STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/10/16 and completed on 10/12/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample include 2 additional residents to verify specific concerns during the survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess and care plan for use of a wedge cushion for 1 of 2 sampled residents (Resident #3) observed using a wedge cushion. Failure to complete the necessary assessment and care plan the use of a wedge cushion prior to implementation placed Resident #3 at risk for loss of freedom of movement and loss of mobility. Findings include: Review of the facility policy titled "Restraint Policy", occurred on 10/11/16. This policy, revised January 2011, stated, "PHILOSOPHY: . . . we promote the health, dignity and well being of the patient/resident through use of the least restrictive methods possible, while fostering independence and maximizing the	F 221	CHI St. Alexius Garrison Memorial Nursing Facility will ensure that residents will be free from physical and chemical restraints. We will promote the health, dignity and well-being of the resident through use of the least restrictive methods possible, while fostering independence. 1) Resident # 3 wedge cushion was discontinued 10/12/2016. Staff were informed not to use wedges unless assessed and care-planned. 2) Any resident with limited mobility that requires positioning devices may be affected. 3) In the future, if a wedge device is needed for seating and positioning, physical therapy will assess for	11/16/16

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

Electronically Signed | 11/04/2016

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F 221	Continued From page 1 patient's/resident's functional abilities. PURPOSE: The policy and procedure provides guidelines for the appropriate and safe use of restraints and preserving patient rights to least restrictive interventions. All patients have the right to be free from restraints that are not medically necessary or are used for purposes other than patient safety and benefit. . . . DEFINITIONS OF RESTRAINT. . . A Restraint is: Any manual method, physical or mechanical, material or equipment that restricts, immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely that cannot be removed easily by the patient . . . PROCEDURE: Restraint use is based on the assessed needs of the patient/resident . . . a. Alternatives to restraints are attempted. b. The least restrictive safe and effective method is attempted, when alternatives are insufficient. . . . c. The RN [registered nurse] is to complete the initial restraint assessment . . . Alternatives to restraint usage: Document all alternatives that have been tried to manage the patients behavior prior to restraint usage. . . . Document all the least restrictive restraint measures that have been attempted. If the least restrictive measure is a restraint then the appropriate documentation needs to be completed. . . . Other Suggestions for Specific Situations: . . . Falls: . . . Room close to desk . . . Special beds if possible . . . Close supervision . . . Improper Body Alignment: use pillows and foam pads as needed. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses include Alzheimer's disease, anxiety, and schizophrenia. A significant change Minimum Data Set (MDS), dated 08/10/16, identified extensive assistance of	F 221	appropriate use. Nursing will care plan according to direction of use. Staff meeting on October 27, 2016 reviewed with staff deficient practice of using wedges when not care planned for use (Exhibit A). A mandatory staff meeting will be held November 7, 2016 to review Plan of correction with staff. Will educate staff on November 7th, 2016 on new communication form to utilize for multidisciplinary approach to assessment and care planning (Exhibit B). An adaptive device communication tool that lists all residents and devices will be reviewed and updated weekly at Fall/Risk Management Committee (Exhibit C). A review of the restraint policy will be done with the November 7, 2016 meeting (Exhibit D1- D8). 4) A QA study was started on 10/12/16 and will be conducted by the Clinical Care Coordinator on proper assessment and use of seating and positioning device. 3 observations/week X 1 month, 2 observations week/ X 1 month and weekly observations X 2 months (Exhibit E). Clinical Care Coordinator will continue to monitor and observe weekly if standards have not been met and sustained. Results will be reviewed monthly at staff meeting and reviewed at Quarterly QA committee meeting. 5) Date of completion is November 16, 2016.	

