to do a return demonstration of the proper way to position and secure mattresses. b. Education will be provided on 12/15/16 and 12/16/16 to all CNA and nursing staff regarding gait belt use and the importance of following care plans. As	

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MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

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F 323	Continued From page 24 rails . . . All deaths involved entrapment of the head, neck, or thorax, while most injuries involved fractures, cuts, and abrasions to the extremities. . . . the majority of the deaths and injuries involved elderly patients. Patients at high risk for entrapment include those with pre-existing conditions such as confusion, restlessness, lack of muscle control, or a combination of these factors. . . . FDA recommends the following actions to prevent deaths and injuries from entrapment in hospital bed side rails: Inspect all hospital bed frames, bed side rails, and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement, or bed position. . . . Additional safety measures should be considered for patients identified as high risk for entrapment. Such patients include those with altered mental status (organic or medication related) or general restlessness. Increased risk also occurs when the patient's size and/or weight are inappropriate for the bed's dimensions. . . ." Review of the facility policy and procedure "ASSESSING AND REPORTING FALL EVENTS" occurred on 11/23/16. The policy, revised November 2016, stated, ". . . PROCEDURE: . . . In the event of a fall the documentation should include the following information: . . . What was the resident doing prior to the fall, Fall precautions in place at the time of fall, Resident	F 323	part of this education, staff will be required to demonstrate proper gait belt use and an understanding of when a gait belt is necessary. c. An assessment will be developed for use with anyone utilizing a bedrail to determine the potential risk for entrapment. 4. a. QA will be conducted weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year. This QA will be completed by the Nursing Services Coordinator or designee to include gait belt use and following the plan of care. b. A second QA will be conducted weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year by the Support Services Coordinator or her designee on the proper positioning and securing of mattresses.	

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condition prior to fall . . . What is the plan of action to prevent this from happening again . . . The nurse will then update the resident's care plan . . . Nursing will care-plan the fall and initiate a plan to prevent the fall from happening again. . . . by adding the new interventions to the Care-plan Kardex."

Review of the facility policy titled "Standard of Care Policy" occurred on 11/23/16. This policy, revised December 2014, stated, ". . . Transferring Standards, Gait belt will be used when resident needs assistance with walking and transferring . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with hemiplegia (paralysis) of the right dominant side, anxiety disorder, aphasia (difficulty expressing oneself), and dementia with behavioral disturbance.

A quarterly Minimum Data Set (MDS), dated 11/05/16, identified the resident with short and long term memory loss, unclear speech, sometimes able to make self understood, and sometimes able to understand others. The quarterly MDS, and an annual MDS dated 08/05/16, each identified the resident required extensive assistance of two or more persons for bed mobility, transfers, dressing, toileting, and personal hygiene.

Resident #3's current care plan for activities of daily living (ADLs) identified "Self Care Performance Deficit r/t [related to] Stroke, Dementia, Impaired balance . . . My ADL status

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can fluctuate due to how I feel; my mood; and cognition. . . ." Interventions included the use of a full body lift as of 10/16/16 and "BED MOBILITY: I need extensive assistance of 2 for bed mobility but once I am in bed I am independent with repositioning. . . ." The care plan also identified the problem of falls with interventions of "Bed, chair et [and] w/c [wheelchair] alarm [revised at 08/05/13] . . . Blue mats on floor in front of bed when [resident] is laying in bed. [initiated 09/03/14] . . . Encourage/remind me to use call light. I like to gets [sic] up frequently per self. [revised on 10/12/14] . . . I have a hi-low bed, make sure it is in the lowest position when I am in it [revised 09/16/13] . . . . I need extensive assistance with toileting et dressing. Res [resident] able to get to a standing position when sitting at times. . . . I will have my bed alarm placed at shoulder level when laying in bed. When I sit up in bed the bed alarm will trigger the call light and allow staff at least some time to respond before I attempt to slide around on the bed [initiated 03/27/15] . . . Place a pillow between the bed mattress and side rail when side rail not being used to reduce the risk of [resident] bumping into the side rail [initiated 07/06/16] . . . . right side of bed against the wall. When repositioning on left side-reposition to far right of the bed with my back against the wall so I don't attempt to climb out of bed [initiated 11/18/16] . . ." The care plan failed to identify the reason for the side rail.

