STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 05/27/14 and completed on 05/29/14, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary interior regarding dusty fans and bathroom vents on 3 of 3 units (Dakota, Prairie Rose, and Sunflower). Failure to keep fans and bathroom vents free from accumulated dust and debris placed facility residents at risk of exposure to dust and airborne allergens. Findings include: Observation during the facility environmental tour, on 05/28/14 at 1:00 p.m. with a maintenance management staff member (#10) and a maintenance assistant (#11) identified the following: * Fans with accumulated dust and debris - Dakota hallway - one fan Sunflower hallway - one fan * Bathroom vent with accumulated dust and debris -	F 253	This plan of correction is this facility's allegation of compliance with applicable regulatory requirements. F 253 HOUSEKEEPING/MAINT SERVICES 1) Fans and exhaust vents will be cleaned. 2) Environmental services will visually inspect all fans and exhaust vents to ensure cleanliness. 3) All fans and exhaust vents will be cleaned monthly. 4) Environmental services will inspect all fans and exhaust fans monthly. Audit sheets will be maintained to monitor completion of task. 5) Date certain is 6/30/14	6/30/14

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

administrator — 7/7/14

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 253	Continued From page 1 Dakota Unit - one room Prairie Rose Unit - three rooms Sunflower Unit - one room During an interview on 05/28/14 at 2:00 p.m. a maintenance management staff member (#11) stated staff clean fans monthly and check/clean bathroom vents on a daily bases. The housekeeping assignment list for cleaning fans identified staff cleaned the facility fans 01/08/14.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure services met professional standards of quality following a fall for 2 of 3 sampled residents (Resident #1 and #5) who experienced an unwitnessed fall requiring a neurological assessment. Failure to complete a thorough examination after a fall has the potential for injuries to go undetected. Findings include: Review of the facility policy "Neurochecks" occurred on 05/28/14. This undated policy stated, "Anytime someone falls and hits their head or is suspected to have hit their head, neurochecks should be completed. The initial neurocheck is completed at the time of the fall and documented under the fall event. Four subsequent	F 281		

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F 281	Continued From page 2 neurochecks are completed and documented under the neuro-checks observation in Matrix [electronic computer charting system] . . . Example: Fall - date and time . . . 4 hrs [hours] after fall . . . 4 hrs after last check . . . 8 hrs after last check . . . 8 hrs after last check . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, anxiety, and a history of falls. The quarterly Minimum Data Set (MDS), dated 05/15/14, identified extensive assistance required for transfers and toilet use and one fall during the assessment period. Review of Resident #5's "Events" and "Neurological Checks" reports identified the following: * 03/15/14 - Resident #5 fell in the kitchenette and received a laceration to his forehead. The nurse failed to sign, date, and time the third and fourth set of neuro-checks (16 and 24 hours after the fall). * 04/18/14 - Resident #5 fell in his room. The nurse failed to complete the first set of neuro-checks (4 hours after the fall) and the fourth set of neuro-checks (24 hours after the fall). * 05/27/14 - Resident #5 fell in his room. The nurse failed to document the initial vital signs after the fall (blood pressure, pulse, respiration, temperature, and oxygen saturation). During an interview on the afternoon of 05/29/14, an administrative nurse (#1) agreed nursing staff failed to complete all the neuro-checks and expected nurses to follow the facility policy. - Review of Resident #1's medical record	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS: Neuro checks 1) Neighbor's #1 and #5 did not have any adverse effects as the result of their neuro check observations not being complete. 2) All neighbors who fall and bump their head or are suspected to have bumped their head have the potential to be affected. 3) The neuro check policy will be reviewed with nurses at a meeting on July 11, 2014. Upon completion of a set of neuro checks, the fall coordinator will receive the neuro check cheat sheet used by the nurses. (Attachment A) She will review the observation to ensure that all neuro checks were documented appropriately. If concerns are identified, she will immediately contact the appropriate nurse for corrective action. 4) DON will double check that neuro check observations are being completed appropriately. Starting July 11, 2014, the DON will audit 3 neuro check observations for completion x6 months. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment B) 5) Date certain will be 7/11/14.	7/11/14

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F 281	Continued From page 3 occurred on all days of survey. Diagnoses included Alzheimer's disease and secondary Parkinsonism. The quarterly MDS, dated 02/28/14, indicated extensive assistance of 1 person with transfers, supervision with walking in the room/corridor, and two falls with no injury during the assessment period. Resident #1's "Events" and "Neurological Checks" reports revealed the following: * 12/15/13 at 5:51 p.m. - Resident #1 fell and hit his head against the bedroom door. The nurse failed to record vital signs for the second set of neuro-checks (8 hours after the fall), and failed to complete the third and fourth set of neuro-checks (16 and 24 hours after the fall). During an interview on 05/29/14 at 1:30 p.m., an administrative nurse (#1) agreed staff failed to complete the neurological check form for the third and fourth set of neuro-checks as per facility policy.	F 281		
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: BLOOD SUGAR MANAGEMENT	F 309		

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F 309	Continued From page 4 Base 1. Based on record review and professional reference, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #9) receiving insulin. Failure to assess for signs and symptoms of hypoglycemia, give insulin when ordered or obtain a physician's order to hold the insulin, recheck blood sugars when indicated, and notify the physician of a pattern of low blood sugars does not allow for timely adjustments to treatment, has the potential to result in poorly controlled diabetes, and places all diabetic residents at risk for harm. Findings include: "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, pages 736-738, "Administration: . . . Give NovoLog 5 to 10 minutes before start of meal. . . . Nursing Considerations: . . . Adjustments in the dose of NovoLog or of any insulin may be needed with changes in physical activity or meal routine. Insulin requirements also may be altered during emotional disturbances, illness, or other stresses. . . . Assess patient and notify prescriber for signs and symptoms of hypoglycemia (sweating, shaking, trembling, confusion, headache, irritability, hunger, rapid pulse, nausea) [low blood sugar] and hyperglycemia [high blood sugar] . . . Patient Teaching: Tell patient not to stop insulin therapy without medical approval. . . ." Review of Resident #9's medical record occurred on 05/29/14. Diagnoses included diabetes. Physician orders included: * "BS [blood sugar] q [every] am [morning] . . . call md [medical doctor] for blood sugar > [greater than] 400 or < [less than] 60," ordered 05/10/13	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING: Blood Sugar Management 1) Neighbor #1's insulin regime was changed to sliding scale coverage after physician review on 1/16/2014. 2) Any diabetic neighbor has the potential to become hypoglycemic. 3) The current blood sugar monitoring policy will be reviewed with nurses at a meeting on July 11, 2014. An event will be completed for all hypoglycemic episodes in Matrix and the physician notified by the charge nurse on duty. 4) The RN Coordinator will monitor to ensure that events are being completed for hypoglycemic episodes and the physician notified. Starting July 11, 2014, an audit will be completed on 5 diabetic neighbors a month x6 months, looking for blood sugars that qualify as hypoglycemic readings. If discovered, the RN will review for the completion of the appropriate event and MD notification. If any issues are discovered within the audit, the length of the time will be extended. If concerns are identified, the RN Coordinator will report to the DON and corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment C) 5) Date certain will be 7/11/14.	7/11/14

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F 309	Continued From page 5	F 309		

and discontinued 01/31/14
* "Accucheck three times daily prior to meals," ordered 01/16/14
Medications included:
* Lantus (long-acting) insulin, 20 units every day upon arising, ordered 01/31/13 to 01/16/14
* Lantus 40 units q bedtime (HS), ordered 01/31/13; decreased to 30 units on 01/13/14; and decreased to 25 units on 02/17/14
* NovoLog (fast-acting) insulin 12 units three times daily (TID) upon arising, lunch, supper, and 6 units q HS, ordered 01/31/13; changed to sliding scale (amount of insulin based on blood sugar level) TID breakfast, lunch, and supper on 01/16/14

The nurses' progress notes stated the following:
* 12/25/13 at 9:47 a.m. - "Neighbor's BS was 74 [milligrams per deciliter] then at 0930 [9:30 a.m.] was 35. Probable [sic] due to the fact he was late getting to the dining room for breakfast after morning insulin shots. Gave neighbor large glass of orange juice and BS went up to 55. . . ." After administering Resident #9's morning insulin, staff failed to ensure he received breakfast in 5 to 10 minutes. The nurse failed to complete the following sections of the hypoglycemia event report, dated 12/25/13: Physical Assessment (includes signs and symptoms of hypoglycemia), Mental Status, Possible Contributing Factors, Interventions, Notification Guidelines, and Orders.