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F 221	Continued From page 2 two persons required for bed mobility and transfers. The current care plan stated, " Problem: At risk for falls due to use of psychotropic medications and dementia, non-ambulatory, air mattress. Approaches: . . . Use of EZ lift [sit to stand mechanical lift] for transfers . . . Bed in low position, monitor body positioning, bedside landing strip. Problem: Requires extensive to total assist with ADL's [activities of daily living] due to end stage Alzheimer's. . . . Requires extensive assist to total assist of two staff for bed mobility. Requires extensive to total assist of two staff with transfers and use of EZ lift. Is non ambulatory. . . ." Observations showed the following: * 10/10/16 at 10:30 a.m.: Resident #3 was transferred from the wheelchair to her bed with assist of 2 CNAs (Certified Nursing Assistant) (#14 and #15) and the EZ lift. The CNAs positioned the resident on her right side. A wedge cushion was placed behind the resident's back. A body pillow was placed in front of the resident. A fall mat was placed at the bedside. * 10/11/16 at 9:31 a.m.: Resident was transferred from the wheelchair to the bed with assist of 2 CNAs (#14 and #15) and the EZ lift. The CNAs positioned Resident #3 on her left side. A pillow was placed between her knees, a wedge cushion was placed behind the resident's back and a body pillow placed in front of the resident. A progress note dated 09/27/16 at 4:00 a.m. stated, "Found by staff sitting on floor with back against bed, wedges were on the floor by the bed. No injuries noted. . . ."	F 221		

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F 221	Continued From page 3 A Physical Therapy progress note dated 09/28/16 stated, ". . . Patient was found sitting on the floor with her back against the bed. No injuries or bruising noted . . . Bed was in the lowest position. . . . Patient has not had an incident like this out of bed for quite some time. Just a few weeks ago we did discontinue the floor mat by the bed and today because patient did manage to roll out of bed, we will initiate use of floor mat again. . . . " During an interview on 10/12/16 at 9:35 a.m., a physical therapist (#6) stated she was not aware a wedge cushion could be considered a restraint and confirmed Resident #3's medical record lacked an assessment to ensure the safety of a wedge cushion. During an interview on 10/12/16 at 10:45 a.m., administrative nurses (#1 and #2) stated they consult physical therapy for positioning needs and therapy implements assistive devices as needed. The administrative nurses stated they were unaware if staff completed an assessment on the wedges being used for Resident #3. Resident #3's medical record lacked evidence the facility assessed, care planned and provided direction for the use of the wedge cushion when the resident is in bed.	F 221		
F 241 SS=D	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.	F 241		11/16/16

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide care for 1 of 6 sampled residents (Resident #2) in a manner and environment that maintained, enhanced, and respected the resident's dignity/self-esteem and individuality. Failure to knock on doors and ensure privacy during toileting does not promote the residents' dignity or enhance their quality of life. Findings include: Observation on 10/11/16 at 9:51 a.m. showed a certified nursing assistant (CNA) (#2) transferred Resident #2 from the toilet utilizing a sit to stand lift. During this transfer, while the resident was in a standing position, with his pants and brief down to his ankles and fully exposed, another CNA (#1) entered into the bathroom from the room next door without knocking. The CNA (#1) stated "I guess I should have knocked first," retrieved a pair of gloves, and left the bathroom. During a resident interview on 10/11/16 at 4:31 p.m., when asked if the facility respects the residents' privacy, Resident #9 stated there are times when staff walk right into the room during cares without knocking first. During an interview on 10/12/16 at 11:13 a.m., an administrative nurse (#3) stated she expected staff to knock before entering the resident's room.	F 241	It is the intent of CHI St. Alexius Garrison Memorial Nursing Facility to maintain and enhance the resident□s dignity and to be respectful of their individuality, recognizing that this is their home. 1) A Mandatory in-service was held on 10/27/16. Staff was educated on the fact that the residents have an expectation of privacy to promote dignity. Staff members were reminded that this is the resident□s home, not the staff□s place of work (Exhibit A). CNA #2 was educated by Clinical Care Coordinator about knocking on doors and residents□ dignity and privacy rights. 2) All residents who live in this facility may be affected by this practice. 3) All staff will review the Residents□ Rights policy and sign by November 7, 2016 (Exhibit F1-F3). Education for staff will be provided annually by DON and clinical care coordinator. 4) A QA study of staff knocking on resident□s doors will be done by Clinical Care Coordinator; the QA was started on 10/14/2016. These observations will be done as follows: 10 observations all three shifts /week x1 month, 5 observations per week x1 month then random observations /week x 1 month (Exhibit G1- G2). Clinical Care Coordinator will continue with random observations if standards have not been met and sustained. There will be five resident interviews, (this QA	

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F 241	Continued From page 5	F 241	was started on 10/17/16), to be done/month x 3 months asking residents about dignity and care and if staff knock on their door before entering their home. The Clinical Care Coordinator will interview resident #9 every month x3 with dignity concerns. QA will be reviewed at nursing meetings as they occur and at quarterly Hospital QA committee meetings. 5) Date of completion is November 16, 2016.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA)	F 274	It is the intent of CHI St. Alexius Garrison Memorial Nursing Facility to recognize when a significant change in status of either decline or improvement occurs, ensuring MDS assessments are	11/16/16