Observation on November 21-22, 2016, showed the presence of plastic rails on both sides of the resident's bed. The rails extended the upper third of the bed. Observation showed the bed rail on the resident's right side, against the wall, in the

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down position, and the rail on the resident's left side (exit side of bed) in an upward position. Measurements taken at 2:40 p.m. identified a distance of the rail from the mattress as two inches on each size of the mattress, for a total opening potential of four inches with shifting of the mattress in either direction (large enough to allow an entrapment of a body part).

Progress notes regarding the falls included:
* 03/21/16 at 1:30 a.m. in his room: ". . . At 0130 [1:30 a.m.] the bed alarm had not sounded and Night CNA's [sic] [certified nursing assistants] went into the room and found [resident] laying on his right side with full body laying on the blue mat including his head. [Resident's] head though was by the night stand and [resident] could have rolled his head around and hit his head on the night stand. . . . Bed rail was down and Bed alarm was not functioning but when the CNA's set up the bed alarm again it was functioning normally. . . . plan of action . . . Make sure bed alarm is functioning when setting the bed alarm. Make sure side rail is securely in upright position." The note identified the resident sustained a "rug burn type skin tear right elbow" and had an undigested emesis of food and juice.
* 06/21/16 at 4:20 a.m. in his room: "No call light on. Writer heard [resident] yelling out and entered the room immediately. [Resident] was found with his legs crossed tightly and his knees in the blue mats. [Resident's] chin was between the bed mattress and the bed rail. No injuries . . . prior to fall: Sleeping in bed. . . fall precautions were in place at the time of the fall: Bed alarm . . . No head injuries, head was still in bed. . . . bed alarm . . . functioning . . ."
* 07/05/16 at 11:59 p.m. regarding fall on

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F 323	Continued From page 28 06/21/16: ". . . interviewed staff and assessed [resident's] mobility and feel that the benefit of having the side rail for mobility outweighs the risk at this point as he used the side rail most of the time for transfers and repositioning. . . . Mattress placed in the middle of the bed, will continue to check to be sure it is placed appropriately and explore different options for mobility assist. At this time a pillow will be placed between the rail and the mattress to fill any potential for there being a gap between the mattress and the mobility device." Neither the care plan nor the "Resident ADL's Sheet" (provided to direct care staff) identified this intervention. Observations on November 21-22, 2016 failed to show a pillow in place between the side rail and mattress. * 09/03/16 at 8:20 p.m.: "No call light was set by bed alarm. Was found with upper body still on bed alarm sensor pad at the middle of the bed and his lower body sitting on the blue mats in front of his bed. [Resident] had been sleeping quietly when checked with the head of the bed slightly up and call light in place . . . No injuries observed . . . Upper body had not slid out of bed. . . . Bed rail up x [times] 1, Call light in place, Bed alarm on bed but not positioned underneath the residents shoulder blades per care plan. . . . No injuries. . . . Note to communications sheet to remind CNA's to place the sensor alarm pad at shoulder blade level per care plan." * 11/18/16 at 2:33 a.m. in the room: "Was yelling out and night CNA entered room and was found kneeling on the blue mats beside his bed and leaning with his left side against the bed and his left arm on top of the bed. Bed alarm did not function and did not set the call light. Bed alarm checked and is functioning properly now. . . . precautions in place . . . Blue mats. Bed alarm	F 323		

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alarm [sic] which did not function when the incident occurred. . . . plan of action . . . has a history of crawling out of bed when laying on his left side. However does not crawl out if his [sic] is repositioned far enough way [sic] from the left side of the bed. Will position the bed with the right side against the wall. Will care plan when repositioning [resident] to his left side that he must be positioned with his back to the far right side of the bed with his back against the wall."

The progress notes identified the following:
* Each of the falls, along with the current care plan, indicated the presence/use of a side rail on the bed. The fall on 06/21/16 showed the hazard of the side rail when the resident's "chin was between the bed mattress and the bed rail."
* A follow-up progress note/assessment after the fall on 06/21/16 involving the entrapment with the side rail did not occur until 07/05/16, 15 days later.
* On three of the five occasions with Resident #3 in bed, the bed alarm/call light did not activate.
* The description of two of the falls are consistent with the resident having right sided hemiplegia (paralysis) from the CVA (fall onto right side and "leaning with his left side against the bed and his left arm on top of the bed."