* 01/10/14 at 11:50 a.m. - "AM novolog held for a blood sugar of 66 . . . Neighbor's accu check at 1145 [11:45 a.m.] is 123. . ." The record lacked evidence of an assessment for symptoms of hypoglycemia, treatment provided, a timely recheck of the BS, and evidence staff notified or obtained an order from the physician to hold the

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F 309	Continued From page 6 insulin. * 01/11/14 at 10:39 p.m. - "BG [blood glucose] checked at HS. . . . BG 147. HS insulin held. Nurse told neighbor she will check at 12M [midnight] and depending on results, will give HS insulin then. . . ." At 2:02 a.m. - " BG check reveals blood glucose level reading of 151. Decision to continue to hold insulin until AM rading [sic]. . . ." The record lacked evidence staff notified or obtained an order from the physician to hold the insulin. * 01/12/14 at 9:40 p.m. - "Day nurse reports AM BG 80. Checked at HS and BG after supper and snack was 167. Insulin held until AM check." The record lacked evidence staff notified or obtained an order from the physician to hold the insulin. * 01/13/14 at 5:35 p.m. - ". . . Received order to decrease the HS Lantus to 30 u [units] and observe. Held his noon and supper NovoLog. Held the noon does [sic] because he got up at 1030 [10:30 a.m.] and received it almost at lunch. Held supper [dose] because he was diaphoretic and symptomatic. I checked his BS and it was 124." At 10:19 p.m. - "BG 174 at HS. . . . Held novolog due to neighbor only eating crackers for a snack . . ." The record lacked evidence of treatment provided for symptoms of hypoglycemia, physician notification of the symptoms, a timely recheck of the BS, and evidence staff notified or obtained an order from the physician to hold two doses of insulin. * 01/14/14 at 7:59 a.m. - "BS at 0730 [7:30 a.m.] was 103. Held am does [sic] of insulin until receive instruction from on call Doctor." At 1:35 p.m. - "BS at noon 209 so I gave his Lantus and	F 309		

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F 309	Continued From page 7 NovoLog am dose. . . ." At 3:15 p.m. - "Received instructions to continue with insulin order as directed. However, put him on doctor rounds so we may investigate other problems. . . . instruct staff to not check BS at noc [night] or in early am. . . ." The record lacked evidence the resident displayed symptoms of hypoglycemia and staff notified or obtained an order from the physician to hold the insulin. The January 2014 Licensed Nurse Flowsheet revealed the following: * 01/09/14 - "Held HS Novolog BS 160" * 01/11/14 - "BS 70 held AM Novolog" * Entries recorded in margin above and below the NovoLog TID order: - Uncertain date - "Accu[check] - 76 novolog held this AM" - Uncertain date - "Accu[check] - 81 1/2 of novolog given" - Uncertain date - "Lunch insulin held - accu[check] - 65" - "Held [insulin] 1/5 [January 5] Lunch received AM dose 1000 [10 a.m.] BS [downward arrow] 90" The record lacked evidence of resident assessment for symptoms of hypoglycemia, evidence of treatment provided, a timely recheck of the BS, or evidence staff notified or obtained an order from the physician to hold the insulin. The record lacked evidence staff informed the physician of the pattern of low blood sugars/ holding insulin in a timely manner. CONSTIPATION TREATMENT PREVENTION 2. Based on record review, review of facility policy, and staff interview, the facility failed to	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING: Constipation Treatment/Prevention 1) Neighbor #13 did not have any adverse effects from not receiving MOM prior to receiving a suppository. She expired without complications on 2/8/14.	

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F 309	Continued From page 8 provide care and services as identified in 1 of 1 closed record (Resident #13). Failure to implement appropriate and timely interventions to manage constipation may have resulted in unrelieved constipation and use of unnecessary medications. Findings include: Review of the facility policy titled "Constipation, Treatment/Prevention Of" occurred on 05/29/14. This policy, dated 2012, stated, ". . . 4. The night nurse will check the medical record nightly to determine the neighbor who have not had a BM [bowel movement] in 2 days. MOM [milk of magnesia] will be offered during the following day shift. If they have not had a BM in 3 days, the standing orders will be initiated for a Dulcolax suppository, given early in the am. . . ." Review of Resident #13's medical record occurred on 05/29/14. Diagnoses included Alzheimer's disease and constipation. PRN (as needed) bowel elimination medications included MOM and a bisacodyl (Ducolax) suppository. Review of Resident #13's medication administration record (MAR) for December 1-31, 2013 and January 1-31, 2014 identified the resident received PRN Ducolax suppository 9 occasions without receiving MOM. The facility failed to follow the constipation policy and administer MOM before a Ducolax suppository. During an interview on 05/29/14 at 1:40 p.m., an administrative nurse (#1) confirmed facility staff are expected to administer MOM before a suppository per the facility constipation policy.	F 309	2) All neighbors have the potential to become constipated. 3) The current bowel management policy will be reviewed with all nursing staff at a meeting on 7/15/14. It was discovered that staff were not properly documenting the administration of MOM on the MAR record so that is what our efforts will focus on. 4) The Care Coordinator will monitor to ensure that MOM is being documented on the MAR. Vitals/BM sheets (Attachment D) that are used by the CMA's, that have neighbors listed as due for MOM, will be given to the Care Coordinator who will also review the MAR for appropriate documentation of administration of MOM. Starting July 11, 2014, an audit will be completed on 5 neighbors a month x6 months. If any issues are discovered within the audit, the length of the time will be extended. If concerns are identified, the Care Coordinator will report to the DON and corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment E) 5) Date certain will be 7/15/14.	7/15/14

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F 323 SS=G	Continued From page 9 483.25(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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: BURNS 1. Based on record review and staff interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent burns from hot liquids for 2 of 2 sampled residents (Resident #9 and Resident #13 - closed record). Failure to provide adequate supervision and/or appropriate drinking devices and monitor the temperature of the coffee dispensing machines resulted in Resident #13's burn, may have contributed to Resident #9's burn, and may result in additional or new burns to residents who drink hot liquids. Findings include: Review of Resident #13's closed medical record occurred on 05/29/14. Diagnoses included Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS), dated 09/09/13, identified severely impaired cognition and eating with extensive assistance of one person. Resident #13's current care plan stated, ". . . Problem: Communication: I have trouble	F 323	F 323 FREE OF ACCIDENT HAZARDS HOT BEVERAGES 1) Staff will be educated on hot beverage safety. Neighbors will be evaluated for ability to handle hot beverages, and hot water and coffee temperatures will be monitored on a regular basis. 2) Staff will be educated on hot beverage safety and offered possible interventions if a neighbor is thought to be unsafe in handling hot beverage at staff meeting on 7/15/14. All neighbors will be reviewed on admission, quarterly, annually and on significant change for safety in dining. Temperatures of hot water and coffee will be monitored to ensure proper temps between 150 to 170 degrees F. 3) Neighbors will be evaluated on a regular basis. Safety concerns or changes to plan of care in regards to safety will be communicated to staff through communication books. Coffee and hot water coming out of machines will not exceed 170 degrees F. 4) Culinary director will audit temperatures of both hot water and coffee weekly to ensure proper temps between 150 and 170 degrees F. 5) Date Certain 7/15/14	7/15/14

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communicating my needs at times due to my Alzheimer's. . . . Approach: [dated 05/01/12] . . . I do need you to anticipate my needs. . . . Problem: Culinary - I need some help at meals. . . . Approach: [dated 12/15/10] Bring my meals to the table for me. set up my meal. encourage me to eat. Offer cueing and supervision. . . ." This conflicts with Resident #13's MDS, dated 09/09/13, which indicated the resident required extensive assistance of one person to eat.