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F 274	Continued From page 6 for 1 of 1 sampled resident (Resident #6) after an improvement in the resident's condition. This failure limited the facility's ability to accurately assess the resident's status and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement), . . ." - Resident #6's medical record, reviewed on all days of survey, identified the resident experienced a cerebral vascular accident (stroke) in May 2016 which resulted in a significant decline in her status. A SCSA Minimum Data Set (MDS), dated 05/31/16, identified a Brief Interview for Mental Status (BIMS) score of 12 - moderate cognitive impairment; disorganized thinking which fluctuated, a depression score of 9 - mild depression; hallucinations; and required extensive assistance of one person for bed mobility, transfers, and locomotion off the unit. A Quarterly MDS, dated 07/25/16, identified a BIMS score of 15 - cognitively intact; no	F 274	completed and care plans are addressed. 1) Following exit conference, facility contacted the ND RAI coordinator, to discuss how to proceed with change of status assessment. Resident #6 had an upcoming MDS with an ARD of 10/24/2016 (Exhibit A). The ND RAI coordinator instructed us to complete any change to this assessment. MDS team did complete a Significant Change of Status for Improvement with care plan review and CAA for 10/24/16 on resident #6. 2) All residents in this facility may be affected. 3) Multidisciplinary staff met and developed a plan on who will complete sections of MDS and have reviewed RAI section on significant changes (Exhibit H1-H6). MDS coordinator and multidisciplinary staff will meet bi-monthly to review MDS and possible significant changes in residents. 4) A QA study will be initiated to monitor MDS-100% of MDS from October 13-Oct 31, 75% of November MDS, 50 % of December MDS, and then 25% of January MDS. Unit Manager and DON will monitor MDS (Exhibit I). This information will be reviewed at the nursing departmental meetings as they occur and reported to the quarterly Hospital QA Committee for further recommendations if needed. 5) Date of completion is November 16, 2016.	

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F 274	Continued From page 7 disorganized thinking; depression score of 2 - mild depression; no hallucinations, and required limited assistance with bed mobility, transfers, and locomotion off the unit. During an interview on 10/12/16 at 10:35 a.m., an administrative nurse (#3) and an MDS nurse (#10) verified Resident #6's improvement in two or more areas of the resident's status.	F 274		
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 observation, review of facility policy, and staff interview, the facility failed to appropriately prime insulin pens prior to insulin administration for 1 of 1 sampled resident (Resident #4) and 1 of 1 supplemental resident (Resident #11) observed during 2 of 3 insulin administration observations. Failure to prime insulin pens according to facility policy may result in an incorrect dose of insulin. Findings include: Review of the facility policy titled "Insulin Pen Use-Nursing Guidelines" occurred on 10/12/16. This policy, dated January 2010, stated, " . . . prime safety needle with 2 units prior to each administration . . . " - Observation on 10/10/16 at 12:41 p.m., showed a nurse (#2) obtained Resident #11's NovoLog	F 281	It is the intent of CHI St. Alexius Garrison Memorial Nursing Facility to provide services that meet professional standards of quality in appropriate use of insulin pens. 1) Nurses that were administering inulin to resident #4 and #11 were immediately educated on 10/12/16 about the proper way to administer insulin through an insulin pen. Mandatory Staff Meeting held October 27, 2016 to review deficiency (Exhibit A). Education was provided by DON and Clinical Care Coordinator on how to properly administer medication to a resident from an insulin pen. Starting on 10/13/16 all nursing staff who give insulin have been monitored, observed, and educated as needed on administering insulin through an insulin pen on resident	11/16/16

