STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 06/17/2010

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 and complaint survey started on 06/14/10 and completed on 06/17/10, the sample included four (4) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review.	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the Facility has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the Facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 9, 2009. Based on observation, record review, review of facility policies and procedures, resident interview, and staff interview, the facility staff failed to promote and preserve resident's dignity and privacy for 4 of 16 sampled residents (Residents #6, #10, #12, and Resident A). Findings include: Review of the facility policy titled "Bathing" occurred on 06/16/10. This policy, dated 03/16/01, stated, ". . . Remove top bed linens and gown and cover with bath blanket while maintaining dignity . . . Dry all parts well after bathing while keeping covered for warmth and privacy . . ." - Resident #6's record review occurred on June	F 241	F 241 It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. 1. Resident #12's concerns were addressed with facility administration. Re-education on providing privacy during bed baths was conducted by Administrative Director of Nursing Services or designee to Certified Nursing Assistants. 2. Residents receiving care and services at a health care facility could be at risk for privacy or dignity issues.	7/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Steele | TITLE: Administrator | (X6) DATE: 7/5/10

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 15-17, 2010 and indicated the resident's diagnoses included anxiety, depression, and macular degeneration/legal blindness. The resident's Minimum Data Set (MDS) indicated short and long term memory problems, moderately impaired decision making, and dependence upon staff for bed mobility and all personal cares/hygiene. Observation on 06/15/10 at 8:10 a.m., showed a Certified Nursing Assistant (CNA) (#5) provided a bedbath for Resident #6. The CNA (#5) pulled the blankets down to the foot of the bed and removed the resident's nightgown. The CNA (#5) failed to cover the resident with a bath blanket, and the resident remained completely exposed throughout the bedbath. An interview occurred with an administrative nursing staff member (#2) on the morning of 06/17/10. The staff member (#2) stated she would expect staff to cover the resident's upper body when washing the lower body as well as to cover the resident's lower body when washing the upper body. - Observation on 06/15/10, during the evening meal, showed Resident #12 seated in the dining room. The resident requested an additional serving of meat. An unidentified CNA approached the serving window and loudly stated, "[Resident #12's name] wants more meat." This comment was heard from across the dining room. Resident #12's medical record review occurred on June 16-17, 2010. The resident's diagnoses included quadriplegia, depression, and malnutrition. The resident's MDS indicated no short or long term memory loss with modified	F 241	3. Certified Nursing Assistants were re-educated on the provision of privacy during bed baths by the Administrative Director of Nursing Services or designee. Staff was re-educated on knocking and waiting for a response and provision of privacy when requesting food items for patients by individual department managers or designee. 4. Observations of bed baths for the provision of privacy will be conducted three times per week for the first four weeks, three times per month for the next two months and as needed there after for continued compliance. These observations will be conducted by the Directors of Care Delivery or designees. Observations of provision of privacy for patients requesting food will be conducted three times per week for the first four weeks, three times per month for the next two months and as needed there after for continued compliance. These observations will be conducted by the dining room monitors. Hallway observations for knocking and waiting for a	

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F 241	Continued From page 2 independence in daily decisions. During an interview with Resident #12, on 06/16/10 at 2:50 p.m., an unidentified physical therapy staff member briefly knocked and immediately entered the resident's room without announcing himself or waiting for a response from the resident. Resident #12 stated, "Did you see that? They just walk in. It doesn't matter if I'm on the bedpan. Staff just barge into my room. It would be nice if they'd wait until I say come in. I have real privacy issues here. Nothing changes." During an interview with Resident #12 on 06/16/10 at 5:50 p.m., a CNA (#8) knocked and immediately entered the resident's room without announcing himself or waiting for a response. The resident stated, "See? He didn't know you were in here." Resident #12 stated it upsets him when staff enter his room when he is out, move items around, and discard things he wished to keep. He stated he feels his privacy is not respected in the dining room when he requested extra food and the staff stated this aloud and used his name. - Review of Resident #10's medical record occurred June 15-17, 2010. The resident's diagnoses included depression disorder, aphasia, and hemiplegia affecting her dominant lower extremity. The resident's current Minimum Data Set (MDS), dated 05/21/10, identified short term memory problems, no long term memory problems, and extensive assistance with bathing and personal hygiene. Observation on 06/15/10 at 8:30 a.m., showed a CNA (#12) provided a bed bath for Resident #10. The CNA moved the resident's blankets to the	F 241	response prior to entering a resident's room will be conducted three times per week for the first four weeks, three times per month for the next two months and as needed there after to ensure continued compliance. Observations will be made by department managers. Results of observations will be reviewed monthly by the Quality Assurance Committee for compliance.	