Review of Resident #13's progress notes stated the following:
* 11/14/13 at 9:21 a.m. - "Neighbor spilled coffee on her lap. Bright pink skin noted to inner thighs and back of thighs. Small flat blisters noted to back of left thigh and inner right thigh. Peri-area was not affected. Area was cooled, then silvadene applied and wounds were dressed. [nurse practitioner name] was notified."
* 11/15/13 at 9:23 a.m. - "Coffee burns to thighs continue. Areas on both thighs are blistered with redness around the blisters. Blisters are intact and fluid filled. Both thighs cleansed and silvadene applied and then dressed. Some discomfort noted when dressing were put on . . ."
* 11/17/13 at 9:26 a.m. - "Dressings changed to burned thighs bilat. [bilateral] Continue to improve. Minimal serous drainage."
* 11/29/13 at 8:56 a.m. - "Dressing changed on both legs. Out of Silvadene so I used Adaptic to cover blisters and covered with Kerlix gauge [sic] to keep covered. Blisters to LFT [left] leg resolving but to the right leg the blister is still draining and yellowish in color."
* 12/05/13 at 11:04 a.m. - "Order received from [physician name] on dr. round . . . D/C [discontinue] Silvadene to [right] thigh burn, and cover area with a Tegaderm absorbent dressing

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to be changed on shower days until healed."
* 12/25/13 at 9:20 p.m. - ". . . Tegaderm in place to burn area which is healing extremely slowly. . . ."
* 01/01/14 at 10:19 a.m. - " . . . seen on dr. rounds on 01/02/14 by [nurse practitioner name] for concern of leg wound not healing. . . ."
* 01/08/14 at 09:10 p.m. - "Changed her dressing to the Right thigh; it continues to be red and sore. Also some small amount of drainage."
* 01/23/14 at 1:25 a.m. ". . . Burns are healed on thighs."

Review of Resident #13's progress notes from 11/14/13 until 01/23/14 failed to identify the dimensions of the burn.

A facility "Event Report" "Skin Integrity Events-Burn Event" dated, 11/14/13 at 9:01 a.m. stated, "Description: coffee burns to thighs . . . Location and size of burn: Inner and back of thighs. Etiology of burn: Moist heat (scald): Hot liquids . . . Classification of burn: Superficial Partial - Thickness- Damage to first and second layer of skin, skin turns white when pressed then returns or red, burn is moist and painful with blistering and swelling. Does resident complain of pain at site? If yes rate the pain on the pain scale from 1-10: yes 8. Interventions: cold - silvadene . . ."

A physicians assistant progress note dated, 1/09/14, stated, ". . . Assessment: . . . 3) Burn with scar formation started to the right inner thigh. Plan: . . . If there is drainage or seems to be increasing redness then we will have to have further evaluation if family would like to. . . It is starting to form some scarring to the site . . ."

Review of Resident #13's "Investigation Report"

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dated 11/14/13 at 9 a.m., stated, " . . . Neighbor was eating breakfast in the Dakota DR [dining room]. Neighbor requires cues [with] eating. Staff was across table assisting another neighbor. [Resident name] picked up coffee mug [and] it slipped out of her hands onto her lap. . . . neighbor is able to assist herself - requires cues. She loves coffee. Immediate intervention: First aid to burn. IDT [interdisciplinary team] Intervention Plan: Dilute coffee [with a] little cold water, do not fill mug full." This conflicts with Resident #13's MDS, dated 09/09/13, which indicated the resident required extensive assistance of one person to eat.

Resident #13's care plan failed to identify the resident sustained a coffee burn and the interventions to be implemented: medical treatment of the burns, staff assistance with meals, dilution of coffee with cold water, and not to fill the mug full.

On 05/29/14 at 1:15 p.m., a surveyor obtained a temperature reading of 164 degrees Fahrenheit for the coffee dispensed from the machine located in the kitchen of the Dakota dining room.

During an interview on the afternoon on 05/29/14, a dietary manager (#13) stated staff does not check the temperature of the coffee and she is aware of two residents that sustained burns in the facility.

During an interview on 05/29/14 at 1:40 p.m. an administrative nurse (#1) confirmed the staff did not check the temperature of the coffee after Resident #13 sustained a burn. She also confirmed staff failed to update Resident #13's care plan regarding the burn from the coffee, with

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the interventions to dilute coffee with cold water and not to fill the mug full.

Based on Resident #13's cognitive status, need to anticipate her needs, and need for extensive assistance to eat, failure of the facility to put safety measures in place and/or provide assistance with eating contributed to her burn with hot coffee.

- Review of Resident #9's medical record occurred on 05/29/14. Diagnoses included quadriplegia and paralysis agitans (Parkinson's disease). The quarterly MDS, dated 03/08/14, indicated intact cognition and eating with supervision and set up help only. The current care plan stated the resident ate independently after set up.

A physician order, dated 03/07/14, stated, "Silvadene to burn on 4th finger of right hand BID [twice daily] and cover with bandage."

Resident #9's nursing progress notes stated:
* 03/07/14 at 12:17 p.m. - "Neighbor states he burned his finger on coffee a few days ago, area blistered and measures 2 CM [centimeter] x [by] 2 CM, did open today and is draining serous drainage. Denies c/o [complaint of] pain or discomfort . . . will dress and apply silvadene BID till [until] healed."
* 03/11/14 at 9:37 a.m. - "Quarterly assessment [dietary] . . . He spends a lot of his time in the coffee nook area . . . drinking coffee. . . ."
* 03/15/14 at 11:15 a.m. - "Dressing change to RT [right] middle finger . . . Blister gone but skin under blister continues to need care. The wound is red and there is an area 1/2 cm that is opened. . . ."

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* 03/21/14 at 3:53 p.m. - "Did d/c [discontinue] order for silvadene will just leave open to air, area is healing nicely . . ."

The Event Report, with event date 03/05/14 at 12:12 p.m. and completed date 03/07/14, stated, "Description: Coffee burn to fourth finger on right hand . . . Etiology of Burn: Moist Heat (scald): Hot Liquids; Additional Description: area is blistered, but broke open today. White in color; Classification of Burn: Deep Partial Thickness - Deeper skin layers, skin is white with red areas, remains white when pressed and may appear waxy, not painful but sensation of pressure may be present. . . ."

The facility failed to update the care plan after Resident #9 burned a finger on a hot coffee cup, with interventions to prevent future burns, including an appropriate drinking device.

During an interview on the afternoon of 05/29/14, a dietary manager (#13) stated Resident #9's burn was from the ceramic coffee cup he was holding, not from a spill. Resident #9 was in the hospital at the time of the survey for an unrelated reason and unavailable for observation or interview.