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F 281	Continued From page 8 FlexPen, dialed the FlexPen to 1 unit and primed the pen. The nurse (#2) dialed the insulin pen to 10 units as per physician's order, and administered the insulin. The nurse failed to prime the insulin pen with 2 units prior to dialing the insulin dosage. Observation on 10/10/16 at 12:45 p.m., showed a nurse (#2) obtained Resident #4's NovoLog FlexPen, dialed the FlexPen to 1 unit and primed the pen. The nurse dialed the insulin pen to 3 units per the physician's order, and administered the insulin. The nurse failed to prime the insulin pen with 2 units. During an interview on 10/10/16 at 12:50 p.m., a nurse (#2) stated staff prime insulin pens with 1-2 units before administering the insulin. Facility staff failed to appropriately prime insulin pens prior to administering insulin to residents.	F 281	#4 and #11 by clinical care coordinator. All nursing staff has reviewed the insulin pen policy starting 10/13/16 (Exhibit R1-R2). 2) This practice would affect diabetic residents in facility who receive insulin from an insulin pen. 3) Each nurse will be individually educated on how to properly administer insulin from an insulin pen by the Clinical Care Coordinator and DON. Each nurse will have to demonstrate how to properly administer insulin from an insulin pen. This education will be provided annually by ECRS by February 28, 2017. 4) A QA study of priming of insulin pens will be done by the Clinical Care Coordinator and DON, the QA was started on 10/13/16 and consists of 10 observations/week on all shifts for one month, 5 observations/week on all shifts for one month, and random observations/week for one month (Exhibit S). Random observations will be continued if standards have not been met and sustained. This information will be reviewed at the nursing departmental meetings as they occur and reported to the quarterly Hospital QA Committee for further recommendations if needed. 5) Date of completion is November 16, 2016.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		11/16/16

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F 323	Continued From page 9 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: RESIDENT SAFETY 1. Based on observation, record review, and staff interview, the facility failed to provide supervision to prevent accidents for 1 of 1 sampled residents (Resident #2) assessed to not be left alone in his room while seated in a wheelchair. Failure to ensure facility staff implemented necessary measures to avoid falls placed Resident #2 at risk for injuries related to falls. Findings include: Review of Resident #2's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 02/29/16, identified extensive assistance of two people with bed mobility, transfers, dressing, toileting, and personal hygiene. The current care plan stated, ". . . Problem . . . Resident at risk of falls . . . Approaches . . . bed and chair alarm . . . Don't leave in room in w/c [wheelchair] . . ." Review of Resident #2's fall event follow-up reports identified falls occurred on 11/14/15, 11/15/15, 03/05/16, 03/25/16, and 09/11/16. The fall event report on 09/11/16 stated, ". . . found resident laying on floor with blood on floor behind head. Resident was in w/c . . . Resident sent to ER [emergency room] . . . contusion . . ."	F 323	CHI St. Alexius Garrison Memorial Nursing Facility will ensure that the resident environment will remain as free of accident hazards as possible, with adequate supervision and assistance to prevent accidents. RESIDENT SAFETY 1) Following exit conference on October 12, 2016, in-time training was done with on-duty staff regarding resident #2□s care plan and specifically that resident #2 cannot be left in room alone in the wheelchair. This was also passed on in nursing report on all shifts from 10/12/16 through 10/20/16. Nurses were told of deficient practice and instructed to observe CNA staff for care plan compliance. 2) All residents may be affected that are care planned for necessary measures to avoid falls. 3) On October 27, 2016, a mandatory staff meeting was held. Items discussed were reinforcing existing care plan policy, staff was instructed that it is expected that staff utilize pocket care plans every shift-as changes are made frequently. Staff was instructed if there are any concerns with the care plan to bring to	

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F 323	Continued From page 10 Observations showed the following: * 10/11/16 at 9:23 a.m.: Resident #2 seated in his wheelchair in his room by himself. A certified nursing assistant (CNA) (#2) transferred the resident from his wheelchair to the toilet utilizing a sit to stand lift. * 10/11/16 at 9:51 a.m.: A CNA (#2) entered Resident #2's room, transferred the resident from the toilet to his wheelchair utilizing a sit to stand lift, and left the resident in his room while seated in his wheelchair for approximately an hour. During an interview on the morning of 10/11/16, an administrative nurse (#3) stated Resident #2 is care planned to not be left alone in his room while seated in his wheelchair to prevent falls. The nurse stated the fall committee made this decision as the resident attempts to self transfer when left alone in his wheelchair in his room. The facility failed to provide the supervision required, and per the developed care plan, to ensure Resident #2 was not left alone in his room while seated in his wheelchair. UNSECURED CHEMICALS 2. Based on observation, review of Material Safety Data Sheets (MSDS), and staff interview, the facility failed to maintain an environment free of accident hazards on 1 of 3 days of survey (October 10, 2016). Failure to secure hazardous chemicals placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the MSDS occurred on 10/12/16. The MSDS sheets identified the following:	F 323	nursing staff (Exhibit A). An all staff mandatory staff meeting for Survey Compliance meeting will be held November 7, 2016. 4) QA study was developed and started by Clinical Care Coordinator to observe usage of pocket care plans by CNA on November 2, 2016. QA study will provide 10 observations/week times 1 month, 5 observations/week times 1 month and then random times 1 month-all shifts (Exhibit N). A second QA study was developed and started on 11/2/16 to observe that residents are free of accidents/hazards. The second QA study will provide10 observations/week times 1 month, 5 observations/week times 1 month and then randomly times 1 month over all 3 shifts (Exhibit O). If standards are not met and sustained then clinical coordinator and delegated staff will continue observations and monitoring. All QA results will be reviewed at monthly staff meeting and reported the hospital QA Committee for further recommendations. 5) Date of completion is November 16, 2016. UNSECURED CHEMICALS 1) Following the exit conference on October 12, 2016, the housekeeping staff was educated by the Housekeeping Supervisor that all cleaning chemicals will be locked in housekeeping carts when cart is left unattended by housekeeping staff. The cupboard in the nourishment center on 3rd floor that houses chemicals will have a child proof lock at all times.	