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F 241	Continued From page 3 foot of her bed. The CNA then removed the resident's gown exposing her upper and lower body. The CNA failed to cover the resident; leaving the resident exposed throughout the bed bath. The CNA dressed the resident in pants and then an upper body undergarment at 8:40 a.m. An interview occurred on 06/16/10 at 4:45 p.m with Resident #10. When asked if she had been uncomfortable while uncovered during the observed bed bath, she replied, ""Right on." During an interview on 06/17/10 at 9:15 a.m., an administrative nursing staff member (#13) stated the CNA "shouldn't be leaving her exposed" and confirmed staff should cover residents' upper body when washing the lower body and cover residents' lower body when washing the upper body. - During an interview on 06/14/10 at 4:45 p.m., Resident A, identified by the facility as interviewable, stated on occasions, night staff entered her room without knocking. Resident A stated she sleeps lightly and was startled when she opened her eyes and found someone in her room. She stated she's asked the night staff to knock before entering her room but it continued to occur. Failure to provide coverage of the residents' bodies during personal cares and failure to knock prior to entering residents' rooms is an infringement of the residents' right to privacy and dignity.	F 241		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	F315 It is the practice of this facility to ensure that a resident who is incontinent receives appropriate treatment to restore as much normal bladder function as possible.	7/21/10

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F 315	Continued From page 4 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, record review, and staff interview facility staff failed to provide the treatment and services to restore normal bladder function for 1 of 1 sampled resident (Resident #3) identified by the facility as on a toileting program. Failure of facility staff to toilet Resident #3 has the potential to hinder the resident's rehabilitation potential and ability to return home. Findings include: Record review for Resident #3 occurred June 14-17, 2010. The medical record identified the facility admitted the resident in August 2009. The resident went to the hospital 05/04/10 and returned to the facility 06/08/10. Diagnoses on return from the hospital included pneumonia, and weakness. A quarterly Minimum Data Set (MDS), dated 02/23/10, identified Resident #3 with intact long and short-term memory, modified independence with daily decisions - some difficulty in new situations only. This MDS identified Resident #3 required extensive assistance of two staff members for toilet use and personal hygiene. This MDS indicated Resident	F 315	1. Resident #3 is currently using a mechanical lift to transfer to the toilet. Occupational therapy is assisting Resident #3 with bladder retraining. Resident #3's care plan was modified to contain this information. 2. The care plan of residents readmitted following a hospitalization since June 14, 2010 were reviewed and revised as necessary to accurately reflect the toileting/incontinence care being provided upon readmission. 3. Nursing staff were re-educated on the provision of toileting according to the care plan by the Administrative Director of Nursing Services or designee. Directors of Care Delivery and Resident Assessment Coordinator were re-educated on the review of toileting care upon re-admission by the Administrative Director of Nursing Services or designee. 4. If applicable, two care plans of re-admission will be reviewed for accuracy of current toileting per week for the first four weeks and monthly for the next two months and as needed there after to ensure continued compliance.	

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F 315	Continued From page 5 #3 experienced a decline in bladder continence, used pads/briefs, and as occasionally incontinent of bladder, defined as incontinent two or more times a week but not daily. The MDS further indicated, for discharge potential, the resident expresses/indicates preference to return to the community and has a support person who is positive towards discharge. Resident #3's care plan for bowel and bladder incontinence, date initiated 11/24/09 revised 06/14/10, stated, "Focus: Bowel and urinary incontinence related to decreased mobility. Continent of bowel and bladder at times. . . . Interventions: . . . Bladder Retraining by O.T. [occupational therapy]. Check for incontinence frequently and provide incontinent care as needed. Encourage to use bathroom to regain continence. This same care plan, revised 06/15/10, stated: "Focus Bowel and urinary incontinence related to decreased mobility. Continent of bowel and bladder at times. Uses bedpan for toileting. . . . Intervention: . . . Remind and assist as needed with toileting at routine times such as upon arising in AM [morning] before/after meals, activities, therapy and at bedtime. . . .[facility staff deleted bladder retaining from O.T.]" The information sheet for cares, printed 06/16/10, provided to CNAs for Resident #3 stated, "Remind and assist as needed with toileting at routine times such as upon arising in AM, before/after meals, activities, therapy and at bedtime." This information sheet lacked direction to assist Resident #3 in using the bedpan. Observations of Resident #3 on the morning of	F 315	This will be conducted by the Directors of Care Delivery or designees. CNA documentation will be reviewed for a period of seven (7) days for each of the care plans identified in the reviews to ensure care plans are being followed. This will be done by the Directors of Care Delivery or designees according to the time schedule identified above. Reviews will be brought to the Quality Assurance Committee monthly to monitor compliance.	