SAFE ENVIRONMENT

2. Based on observation and staff interview, the facility failed to maintain an environment free of hazardous chemicals and tools for 2 of 3 (May 27-28, 2014) days of survey. Accessible hazardous chemicals and tools and access to the maintenance room placed cognitively impaired and wandering residents at risk for accidents and injury.

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F 323	Continued From page 15 Findings include: The facility failed to provide a policy specific to the storage of chemicals and tools when requested. Observation on 05/27/14 at 10:45 a.m. showed a maintenance room at the end of the Dakota unit. The door to this room remained unlocked the entire day. The room contained numerous hazardous chemicals and tools such as a spray bottle of Clorox cleaner, a spray can of battery terminal protection, a box cutter, a screwdriver, a hand drill etc. Observation on 05/28/14 at 08:45 a.m. and 12:25 p.m. identified the same maintenance door unlocked. During an interview on 05/27/14 at 6:10 p.m., an administrative nurse (#1) confirmed the maintenance room contained numerous hazardous chemicals and tools and the door needed to remain locked at all times. Observation in the afternoon on 05/28/14 identified a small screwdriver hanging on the outside of an AVI panel (fire alarm panel) door, in the coffee lounge area. A maintenance supervisor (#10) stated the screwdriver should not be stored on the panel.	F 323	F 323 FREE OF ACCIDENT HAZARDS ES OFFICE DOOR 1) Environmental Services office door will remain closed and locked. 2) Staff will be educated on need to leave ES office door closed and locked at all times at staff meeting on 7/15/14. 3) Door will remain closed and locked. 4) ES staff will ensure door is locked each time they exit the office. 5) Date Certain 7/15/14 F 323 FREE OF ACCIDENT HAZARDS SCREWDRIVER ON FIRE PANEL 1) Screwdriver was removed from fire panel. 2) No screwdriver to be left near fire panel. 3) Fire panel will be checked in conjunction with every fire drill to ensure no items/tools are hanging near the panel.	7/15/14
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327	4) ES staff will monitor during fire drills to ensure to items/tools are hanging near the fire panel. 5) Date Certain 6/30/14	6/30/14

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F 327	Continued From page 16	F 327	F 327 SUFFICIENT FLUID/HYDRATION	

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 fluids to maintain adequate hydration for 3 of 5 sampled residents (Resident #4, #6, and #10) identified by the facility as on the "Hydration List." Failure to offer fluids during cares increased the residents' risk of dehydration, constipation, and urinary tract infections (UTIs).

Findings include:

Review of the facility's "Hydration List" occurred on 05/27/14. This list, dated 05/15/14, stated, "the following neighbors do not always accept adequate fluids. Offer encouragement and cuing to drink, and offer a variety of fluids." The list included Resident #4, #6, and #10.

Review of the facility policy titled "Hydration" occurred on 05/29/14. This undated policy stated, "The facility must provide each resident with sufficient fluid intake, based on individual needs, to maintain proper hydration and health. . . . All staff will offer and encourage fluids as a part of daily interactions with residents, unless fluids are restricted. . . ."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and constipation. The significant change Minimum Data Set (MDS), dated 05/05/14, identified extensive assistance required for eating. Resident #6's current care plan stated, ". . . Encourage me to drink lots of fluids so I don't

1) Staff will be educated to offer fluids with cares, provide fluids in neighbor rooms daily, offer fluids at all meals, and ensure fluids are within neighbors' reach at meals at staff meeting on 7/15/14.

2) All neighbors will be provided with adequate fluids to prevent dehydration.

3) Audit to be completed to ensure water is available for neighbors in their rooms and offered during cares. Audit to ensure water is being offered at all meals and fluids are within reach for all neighbors.

4) Culinary director to complete audit to ensure water is available in neighbor rooms and offered during cares 2x/wk, per household, x 6 weeks; then monthly x 3 month. Culinary director to audit to ensure water is being offered at all meals and fluids are within neighbors' reach 2x/wk, per household, x 6 weeks; then monthly x 3 months.

5) Date Certain will be 7/15/14 — 7/15/14

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F 327	Continued From page 17 develop UTIs . . ." Observation on 05/27/14 at 4:00 p.m. showed two Certified Nursing Assistants (CNAs) (#6 and #15) provided cares for Resident #6 in her room and then transported her to the TV lounge area. The CNAs failed to offer and/or assist with fluids during or after cares and failed to offer and/or assist with fluids in the TV lounge. Observation on 05/28/14 at 2:45 p.m. showed two CNAs (#6 and #15) provided cares for Resident #6 in her room and then transported her to the main dining room for Bingo without offering and/or assisting with fluids. At approximately 3:00 p.m., an unidentified activity staff member asked if any of the residents present would like something to drink before Bingo. Resident #6 did not reply, and staff provided no fluids. - Resident #10's medical record, reviewed on 05/29/14, identified diagnoses including congestive heart failure, anemia, and recent clostridium difficile infection (which causes frequent loose stools). A quarterly MDS, dated 04/27/14, identified extensive assistance with eating. Resident #10's culinary care plan identified the resident received nectar thick liquids. An approach, dated 02/04/13, stated, "Hydration list. Please offer me fluids often during the day. Encourage me to drink. Watch me for any signs of dehydration." Observation of cares on 05/29/14 at 11:20 a.m. identified a licensed nurse (#4) and a CNA (#3) assisted the resident with incontinence cares. During cares, observation showed no bedside stand in the room and no fluids available for Resident #10. After completing cares, the CNA	F 327		

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(#3) stated she would have offered Resident #10 fluids "If she had her water in here." Staff failed to obtain and offer fluids to Resident #10 at completion of cares.

- Resident #4's medical record, reviewed on all days of survey, identified diagnoses including dementia, and recent right hip and right lower femur fractures. Observations during the survey showed Resident #4 currently experienced frequent loose stools. A quarterly MDS, dated 05/21/14, identified limited assistance with eating. Resident #4's culinary care plan identified an approach, dated 02/05/24: "I am on the hydration list. Please encourage me to drink. Make sure I have fluids available."

Observations of Resident #4 in the dining room showed the following:
* 05/28/14 at 10:40 a.m.: Resident #4 fed herself breakfast with an occupational therapy staff member (#2) seated near her. Observation showed the resident had a cup of tea, but no other fluids available at the table.
* 05/28/14 at 5:30 p.m.: Resident #4 fed herself supper in the dining room. The resident had a cup of tea within her reach and a glass of water on the table, but out of her reach. Observation at 6:10 p.m. showed the water remained out of reach. Resident #4 consumed half the tea and no water. Observation showed staff failed to encourage or assist Resident #4 to consume her fluids.

During an interview on the afternoon of 05/29/14, an administrative nurse (#1) stated she expected facility staff to offer fluids to dependent residents during cares.