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F 323	Continued From page 11 * Purex liquid bleach: ". . . eye/skin/inhale . . . prone to aggravation by exposure . . ." * Virex II 256: ". . . Hazards . . . Inhalation. Skin Contact. Eye Contact. . . . May cause permanent damage including blindness. . . . Skin. Corrosive. May cause permanent damage. . . . Inhalation. . . . May cause irritation and corrosive effects to nose, throat, and respiratory tract. . . . Ingestion . . May cause burns to mouth, throat, and stomach. . . ." * MasterCare Bath Aire System Disinfectant: ". . . Keep out of reach of children . . . Causes severe skin burns and eye damage . . ." Observation showed the following: * 10/10/16 at 7:40 a.m.: During initial tour an unlocked cupboard in the nourishment center contained a spray bottle of MasterCare whirlpool bath disinfectant and a jug of Purex laundry detergent. *10/10/16 at 7:55 a.m.: Two unattended housekeeping carts located in the hallway outside of residents rooms. Both carts contained open buckets filled with Virex II solution on top of the carts. * 10/10/16 at 1:59 p.m.: An unattended housekeeping cart located across from room 320 with a bucket filled with Virex II cleaning solution placed on top of the cart. *10/10/16 at 2:13 p.m.: An unattended housekeeping cart located in the hallway outside of room 310 with a bucket filled with Virex II cleaning solution on top of the cart. During an interview on the afternoon of 10/10/16, an administrative housekeeping staff member (#4) stated she did not know if the buckets filled with cleaning solutions should be kept in a	F 323	2) All residents in the facility have the potential to be affected by this identified concern. 3) On October 19, 2016 a meeting was held for all housekeeping personnel. They were informed that a new policy for storing chemicals on housekeeping carts will be implemented to provide that all chemicals will be locked up when cart is left unattended. The new policy (Exhibit L) will be in-serviced to the housekeeping personnel on November 16, 2016. 4) A QA study done by the Housekeeping Supervisor was developed to observe that chemicals are properly stored on the housekeeping carts and nourishment room on 3rd floor. This QA was started on 10/18/16. This study will be conducted 3 times/week times one month, 2 times/week times one month, weekly times 2 months. Any in-time training will be conducted at time of observation. (Exhibit M). Housekeeping Supervisor will continue to randomly observe and monitor if the standards have not been met and sustained. All QA results will be reviewed at monthly staff meetings, and reported to the hospital QA Committee for further recommendations. 5) Date of completion is November 16, 2016.	

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F 323	Continued From page 12 locked/secured area. The facility failed to secure hazardous chemicals to maintain an environment free of accident hazards.	F 323		
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, review of the facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to clean and sanitize per manufacturer's direction 1 of 2 ice machines utilized for residents and staff. Failure to maintain ice dispensing equipment may result in foodborne illness and unsanitary dining conditions. Findings include: Review of the facility policy titled "PROCEDURE FOR SANITIZING ICE MACHINE" occurred on 10/12/16. This undated policy stated, ". . . Quarterly Cleaning and Sanitizing . . . 10. Initial quarterly cleaning log when cleaning is completed . . ."	F 371	It is the intent of CHI St. Alexius Garrison Memorial Nursing Facility to store, prepare, distribute and serve food under sanitary conditions. Garrison will follow proper sanitizing and maintenance procedures according to manufacture instructions. A log will be kept of the cleaning of the ice machines. This log will be maintained by Housekeeping Supervisor. 1) The survey did not identify any patients that were affected by this deficiency. 2) All patients and residents have the potential to be affected by unsanitary conditions if ice machines are not	11/16/16