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F 315	Continued From page 6 06/15/10 showed the following: * 8:30 a.m., eating breakfast in the Court Yard dining room. * 8:55 a.m., in wheelchair propelling herself down the hallway toward physical therapy. * 9:35 a.m., pedaling a stationary bike in physical therapy. *10:40 a.m., working with occupational therapy. * 12:15 p.m., waiting in the hall while staff assisted her roommate, then staff transported the resident to the dining room without toileting. On 06/15/10 at 1:22 p.m., two Certified Nursing Assistants (CNAs) (#3 and #4) transferred Resident #3 to bed using a full body mechanical lift. As the CNAs (#3 and #4) lifted Resident #3, from the wheelchair, a stream of urine flowed from Resident #3 onto the wheelchair and floor. During the transfer, one CNA (#4) held a disposable linen protector under the resident as the other CNA (#3) moved the resident to the bed. The CNAs (#3 and #4) removed the wet brief, provided pericare, and applied a clean brief. The CNAs (#3 and #4) failed to provide or offer Resident #3 with an opportunity to use the bedpan. An interview with one of the CNAs (#4) identified this was the first time staff assisted Resident #3 with toileting since morning cares before breakfast. The CNA (#4) stated staff were aware of the need to assist Resident #3, but the resident had gone to therapy and then it was meal time. CNA documentation on 06/15/10 indicated staff had toileted Resident #3 at 11:26 a.m., which conflicts with the interview. On 06/15/10 at 3:00 p.m., two CNAs (#6 and #7) assisted Resident #3 from bed to the resident's	F 315		

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F 315	Continued From page 7 wheelchair using a full body lift. Prior to transferring Resident #3, the CNAs removed the resident's wet brief, provided pericare and applied a clean brief. The CNAs (#6 and #7) failed to offer Resident #3 the opportunity to use the bedpan. Review of the CNA documentation of toileting assistance provided to Resident #3 from 06/08-15/2010 showed the resident went as long as ten hours without being offered an opportunity to toilet. Documentation of care provided did not indicate if staff used a bedpan or if staff checked and changed Resident #3 as the observations of care demonstrated. During an interview with Resident #3 on 06/16/10 at 4:05 p.m., the resident identified she had not used the bedpan since returning from the hospital. Resident #3 stated prior to her hospital stay she used the bathroom for toileting. Resident #3 further stated the current system as "so easy" (being checked and changed), but that she needs to get better. Stating "I want to go home." During an interview, on 06/16/10 at 7:50 a.m., with an administrative nurse (#2), this nurse indicated staff were to use the bedpan for Resident #3. This nurse (#2) also stated staff are to assist Resident #3 with toileting after breakfast before going to therapy.	F 315		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	F363 It is the practice of this facility to serve food from our menus in the correct portions for each diet.	7/21/10

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F 363	Continued From page 8	F 363		

This REQUIREMENT is not met as evidenced by:
Based on observation, policy and procedure review, and staff interview, the facility failed to serve food in the correct portions for each diet identified in the prepared menus during 2 of 2 meal observations (06/15/10 evening meal and 06/16/10 noon meal). Failure to serve residents with the correct serving utensil has the potential to result in residents' nutritional needs (calories and protein) not being met and may result in resident(s) experiencing weight loss.
Findings include:

Review of the facility's policy "Portion Control Equipment," dated 04/07/10, occurred on the afternoon of 06/16/10. The policy stated, ". . . Portioning is used with standardized recipes to meet menu requirements. 1. Identify portion control equipment needed by checking recipes and the Diet Spreadsheet. . . . 6. Post charts of portion control sizes and colors for color coded equipment. 7. Review serving sizes on recipes and menus with staff before meal preparation and service. . . ."