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F 333 SS=D	Continued From page 19 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: INCORRECT INSULIN ADMINISTERED: 1. Based on record review, policy review, and staff interview, the facility failed to ensure residents are free of significant medication errors for 2 of 3 sampled residents (Resident #9 and #10) on Lantus insulin. Failure to administer the correct type of insulin has the potential to adversely affect the resident's blood sugar resulting in hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Findings include: Review of the facility policy titled "Insulin Administration" occurred on 05/29/14. This undated policy stated, "Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes. Preparation: . . . 3. The type of insulin, dosage requirements, . . . must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. . . . Characteristics and Types of Insulin: . . . 2. . . . Rapid-acting [NovoLog], [onset of action]: 10-15 min . . . [duration of action]: 3-6 hrs [hours] . . . Long-acting [Lantus], [onset of action]: 1-2 hrs . . . [duration of action]: up to 24 hours . . . Steps in the Procedure: . . . 7. Check and re-check that the type of insulin on the vial matches the type of	F 333 F 333	F 333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS: Incorrect Insulin Administered 1) Neighbor's #9 and #10 did not have any immediate or long-standing adverse effects of being administered the incorrect insulin. 2) All diabetic neighbors who are insulin dependent have the potential to be affected. 3) The 5 rights of medication administration will be reviewed with nurses at a meeting on July 11, 2014. A second storage container will be obtained to separate short-acting and long-acting insulin in the med room. 4) The DON will monitor to ensure that the nurses are administering the correct insulin. Starting July 11, 2014, an audit will be completed on 3 occasions of insulin administration per week x3 weeks, then 1 occasion per week x8 weeks. If any issues are discovered within the audit, the length of the time will be extended. Corrective action will be implemented immediately. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment F) 5) Date certain will be 7/11/14.	7/11/14

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insulin ordered. . . ."

- Review of Resident #9's medical record occurred on 05/29/14. Diagnoses include type two diabetes. Medications included:
* Lantus 30 units every (q) bedtime (HS), ordered 01/13/14; and decreased to 25 units on 02/17/14
* NovoLog insulin sliding scale (amount of insulin based on blood sugar level) three times daily (TID) - breakfast, lunch, and supper, ordered 01/16/14

Resident #9's nursing progress notes stated:
* 01/23/14 at 8:00 p.m. - "Gave Neighbor 30 units of Novalog [sic] instead of Lantus. I notified [name of doctor] and was instructed to ck [check] his bs [blood sugar] q hr [hour]. . . . Neighbor bs was WNL [within normal limits] and was watched all noc [night] with no further incidents." At 12:10 a.m. - "Neighbor BS 101 at midnight. Gave orange juice and sandwich."

03/20/14 at 8:28 p.m. - "Neighbor received 25 u [units] of novalog [sic] instead of Lantus. Gave him OJ [orange juice] and peanut butter/cheese sandwhich [sic] and will monitor throughout night."

Review of the Event Reports for the above incidents failed to include corrective action to prevent staff from administering the wrong type of insulin again.

On the afternoon of 05/29/14, an administrative nurse (#1) stated the nurse [Nurse A] involved in the incidents wrote her own corrective action and has insulin double checked by other staff all the time now. The corrective action, dated 01/23/14, stated, "I needed to make sure the 5 rights [of

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medication administration] - Right Drug, Patient, Dose, Time, Route. Was in a hurry - need to slow down." This corrective action failed to prevent Nurse A from making the second insulin error in March.

- Resident #10's medical record, reviewed on 05/29/14, identified a physician's order for Lantus insulin 20 units daily for type two diabetes mellitus. A progress note, dated 12/10/13 at 7:56 a.m., stated, "Nurse gave 20 Units NovoLog this AM [morning], when 20 Units of Lantus was to be given. [Provider name] was notified orders rec'd [received]. Will continue to monitor sugars every 15 minutes for the next two hours. And will give fluid and foods high in sugar."

Review of Resident #10's December 2013 medication administration record (MAR) showed staff recorded the administration time of the insulin as "upon rising" therefore, the exact time of administration could not be determined. The record showed Resident #10's blood glucose level was 81 milligrams per deciliter (mg/dL) at 7:20 a.m., 91 mg/dL at 7:35 a.m., 122 mg/dL at 7:50 a.m. and continued to climb throughout the three hour monitoring period.

During an interview on 05/29/14 at 2:30 p.m., an administrative nurse (#1) confirmed Resident #10 did not have a physician's order for NovoLog insulin at the time of the incident. She stated Resident #10 received another resident's insulin. The nurse did not provide an analysis of the cause of the error or interventions put in place to decrease the risk of similar medication errors.

Later that afternoon, an administrative nurse (#1) provided an event report, dated 12/10/13 at 7:20

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F 333	Continued From page 22 a.m. The section titled "What precautions have been taken to prevent a similar incident" contained no information. When asked at 4:30 p.m., the nurse (#1) stated Resident #10 received the NovoLog insulin via an insulin pen. The nurse confirmed the facility provided no staff education following the incident regarding medication errors and insulin pens. MEDICATION UNAVAILABLE: 2. Based on record review and staff interview, the facility failed to ensure residents were free of any significant medication errors for 1 of 1 sampled resident (Resident #6) who did not receive a scheduled laxative medication for 14 days. Failure to ensure the administration of the medication and inform the physician regarding it's unavailability has the potential to affect Resident #6's health and may result in unnecessary pain, discomfort, or constipation. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation. Daily medications included MiraLax twice a day. The significant change Minimum Data Set (MDS), dated 05/05/14, identified the resident experienced constipation during the assessment period. Review of the MAR identified 24 occasions Resident #6 did not receive MiraLax from May 14-27, 2014. On seven of the 24 occasions, the staff member documented "NA" (not available). During an interview on the afternoon of 05/29/14,	F 333	F 333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS: Medication Unavailable 1) MiraLax was obtained by the facility for neighbor #6 and it was administered the entire month of June. 2) No other neighbors were identified that their Part D plan would not pay for their medications to prevent constipation. 3) All nursing staff that pass medications will be educated at a meeting on 7/15/14, that when a medication is not available, they must notify the charge nurse who then must notify the physician. If required by the ND rate setting manual, the facility must provide the medication for the neighbor. 4) The Care Coordinator will monitor to ensure that the all medications are available for neighbors or that the physician is notified if one is not. Starting July 11, 2014, an audit will be completed on 5 neighbors a month x6 months. If any issues are discovered within the audit, the length of the time will be extended. The DON will be notified of any issues that arise. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment G) 5) Date certain will be 7/15/14.	7/15/14

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F 333	Continued From page 23 an administrative nurse (#1) stated she expected facility staff to notify a resident's physician if a medication is not available. During medication pass on 05/28/14 at 7:50 a.m., a CMA (certified medication assistant) (#12) stated Resident #6 will not get her MiraLax as it has not been available since the 14th of the month due to insurance not paying for it.	F 333		
F 363 SS=B	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. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily menus, and staff interview, the facility failed to meet nutritional needs of residents by serving incorrect portion sizes in 2 of 3 dining rooms (Dakota and Sunflower dining rooms). Failure to follow recommended portion sizes as outlined on the facility's menus has the potential to result in weight loss and inadequate nutritional intake. Findings include: Observation of tray line during the evening meal on 05/27/14 showed the following inconsistencies: * Dakota dining room - sausage and potato casserole served with a 1/2 cup scoop (the menu	F 363	F 363 MENUS MEET RESIDENT NEEDS 1) All culinary staff (cooks and homemakers) will be trained in the proper way to read the menu extensions. 2) Culinary director will complete audits to ensure proper portions are being served. 3) Every household will have a reference sheet for correct portion sizes in their serving area. Culinary staff will communicate any utensil needs to culinary director to ensure proper tools available and in use. 4) Audits will be completed to ensure menus are being followed and proper portion sizes are being utilized. Audits will be done twice a week, per household, x 6 weeks; then monthly, per household, x 3 months. 5) Date Certain 7/15/14	7/15/14

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F 363	Continued From page 24 identified 2/3 cup scoop) * Sunflower dining room - sausage and potato casserole served with a silver slotted spoon (no portion size identified) During an interview at 9:55 a.m. on 05/29/14, an administrative dietary staff member (#13) confirmed staff should follow the serving sizes listed on the menu.	F 363		
F 371 SS=D	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, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure sanitary conditions in 2 of 3 kitchens (Sunflower Unit and Prairie View Unit). Failure to monitor dishwasher temperature, properly sanitize tables, use proper handwashing, and cover hair completely with a hair net has the potential to contaminate food or cause a food borne illness. Findings include: Review of the facility policy titled "Dishwashing	F 371	F 371 FOOD STORED/SERVED IN SANITARY MANNER 1) All staff will be educated on operation of dishwasher, dishwasher temps and what to do if dishwasher is not working properly, proper use of hairnets for hair restraint, hand washing, and table sanitizing at staff meeting on 7/15/14. Hand sanitizers will not be used in food service. 2) Sunflower dishwasher will be inspected to ensure it is working properly. Hair will be properly restrained when handling food. Proper handwashing will be utilized by all culinary staff. Dining room tables will be properly sanitized. Hand sanitizer dispensers will be removed from all foodservice areas.	