During interview on 11/22/16 at 4:35 p.m. an administrative staff member (#1) defined the rail used on Resident #3's bed as a "soft safe" rail and stated following the fall incident/entrapment on 06/21/16: 1) the side rail should not have been up; 2) the mattress was pushed over towards the wall side of the bed and not placed securely within the bed frame and agreed this would create more of a gap between the

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mattress and bed rail; 3) Resident #3 utilized the side rail for repositioning/positioning and to improve the resident's quality of life. The decision was made to keep it on the bed; 4) within the facility side rails are evaluated quarterly; 5) Resident #3 holds onto the rail during twice (currently) daily catheterization; 6) when catherization is not occurring staff are to place a pillow by the side rail; and 7) the reason the bed alarm did not sound was because the resident was still laying on it.

The facility failed to recognize the potential hazards for entrapment in elderly residents, including those with cognitive impairment, confusion and pre-disposing factors, while utilizing side rails.

- Review of Resident #5's medical record occurred on all days of survey and identified diagnoses of severe dementia and anxiety. The quarterly MDS, dated 08/18/16, identified long and short-term memory impairment, severely impaired daily decision making, limited range of motion to both upper and lower extremities, and a fall since the prior assessment. The MDS identified the resident required extensive assistance of two staff members for bed mobility and total assistance of two staff members for toileting.

The current care plan stated, ". . . I have an ADL Self Care Performance Deficit r/t [related to] Alzheimer's . . . Interventions . . . Toilet Use: I am not able to be transferred onto the toilet anymore due to decreased mobility and impaired cognition . . . Bed Mobility: I need extensive assistance of 1 to 2 for bedmobility [sic] . . . I am at risk for falls

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r/t unaware of safety needs, confusion . . . 6/16/16 rolled out of bed . . . Interventions . . . 2 staff members when changing linen, when [Resident #5] is in bed . . ." Review of the "Resident ADLs Sheet" identified Resident #5 required the assistance of two staff members for toileting.

A nurse's note, dated 06/16/16 at 10:45 a.m., identified during Resident #5's partial bath, staff removed the soiled linens and when they turned to obtain the clean ones, the resident rolled on to the floor. The note identified following this incident, the facility would ensure two staff members present when changing the linen if Resident #5 remained in bed.

Observation on 11/22/16 at 10:30 a.m. identified a CNA (#3) rolled Resident #5 on to her left side, performed perianal cares, and removed the resident's soiled fitted sheet and brief. The CNA (#3) rolled the resident on to her left side again and placed a clean fitted sheet and brief. A second CNA (#7) came to assist while the CNA (#3) secured all corners of the fitted sheet.

During an interview on 11/23/16 at 12:00 p.m., an administrative nurse (#1) stated she expected two staff members to assist when changing Resident #5's brief and linen. The nurse (#1) confirmed CNAs should not determine the number of staff required to move the resident in bed and stated she would specify "2" on the care plan versus "1 or 2" for bed mobility.

- Review of Resident #4's medical record occurred on all days of survey and identified a history of falls and diagnoses of osteoporosis and

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F 323	Continued From page 32 lumbar degenerative disc disease. The quarterly MDS, dated 10/15/16, identified extensive assistance of one staff member for transfers and walking in the resident's room and a fall since the prior assessment. Observation on 11/22/16 at 11:10 a.m. identified a CNA (#3) assisted Resident #4 to walk from her bed to the bathroom, and from the bathroom to her wheelchair, by wrapping her left arm around the resident's waist and using her right hand to guide the resident's right arm. The CNA (#3) failed to use a gait belt while assisting Resident #4. During an interview on 11/23/16 at 12:00 p.m., an administrative nurse (#1) stated she expected staff to use a gait belt when providing "extensive assistance" to residents.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference,	F 328	1. The oxygen tank was secured by the	12/28/16