- Observation of tray line at the evening meal, on 06/15/10 at 5:50 p.m., showed a dietary staff member (#16) served the meal using the following serving utensils:
*Regular Sweet and Sour Pork - one #8 (4 ounces) scoop
*Ground Sweet and Sour Pork - one #8 (4 ounces) scoop
*Pureed Parslied Rice - one #12 (2.6 ounces) scoop

1. Cooks and dietary staff have been re-educated on using correct serving utensils by the Food Service Manager.

2. All residents may be affected. The Food Service Manager or designee will audit 5 meals per week for two weeks and 3 meals per week for 2 months to ensure proper food portioning.

3. The Food Service Manager or designee will audit staff for use of correct serving utensils at 5 meals per week for two weeks and 3 meals per week for 2 months.

4. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance.

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F 363	Continued From page 9 Interview of dietary staff members (#16 and #17) occurred on 06/15/10 at 5:50 p.m. The dietary staff member (#16) stated she would "fill fuller" (heaping) the scoops of pureed rice, because she didn't think the scoop she used served enough rice. Dietary staff members (#16 and #17), identified four residents received pureed diets and at least ten residents received ground diets. - Observation of tray line at the noon meal on 06/16/10 at 12:45 p.m., showed a dietary staff member (#17) served a food item using the following serving utensil: *Pureed Zucchini - one #16 (2 ounces) scoop Review of the menu on 06/16/10 revealed the portions, served at the evening and noon meal, to be less than the following planned serving sizes: *Regular Sweet and Sour Pork - one 6 ounce scoop *Ground Sweet and Sour Pork - one 6 ounce scoop *Pureed Parslied Rice - one #8 (4 ounces) scoop *Pureed Zucchini - one #8 scoop During an interview on 06/16/10 at 12:45 p.m., a dietary staff member (#17), stated dietary staff reviewed the menu (Diet Spreadsheet) for portion sizes, however failed to use the correct size serving utensil. During an interview on 06/16/10 at 2:00 p.m., an administrative dietary staff member (#9) stated she had not posted charts of portion control sizes as a guide for dietary staff. The staff member agreed a portion control guide should be available for staff as a reference and dietary staff should serve menu items in the correct amounts identified on the menu. On 06/17/10 at 9:20 a.m.,	F 363		

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F 363	Continued From page 10 an administrative dietary staff member (#18) provided a list of five residents with poor intake and two residents with significant weight loss served pureed or ground diets.	F 363		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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: Based on observation, policy and procedure review, record review, and staff interview, the facility failed to store food and equipment in a safe and sanitary manner in the kitchen and 1 of 3 (South One) nourishment centers on 2 of 2 observation days. Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored in the kitchen or nourishment centers. Findings include: Review of the following facility policies occurred on the morning of 06/17/10. These policies, dated 04/07/06, stated: "Chemical Storage," stated, ". . . Chemicals are stored in dry areas . . ."	F 371	F 371 It is the practice of this facility to store food and clean equipment in a safe and sanitary manner. 1. The pan in contact with the wrapped thawing meat was removed. The shelf identified in the chemical closet has been removed. The wire whip has been discarded and spatulas replaced. Two bins have been cleaned. Exterior surfaces and interior shelves of cupboards were cleaned or replaced. The uncovered carafes of water were covered. The microwave in the nourishment center was cleaned. Utensils identified with debris were cleaned. 2. All areas of the facility will be audited for safe and sanitary conditions.	7/21/10

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F 371	Continued From page 11 "Maintenance Requests," stated, ". . . 1. Determine if the repair is an emergency or if it can be scheduled for a later time. . . 3. When the repair is not an emergency, follow the center's procedures for maintenance requests. In many centers, a work order is completed and given to the maintenance director. 4. Keep a copy of the maintenance request in dietary for follow up. . . ." "Manual Warewashing," stated, " . . . Washing, Rinsing, and Sanitizing 1. Scrape, soak if necessary, remove debris and pre-rinse items to be washed. 2. Wash items in first sink using hot, soapy water. Use a brush, cloth, or nylon scrub pad to loosen remaining soil. . . ." "Storage of Food," stated, ". . . 8. Store raw meat, poultry, and fish separately from cooked and raw ready-to-eat food such as fruits and vegetables by arranging each type of food in equipment or containers so that cross contamination is prevented. . . ." "Cleaning Procedures - Storage Cabinets and Shelves, stated, " . . . 3. Scrub all exposed surfaces with detergent solution. Give special attention to doors . . . 4. Rinse and sanitize all shelves . . ." An initial tour of the kitchen with an administrative dietary staff member (#9) occurred on 06/14/10 at 1:15 p.m. Observation of the walk-in cooler showed a pan containing ready-to-eat, vacuum-packed imitation crab meat. Dietary staff stored the bottom of the pan in contact with thawing, raw ground beef, loosely-wrapped with plastic. If liquid from the thawing meat contacted the bottom surface of the top pan, placing this	F 371	3. The Dietary staff was re-educated on the proper storage of food and sanitation of utensils and equipment by the Food Service Manager or designee. Nursing staff was re-educated on the sanitation of the microwave in the Nourishment Room by the Administrative Director of Nursing Services or designee. 4. The Food Service Manager or designee will conduct dietary audits regarding sanitation and food storage for four weeks and monthly thereafter for 3 months. The audit findings will be reviewed monthly at the Quality Assurance Meeting to monitor compliance.	