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F 371	Continued From page 25 Procedures" occurred on 05/29/14. This undated policy, stated, ". . . 1. Mechanical Dishwasher (Hot Water Sanitizing) d) The temperature of the water shall be maintained . . . at 180 [degrees Fahrenheit] for the rinsing and sanitizing cycle . . ." Review of the facility policy titled "Infection Control - General Practice" occurred on 05/29/14. This undated policy, stated, ". . . Procedure: (Dietary Personnel) . . . 2. Wash hands frequently utilizing the handwashing procedure . . . 7. Wear a hair net to restrain all hair. . . T. Dining Rooms: 1. Table tops: Use warm water detergent solution for washing; rinse using a sanitizing solution at the appropriate strength and allow air-drying. . . ." "Servsafe Essentials," fifth edition, page 4.6, states, ". . . Hand Antiseptics: . . . Only use hand antiseptics after handwashing. NEVER use them in place of it. . . ." - On 05/27/14 at 5:00 p.m., observation showed a dietary assistant (#14) in the Sunflower Unit's kitchenette serving supper to residents on the unit. The dietary assistant's hair failed to be contained in a hair net. At 5:40 p.m., the dietary assistant (#14) added Dawn dish soap into a sink of hot water, wet a cloth in the water mixture, and washed the table tops vacated by residents who finished eating. The dietary assistant failed to disinfect the tables after washing them. At 5:45 p.m., a resident arrived and sat at one of these tables for service of supper. - Observation on 05/28/14 at 8:30 a.m. showed residents seated at tables in the Prairie View Unit dining room and an unidentified dietary aide started to serve the morning meal. All three tables	F 371	3) Audits will be completed on the Sunflower dishwasher to ensure it is working properly. Dishwasher temperature forms will be completed by culinary staff and monitored by culinary director. Audits will be completed to ensure compliance on proper use of hairnets, proper handwashing, proper table sanitizing. 4) Culinary director to complete audit on Sunflower dishwasher 3x/wk x 1 month. Culinary director to monitor dishwasher temp forms every month, and additional training or machine maintenance completed as needed. Culinary director will audit compliance with proper use of hairnets, proper handwashing, table sanitizing 2x/wk, per household, x 6 weeks; then monthly, per household x 3 months. 5) Date Certain 7/15/14	7/15/14

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showed food debris on them. When asked who is responsible for cleaning/disinfecting the tables, the dietary aide stated it is her responsibility if the staff that worked the meal before did not clean them. The dietary aide agreed the tables were soiled and proceeded to clean them with a wet washcloth. At 9:30 a.m., the same dietary aide stated she should have washed the tables with soap and water and then wiped them with a Clorox wipe.

- On 05/28/14 at 9:15 a.m., observation showed a dietary assistant (#14) in the Sunflower Unit's kitchenette serving breakfast. The dietary assistant's hair net failed to cover hair on the back of her head with visible hair hanging three to four inches down the back of her neck. At 12:33 p.m., the dietary assistant's (#14) hair net covered only the bun on the top of her head, with her bangs and hair at the back of her head uncovered. Following lunch, observation showed the dietary assistant (#14) washed all the empty tables with a wet cloth from the kitchenette sink. The dietary assistant failed to wash the area where one resident ate, which contained food crumbs, or sanitize the tables after washing them. At 1:38 p.m., a resident entered the dining room and sat at the soiled and unsanitized table for an activity.

- Review of the Sunflower Unit dishwashing temperature log occurred on 05/28/14. This log identified the following recorded temperatures:
April 1-30, 2014
* Rinse Cycle - 22 times less than 180 degrees and eight times lacked documentation
May 1-27, 2014
*Rinse Cycle - 11 times less than 180 degrees and 16 times lacked documentation

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F 371	Continued From page 27 On 05/28/14 at 10:40 a.m., observation showed the rinse cycle temperature of the Sunflower Unit dishmachine at 186 degrees. - Observation on 05/28/14 at 11:00 a.m. showed a dietary assistant (#14) in the Sunflower Unit kitchen preparing cheesecake. Observation showed this assistant used hand sanitizer without prior handwashing. During an interview on 05/28/14 at 6:00 p.m., a dietary assistant (#14) stated she uses Dawn dish soap and water to wipe tables after meals, and sanitizes them about once a day with a quaternary sanitizing solution. During an interview on 05/29/14 at 9:55 a.m., a dietary supervisor staff member (#13) confirmed the dishwasher water temperature must be 140 degrees for the wash cycle and 180 degrees for the rinse cycle at the temperature gauge. She also stated staff should wash then sanitize dining room tables after each meal using a sanitizing solution. This staff member (#13) confirmed a dietary staff's hair net must cover all their hair.	F 371		
F 441 SS=F	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 -	F 441		

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F 441	Continued From page 28 (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: HAND HYGIENE: 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 7 of 10 sampled residents (Resident #2, #3, #4, #5, #6, and #7) observed during cares. Failure to follow infection control practices related to contact isolation, dressing changes, hand hygiene, and	F 441	F 441 INFECTION CONTROL: Hand Hygiene 1) Neighbor #2, #3, #4, #5, #6 and #7 have had no negative consequences related to improper hand hygiene.	

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F 441	Continued From page 29 glove usage has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Clostridium Difficile" occurred on 05/28/14. This policy, revised in 2012, stated, "Preventative measures will be taken to prevent the occurrence of Clostridium difficile [C. difficile] infections among residents and precautions will be taken while caring for residents with C. difficile (to prevent transmission of C. difficile to others)." Review of the facility's "ISOLATION PRECAUTIONS INSTRUCTIONS" occurred on 05/28/14. The instructions, dated 2011, stated, "PROCEDURES/BARRIERS: . . . Gloves must be worn when touching blood, body fluids, secretions, excretions, and contaminated items . . . Change gloves between tasks and procedures on the same resident. After contact with material that may contain high concentrations or microorganism. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces . . . wash hands immediately to avoid transfer of microorganisms to other residents and environments." Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 05/28/14. This policy, revised in 2012, stated, "This facility considers hand hygiene the primary means to prevent the spread of infections . . . Implementation: . . . Employees must wash their hands . . . When hands are visibly soiled . . . Before and after assisting a resident with toileting . . . After contact with a resident with infectious diarrhea including, but not limited to infections	F 441	2) All neighbors are put at risk to develop or transmit disease/infections due to poor hand hygiene of the staff working with them. 3) The Hand washing/Hand Hygiene policy will be reviewed with all staff at a meeting on 7/15/14. The dressing change policy will be reviewed with all nursing staff at a meeting on July 11, 2014. 4) The Infection Control Nurse will be the owner of this process, but will be assisted by the DON and Care Coordinator, to monitor and ensure that staff is compliant with hand hygiene and dressing change policies. Starting July 11, 2014, an audit will be completed on 6 staff per week x3 weeks, then 3 staff per week x1 month, then 1 staff per week x2 months. Concentration will focus on watching staff during cares, including perineal cares, toileting, dealing with soiled clothing, isolation techniques and dressing changes. If any issues are discovered within the audit, the length of the time will be extended. The Infection Control nurse will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment H) 5) Date certain will be 7/15/14.	7/15/14

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caused by . . . C. difficile . . . After contact with a resident's mucous membranes and body fluids or excretions . . . After removing gloves . . . The use of gloves does not replace handwashing/hand hygiene. . . ."