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F 328	Continued From page 33 and staff interview, the facility failed to safely secure an oxygen tank in 1 of 1 nursing station. Failure to secure the oxygen tank placed residents, visitors and staff at risk of injury in the event the oxygen tank falls, breaks, and becomes a projectile object. Findings include: NFPA 55, 7.1.4.4 states, "Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7". Observation on 11/21/16 at 5:40 p.m. showed an unidentified facility transport staff placed an unsecured oxygen tank in the nurses station. Staff walked between the oxygen tank and the medication cart for approximately 50 minutes without securing the oxygen tank. On 11/21/16 at 6:30 p.m., an administrative nurse (#1), confirmed the oxygen tank should be securely stored. She placed the oxygen tank in the storage cabinet oxygen cart in the back of the nurses station.	F 328	administrative nurse when identified. 2. Any time an oxygen tank is unsecured, there is a potential risk. 3. Education will be provided to staff regarding the hazard of unsecured oxygen tanks at shift-to-shift reportson 11/24/16 through 12/1/16, all staff daily meetings, a CNA/Nursing education meeting on 12/15/16 and 12/16/16, and the all staff newsletter on 12/23/16. 4. A QA will be completed weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter by the Administrator or her designee to ensure that oxygen is properly secured.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		12/28/16

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F 441	Continued From page 34 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, professional reference review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 3 of 7 sampled residents (Resident #1, #2, and #5)	F 441	1. Instructions regarding the need to wipe off catheter drainage spouts after emptying for Resident #1 and the need to remove gloves and wash hands after providing peri cares was provided at	

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F 441	Continued From page 35 observed during personal cares. Failure to provide proper perineal care, remove gloves and perform hand hygiene after completing perineal care and failure to cleanse the urine drainage port of a foley catheter bag may contribute to the spread of infection within the facility. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 11/23/16. This policy, reviewed November 2014, stated, ". . . Hand Hygiene . . . 7. Except for situations where hand washing is specifically required, anti-microbial agents such as ABHR [Alcohol Based Hand Rub] are also appropriate for cleaning hands and can be used for direct resident care: . . . Before and after assisting a resident with personal care . . ." When requested a policy regarding catheters the facility provided copied information from a nursing textbook. This information stated, "Emptying the catheter drainage bag . . . When urine has drained, close spout. Using alcohol wipes clean the drain spout. . . ." - Observation on 11/22/16 at 2:00 p.m. showed a CNA (certified nursing assistant) (#3) emptied the urine from Resident #1's foley leg bag. The CNA failed to wipe the drainage spout with an alcohol swab after emptying the urine. During an interview on the afternoon of 11/23/16 an administrative nurse (#1) stated she expected staff to clean the drain spout with an alcohol wipe after emptying Resident #1's foley catheter.	F 441	shift-to-shift reports beginning on 11/24/16 to 12/1/16. Instructions regarding glove and handwashing for Residents #2 and #5 was included in education provided for nursing staff on 12/15/16 and 12/16/16. was provided at shift-to-shift reports beginning on 11/24/16 to 12/1/16. 2. Any resident with a foley catheter or requiring assistance with toileting has the potential to be affected by this practice. 3. Education will be provided to all CNA and nursing staff regarding proper infection control techniques, including glove usage and removal, handwashing, and proper technique for emptying and sanitizing of foley catheter bags. 4. QA will be conducted weekly for four weeks, bi-weekly for one month, monthly for three months and quarterly thereafter for a year. This QA will be completed by the Nursing Services Coordinator or designee to include the observation of infection control practices.	

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MARYHILL MANOR	110 HILLCREST DR ENDERLIN, ND 58027

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F 441	Continued From page 36 - Observation on 11/21/16 at 3:00 p.m. showed two CNAs (#8 and #9) assisted Resident #2 onto the the toilet using a mechanical lift. After the resident voided the CNA (#8) provided perineal care and removed her gloves. The CNA (#8) assisted Resident #8 into bed, rolled the resident back and forth in bed, adjusted the resident's clothing, removed the sling from under the resident, moved the resident's blanket and performed hand hygiene. The CNA failed to perform hand hygiene prior to completing other tasks. - Observation on 11/22/16 at 10:30 a.m. showed a CNA (#3) provided personal cares for Resident #5 who was incontinent of urine and a smear of stool. Wearing gloves, the CNA (#5) rolled the resident onto her left side and cleansed the resident's buttocks with a wipe. Observation showed stool on the wipe. After wiping the buttocks, the CNA (#3) kept her gloves on and removed the bedding, soiled with urine, placed a clean fitted sheet, placed a clean linen protector and brief, repositioned the resident, placed a pressure-reducing pad and pillow under the resident's legs, covered Resident #5 with a sheet, tucked the sheet around the resident, lowered the bed, and then sanitized her hands. The CNA (#3) failed to perform perineal cares after the resident was incontinent of bladder and failed to perform hand hygiene immediately after completing perianal cares and prior to completing other tasks.	F 441		