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	355024	A. BUILDING _____ B. WING _____	C 06/17/2010

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F 371	Continued From page 12 pan on a work surface could lead to cross contamination. The administrative dietary staff member (#9) removed the pan. A main tour of the kitchen and nourishment centers occurred with an administrative dietary staff member (#9) on 06/16/10 at 8:05 a.m. Observation showed the following in the kitchen: *Chemical storage closet with a musty odor contained a shelf with evidence of water damage and mold. The shelf contained boxes of dishwashing gloves and scouring pads with water damage and a bucket of cleaning supplies with mold on the bottom from the shelf. The administrative dietary staff member (#9) discarded the boxes. The administrative dietary staff member (#9) covered all food in the kitchen and the maintenance staff member (#10) removed the shelf. During an interview on 06/16/10, a maintenance staff member (#10) identified the enclosed chemical closet contained a pipe which channeled water produced by condensation from the walk-in freezer to a drain on the floor of the chemical closet. The staff member stated he had been verbally informed of the need for replacement of the shelf. Dietary staff had not completed a maintenance request and maintenance staff had not completed this replacement based on the verbal notice. *Stored in a drawer: -One rusty, wire whip. -One large rubber spatula with food debris and rough, uncleanable edges. -Two small rubber spatulas with food debris and rough, uncleanable edges. -Two large rubber spatulas with rough, uncleanable edges. The administrative dietary staff member (#9) discarded the wire whip and	F 371		

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F 371	Continued From page 13 replaced the spatulas. *Stored in the dry storage room: - Two bins with significant food debris inside contained packages of dry mixes. Review of the "Weekly Cleaning Schedule" showed had staff cleaned the "Dry Storage Room floor" the prior day. Interview of the administrative dietary staff member stated she expected staff to clean the bins at that time. *Exterior surfaces and interior shelves of four cupboard doors were observed to be heavily soiled. In addition, the surfaces were chipped and not cleanable surfaces. Review of the "Weekly Cleaning Schedule" showed staff would clean the "Food Process Surrounding Wall" in two days. During an interview, the dietary staff member (#9) stated she had attempted to remove the food debris on the cupboards, however observation showed the build-up remained. *Stored in the walk-in cooler: -Two, uncovered carafes of water on a shelf below food items. The administrative dietary staff member (#9) covered the carafes. Observation showed the following in the South One Nourishment Center: *Microwave with food debris on the interior surface. During interview, the administrative dietary staff member (#9) identified the dietary staff or nursing staff cleaning schedule did not include this microwave. The facility opened this new resident area in September 2009. A random observation of utensils stored in a drawer in the kitchen occurred on 06/16/10 at 2:30 p.m. and showed two scoops with food or	F 371		

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F 371	Continued From page 14 paper debris on their interior surfaces. The administrative dietary staff member (#9) removed the utensils from the drawer. During an interview on 06/16/10 at 2:45 p.m., the administrative dietary staff member (#9) agreed food should be stored to prevent contamination and utensils, equipment and surfaces should be clean and the surfaces kept smooth to remain cleanable.	F 371		
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. (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	F 441	F441 It is the practice of this facility to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. 1. Individual re-education was provided to CNA #11 and Nurse #1. CNAs were re-educated on encouraging patients to practice hand hygiene after toileting by the Administrative Director of Nursing Services or designee. 2. Any resident experiencing C. diff or MRSA infection could be at risk. 3. Re-education was provided to CNAs on the use of dedicated equipment in isolation rooms and the encouragement of residents to	7/21/10