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included C. difficile (05/28/14). The current care plan, reviewed on 05/27/14, stated, "I am on isolation precautions r/t [related to] having frequent loose stools. Awaiting culture results for c-diff [C. difficile] . . . wear appropriate PPE [Personal Protective Equipment] when entering my room and providing me with cares. Follow contact isolations precautions . . ."

Observation on 05/27/14 at 2:40 p.m. showed the Certified Nursing Assistant (CNA) (#6), donned in PPE, in the bathroom with Resident #7. The CNA stated the resident had an incontinent bowel movement (BM). The CNA (#6) performed perineal cares for the resident and pulled her brief and pants up. Without removing the soiled gloves and performing hand hygiene, the CNA walked the resident to her recliner and handed her the call light. The CNA then opened the door to the resident's room with his soiled glove, removed his gown and gloves and placed them in the trash, went back into the bathroom and washed his hands, then exited the room. The CNA (#6) failed to remove his gloves, wash his hands, and apply clean gloves after performing perineal cares.

Observation on 05/28/14 at 7:50 a.m. showed the CNA (#16) donned PPE and entered Resident #7's room, and assisted her to the bathroom. The CNA removed the resident's brief soiled with BM, then failed to remove her gloves and wash her

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hands. While the resident sat on the toilet, the CNA performed morning cares, cleaned her dentures, and applied her clothing. Resident #7 then stood up and, as the CNA (#16) applied a barrier cream to her buttocks, the resident had a loose BM which made contact with the CNA's gloved hand and the resident's pants. The CNA wiped the BM off her glove with a disposable wet-wipe and obtained clean pants from the resident's closet. The CNA applied a gait belt to Resident #7 and assisted her to the recliner. The CNA then opened the curtains, gave the resident her glasses and call light, gathered all the soiled towels and clothing and placed them in the soiled laundry bin, and made the bed. The CNA (#16) removed her PPE, washed her hands, and exited the room. The CNA failed to remove her gloves and wash her hands (even when the gloves were visibly soiled) after completing perineal care and prior to completing other tasks.

Observation on 05/28/14 at 11:10 a.m. showed the CNA (#16), donned in a gown, gloves, and shoe protectors, in the bathroom with Resident #7. Observation showed BM on the resident's pants and on the floor. The CNA removed the resident's pants and placed them in the soiled laundry bin. With her gloved hand, the CNA obtained a walkie-talkie from her pocket and asked someone to bring clean towels. An unidentified staff member came to Resident #7's door and the CNA (#16) obtained keys from her pocket and handed them to the staff member. The unidentified staff member returned with the clean towels and handed the keys back to the CNA (#16). The CNA performed pericares and applied a barrier cream to the resident's buttocks, wiped her glove off with a disposable wet-wipe, and assisted the resident to the recliner. The CNA

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returned to the bathroom, cleaned the toilet and floor with Clorox wipes, removed her PPE, washed her hands, and exited the room. The CNA (#16) failed to remove her gloves and wash her hands after handling soiled clothing, after completing perineal cares, and prior to completing other tasks. The CNA (#16) failed to sanitize the walkie-talkie after handling it with her soiled gloves. The CNA (#16) obtained her keys with a soiled gloved hand and handed the keys to another staff member, potentially contaminating the other staff member's hands.

Observation on 05/28/14 at 1:25 p.m. showed the CNA (#16) donned in PPE, performed perineal care for Resident #7 and applied a barrier cream to her buttocks. The CNA wiped her glove with a disposable wet-wipe and assisted the resident to her bed. The CNA removed her PPE, washed her hands, and exited the room. The CNA (#16) failed to remove her gloves and wash her hands after completing perineal care and prior to completing other tasks.

During an interview on the afternoon of 05/29/14, an administrative nurse (#2) stated facility staff are expected to follow contact isolation precautions.

- Observation on 05/27/14 at 4:00 p.m. showed two CNAs (#6 and #15) donned gloves and assisted Resident #6 to and from the toilet with a mechanical lift. The CNA (#6) left the room with the mechanical lift but failed to perform hand hygiene after removing gloves and before leaving the room.

- Observation on 05/28/14 at 2:45 p.m. showed two CNAs (#6 and #15) assisted Resident #6 to

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and from the toilet. Only one CNA (#15) donned gloves. That CNA (#15) completed perineal cares for the resident and without removing her gloves, combed the resident's hair and placed glasses on her. The CNA (#15) then removed her gloves. Both CNAs exited the room and failed to perform hand hygiene.

- Observation on 05/27/14 at 4:45 p.m. showed the CNA (#15) donned gloves and assisted Resident #5 with perineal cares. When completed, the CNA removed her gloves and transported the resident to the dining room. The CNA (#15) failed to perform hand hygiene after cares and before leaving the room.

- On 05/28/14 at 8:45 a.m., observation showed two staff members (#17 and #18) completed morning cares and assisted Resident #2 to ambulate to the bathroom. One CNA (#17) removed the resident's wet brief and then removed her gloves. The CNA failed to perform hand hygiene prior to exiting the bathroom to make Resident #2's bed. The CNA returned to the bathroom and assisted Resident #2 to stand from the toilet while the certified medication assistant (CMA) (#18) provided pericares. The CNA (#17) then used a swab with mouthwash to provide oral cares to the resident. The CNA failed to perform hand hygiene after completing pericares and before providing oral cares.

- Resident #4's medical record, reviewed on all days of survey, identified the facility implemented contact isolation for the resident on 05/27/14 for suspected clostridium difficile.

On 05/27/14 at 3:48 p.m. observation showed two CNAs (#5 and #6) donned gowns, gloves, and

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shoe protectors prior to entering Resident #4's room to provide incontinence cares. Observation showed the resident incontinent of bowel. After providing cares and disposing of the soiled brief, one CNA (#5) removed her gloves and, without performing hand hygiene, donned new gloves, applied a clean brief, and assisted the resident to drink water from a cup at the bedside. The CNA then removed her gown, gloves, and shoe protectors and washed her hands prior to exiting the room.

On 05/28/14 at 9:45 a.m. observation showed two CNAs (#3 and #7) donned gowns, gloves, and shoe protectors prior to entering Resident #4's room to provide cares. Observation showed the resident incontinent of bowel. One CNA (#3) provided incontinence cares, disposed of the soiled brief, and without changing her gloves or performing hand hygiene, handed the resident a cloth and asked her to wash her face. The CNA (#3) then obtained clean clothes from the closet and assisted the resident to dress her upper body. The second CNA (#7) finished dressing the resident while the first CNA (#3) removed her gown, gloves, and shoe protectors and washed her hands. (During this observation a licensed nurse (#8) entered the room and informed staff the resident's test results had shown she did not have a clostridium difficile infection.)

On 05/28/14 at 3:50 p.m. observation showed two CNAs (#6 and #9) entered Resident #4's room and placed the resident on the bedpan. The CNAs then washed their hands and left the room. At 4:10 p.m. the CNAs returned, donned gloves and provided perineal cares. One CNA (#9) provided perineal cares and emptied the bedpan, then still wearing the same gloves and without

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performing hand hygiene, the CNA (#9) obtained a clean brief and gave the resident a drink of water from a container at the bedside.

- Review of the facility procedure "Dressing Changes" occurred on 05/29/14. The undated procedure stated, "OBJECTIVE: To prevent contamination of wounds. . . . PROCEDURE: . . . 3. Set up clean field and place supplies on clean field. 4. Hand hygiene and apply gloves. 5. Remove old dressing and place in trash bag. Cleanse wound. Remove gloves, wash hands and apply new gloves. 6. Apply new dressing. 7. Label dressing with date and initials. 8. Hand hygiene. 9. Note - Multiple dressing changes should go from the most clean to the least clean. . . ."

Resident #3's medical record, reviewed on all days of survey, showed staff identified an open area to the resident's right ankle on 04/01/14. A culture of the area, dated 05/08/14, identified Methicillin Resistant Staphylococcus Aureus (MRSA). The record showed, on 05/09/14, the physician ordered Bactroban (an antibiotic) ointment to be applied to the area three times a day for five days. The record further identified Resident #3 had open areas on his left toes.

On 05/28/14 at 8:05 a.m. observation showed a licensed nurse (#8) in the process of a dressing change to Resident #3's right ankle. Observation showed a dressing saturated with bloody drainage on the resident's bed. The nurse (#8), while wearing gloves, cut an alginate dressing to fit the wound, covered it with Tegaderm dressing, and removed her gloves. Without performing hand hygiene, the nurse (#8) donned new gloves and examined the resident's left foot. Observation

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showed open areas on the first, second, and fourth toes with bloody, odorous drainage from the wounds. The nurse cleansed the toes, removed her gloves, washed her hands, and left the room to obtain dressings for the toes. The nurse (#8) then returned to the room and completed the dressing change.

During an interview on 05/29/14 at 2:30 p.m., an administrative nurse (#1) stated, when changing Resident #3's dressings, the nurse (#8) should have started with the resident's toes then moved to the ankle (moving from most clean to least clean) and also should have performed hand hygiene prior to changing the dressing on the resident's toes. The nurse (#1) also stated the staff members in the above observations for Resident #4 and #10 failed to follow the facility's hand hygiene procedures when performing cares for those residents.

ANTIBIOTIC USE:

2. Based on record review and staff interview, the facility failed to ensure appropriate use of antibiotics for 2 of 4 sampled residents (Resident #8 and #10) with urinary tract infections. Failure to ensure appropriate use of antibiotics may result in the residents contracting an antibiotic resistant infection.

Findings include:

- Review of Resident #10's medical record, on May 29, 2014, identified, on 03/08/14, the physician ordered Bactrim DS (double strength) (an antibiotic) twice a day for 10 days for a urinary tract infection. A urine culture, dated 03/11/14, showed gram negative bacilli (a type of bacteria),

F 441
INFECTION CONTROL:

Antibiotic Use
1) Neighbor #8 and #10 did not have any negative consequences related to not receiving urine culture results from the lab timely or not properly comparing the antibiotics the neighbor was on to the ones susceptible to the organism identified in the culture.

2) Any neighbor who has a lab drawn or develops a UTI and has a culture ordered has the potential to be affected.

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F 441	Continued From page 37 but lacked a list of antibiotics appropriate for that organism. The culture identified "final results to follow." Record review showed no final results available in the medical record. During an interview on the afternoon of 05/29/14, an administrative nurse (#1) stated she would check with the lab regarding the final culture results. Later that afternoon, the nurse (#1) provided a faxed report, dated 05/29/14 at 3:38 p.m. The faxed culture and sensitivity results, dated 03/12/14, showed Escherichia coli and indicated the organism resistant to Bactrim. Resident #10's record lacked evidence staff attempted to obtain the final culture and sensitivity results until requested on 05/29/14. - Review of Resident #8's medical record occurred on May 28-29, 2014. A progress note, dated 03/29/14 at 1:08 p.m., stated, "Neighbor more confused and c/o [complained of] increase burning while urination [sic] . . ." The record showed the physician ordered Bactrim DS 800 milligrams twice a day for 10 days. Resident #8's urine culture and sensitivity results, dated 03/30/14, stated, "Enterococcus species . . . ampicillin and nitrofurantoin [antibiotics] are typically effective in treating most uncomplicated lower urinary tract infections . . . Trimethoprim/sulfamethoxazole [Bactrim] is not reliably effective . . ." The culture and sensitivity also identified the enterococcus species susceptible to both ampicillin and nitrofurantoin, but not tested for susceptibility to Bactrim. The record lacked evidence staff informed the physician of the culture and sensitivity results	F 441	3) Sensitivity analysis training will be completed with the nurses at a meeting on July 11, 2014. The care coordinator currently prints out a list of labs due for the week. We will include an area for follow-up that we have received the results from the lab with special attention to send-out labs. (Attachment I) The Care Coordinator will monitor and ensure that we receive and upload all lab results. The Infection Control nurse will assist in monitoring and ensuring that antibiotics are appropriate for the organism identified on the culture, if ordered. 4) Starting July 11, 2014, the DON will audit 2 labs a week x1 month, then 1 lab a week x1 month to ensure that they were received and uploaded. (Attachment J). She will also audit 3 culture results a month x3 months for appropriate antibiotic use. If any issues are discovered within the audit, the length of the time will be extended. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (Attachment K) 5) Date certain will be 7/11/14.	7/11/14

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F 441	Continued From page 38 indicating the organism not susceptible to Bactrim. INSULIN PENS: 3. Based on record review and staff interview, the facility failed to ensure a resident's insulin pen was not used for another resident for 1 of 3 sampled residents (Resident #10) receiving insulin injections via a pen. Failure to ensure insulin pens are dedicated to one resident may result in the spread of blood-borne pathogens to other residents. Findings include: The Centers for Disease Control and Prevention website (www.cdc.gov) stated the following regarding insulin pens: "Insulin Pens and Insulin Cartridges Must Not Be Shared . . . Insulin cartridges should not be used to administer medication to multiple patients due to the potential risk of transmitting blood-borne pathogens . . . All insulin pens are approved only for single-patient use (one device for only one patient). . . ." Resident #10's medical record, reviewed on 05/29/14, identified a physician's order for Lantus insulin 20 units daily for type two diabetes mellitus. A progress note, dated 12/10/13 at 7:56 a.m., stated, "Nurse gave 20 Units Novolog this AM [morning], when 20 Units of Lantus was to be given. . . ." Resident #10's record failed to identify a physician's order for NovoLog insulin. During interviews on 05/29/14 at 2:30 p.m. and 4:30 p.m., an administrative nurse (#1) confirmed Resident #10 did not have a physician's order for	F 441	F 441 INFECTION CONTROL: Insulin Pens 1) Neighbor's #10 did not have any immediate or long-standing adverse effects of being administered the incorrect insulin. 2) All diabetic neighbors who are insulin dependent have the potential to be affected. 3) The 5 rights of medication administration will be reviewed with nurses at a meeting on July 11, 2014. A second storage container will be obtained to separate short-acting and long-acting insulin in the med room. 4) The DON will monitor to ensure that the nurses are administering the correct insulin. Starting July 11, 2014, an audit will be completed on 3 occasions of insulin administration per week x3 weeks, then 1 occasion per week x8 weeks. If any issues are discovered within the audit, the length of the time will be extended. Corrective action will be implemented immediately. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. (See Attachment F) 5) Date certain will be 7/11/14.	7/11/14

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F 441	Continued From page 39 NovoLog insulin at the time of the incident. She stated Resident #10 received another resident's insulin via that resident's NovoLog pen. Failure to ensure the NovoLog pen is dedicated to one resident placed Resident #10 and the resident whose pen was used at risk of acquiring a blood-borne infection.	F 441		