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F 441	Continued From page 15 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, record review, review of facility policies/procedures, and staff interview, facility staff failed to implement infection control practices that are consistent with acceptable professional standards of practice for 2 of 4 sampled residents on contact precautions observed receiving personal cares (Resident #9) and dressing changes (Resident #2). Failure to implement infection control practices has the potential to affect the health and safety of facility residents, staff, and visitors. Findings include: Review of the facility policy titled "TRANSMISSION-BASED PRECAUTIONS" occurred on 06/17/10. This policy, dated 06/02/06, stated " . . . CONTACT PRECAUTIONS . . . Patient-Care Equipment: Dedicate non-disposable items that cannot be cleaned and disinfected between patients . . . Clean and disinfect equipment between patients. . . ." Review of the facility policy titled "RISK FACTORS FOR NOSOCOMIAL TRANSMISSION" occurred on 06/17/10. This	F 441	practice hand hygiene following toileting. This was provided by the Administrative Director of Nursing Services or designee. Re-education of licensed nurses will be conducted on correct usage and cleaning of wound care equipment by Administrative Director of Nursing Services or designee. 4. Three observations per week will be completed for four weeks of CNA use of dedicated equipment in isolation rooms, monthly for the next two months and as needed thereafter of CNA toileting and encouragement of hand hygiene by the Directors of Care Delivery or designee. Three observations of dressing changes will be observed weekly for the first four weeks, monthly for the next two months and as needed thereafter to ensure proper use of and cleaning of equipment. These will be conducted by the Directors of Care Delivery or designees. Results of observations will be brought to the Quality Assurance Committee monthly to ensure compliance.	

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F 441	Continued From page 16 policy, undated, stated " . . . Patients and employees are at risk for exposure and colonization through . . . direct or indirect contact routes of transmission. Risks reducing measures include: hand hygiene. . . ." - Review of Resident #9's record showed the resident tested positive for Clostridium difficile (C. diff) (a bacterial infection that causes diarrhea) on 06/10/10. The facility placed Resident #9 on contact isolation precautions for all cares, and instructed staff and visitors to gown and glove before entering the room. Observation on 06/15/10 at 9:00 a.m. showed a certified nursing assistant (CNA) (#11) assisted Resident #9 with personal cares. The staff member (#11) placed her own gait belt around the resident's waist, transferred her to the toilet, performed perineal care after a loose bowel movement, and then utilized the gait belt to transfer Resident #9 back to her wheelchair. The staff member (#11) failed to use the gait belt located in the resident's room and designated for Resident #9's use. Observation showed the CNA (#11) placed the gait belt used for transferring Resident #9 around her waist and proceeded to walk about the facility and assist other residents. On 06/16/10 at 10:15 a.m., a CNA (#15) provided perineal care to Resident #9 after a loose bowel movement in the toilet. Resident #9 grabbed the bar located by the toilet and assisted with transferring back to the wheelchair. The CNA (#15) failed to assist/encourage the resident to wash her hands after toileting and transferring back to her wheelchair. During an interview on 06/17/10 at 9:50 a.m., an	F 441	Call placed to Dally Kienenberger DON at Manor Care-Fargo. on 7-8-10 at 3:48pm. Dally stated all education and inservices listed to be offered were completed as of today. DM.	

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F 441	Continued From page 17 administrative nurse (#14) stated she expected staff to use the gait belt designated for a resident in isolation, and located in the resident's room, to prevent the spread of infection. She stated she expected staff to assist residents with washing their hands after toileting if the resident is unable to initiate and perform on their own. - Record review for Resident #2 occurred June 14-17, 2010. The care plan for Resident #2 identified "Focus: At risk for infection wound/skin colonized MRSA [methicillin resistant staphylococcus aureus] [right] groin/hip contained in dressing. . . .Interventions: . . . Use gown and glove to change [Resident #2's first name] right surgical wound. Continue to assess effective containment of MRSA. Dressing to incision fully contains." Observation of care to a right hip surgical wound dressing for Resident #2 occurred on 06/15/10 at 1:00 p.m. The nurse (#1), unable to locate the dedicated facility scissors, used a pair of the resident's scissors removed from a glass used by Resident #2 to store the scissors and assorted pens and pencils. The nurse (#1) failed to sanitize the scissors before and after using them to cut the correct size of clean dressing from a bulk dressing package dedicated to Resident #2's use. The nurse (#1) also failed to use scissors dedicated for Resident #2's use, to cut dressings for an infected surgical wound. During an interview, on 06/16/10 a 7:50 a.m., with an administrative staff nurse (#2) this nurse identified staff should not use the resident's scissors to cut dressing supplies.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 18 Based on record review, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		