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F 371	Continued From page 13 Review of the manufacturer's guidelines for the facility's "Scotsman Ice System" ice machine occurred on October 11-12, 2016. The guidelines, dated August 1989, page 17, stated, ". . . Maintenance and Cleaning should be scheduled at a MINIMUM of twice per year. . . ." During the environmental tour on 10/10/16 at 2:15 p.m., the housekeeping supervisory staff member (#4) stated the ice machine is cleaned once a year. The facility failed to provide a cleaning/sanitizing log for this ice machine.	F 371	properly cleaned and sanitized. 3) On October 18, 2016, the housekeeping department met for their departmental meeting and discussed the deficiencies identified in the survey (Exhibit L). A new policy was written and will be distributed to the housekeeping staff for review and signature. The policy will be brought to the November 16, 2016 housekeeping department meeting by the housekeeping supervisor (Exhibit P1-P5). The new policy includes manufacturers recommendation on how often sanitizing and cleaning needs to occur on Scotsman FB5B and Follett Symphony Plus. Cleaning of Follett Symphony Plus was done on October 20, 2016 and Scotsman FB5B was done on November 1, 2016 (see exhibit Q). 4) A QA study will be conducted by the housekeeping supervisor on the 3rd floor ice machine to ensure that it has been cleaned 3 times per year. This information will be reviewed at the housekeeping departmental meetings as they occur and reported to the Hospital QA Committee for further recommendations if needed. 5) Date of completion is November 16, 2016.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		11/16/16

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F 431	Continued From page 14 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, professional reference review, and staff interview, the facility failed to ensure proper labeling of medications for 1 of 1 sampled residents (Resident #4) and 2 supplemental residents, (Resident #11 and #12) observed during medication pass and identified during	F 431	It is the intent of CHI St. Alexius Garrison Memorial Nursing Facility, in conjunction with the Pharmacist, to provide accurate labels for all resident medications and to store medications in original packages. 1) The Pharmacist provided labels on	

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F 431	Continued From page 15 inspection of the medication cart. Failure to ensure labeling of medications with the residents information and the physician's order prevents staff from using the 6 rights of medication administration and may result in medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice," 10th Edition, Pearson Education, Inc, New Jersey, page 776 states, ". . . Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record]. . . " Review of the facility policy titled " Insulin Pen Use-Nursing Guidelines" occurred on 10/11/16. This policy, dated January 2010, stated, ". . . All insulin pens must have patient identification label and date opened. . . . " Observations during medication pass on 10/11/16 showed a nurse (#11) administered eye drops to Resident #12. The eye drop bottle and/or the container the bottle was stored in failed to contain a label that identified Resident@12's information and physician order. Observations on 10/11/16 at 11:43 a.m. showed a nurse (#11) prepared Resident #4's NovoLog insulin. The NovoLog pen failed to contain a label that identified Resident #4's information and physician order. Review of the medication cart on 10/11/16 at 1:30 p.m., identified the following:	F 431	October 12, 2016 for all medications stored in medication cart that didn□t have labels for residents #4, #11, #12 (Exhibit A). All other medications that needed proper labeling were also provided labels by pharmacy on 10/12/16. Hand held nebulizers were placed in their boxes with labels on them in medication cart. Baggies for insulin pens were removed and will no longer be used. 2) All residents who have insulin, OTC eye drops, and nebulizers have the potential to be affected by this practice. 3) Staff was educated at a mandatory staff meeting on October 27, 2016 on how medications should be properly labeled and stored for safe administration. Monthly cart checks of outdates and labels are now being done by DON and Clinical Care Coordinator. OTC eye drops and nasal sprays were taken out of stock and will now be received from the pharmacist. 4) A QA Study that began on 10/13/16 this will be done by Clinical Care Coordinator checking to see if medications are labeled properly and sent from pharmacy with proper labels. This QA will be done 3 times/week times 1 month, weekly for two months, randomly for one month (Exhibit X). The Clinical Care Coordinator will continue to observe and monitor if standards have not been met and sustained. This information will be reviewed at the nursing departmental meetings as they occur and reported to the quarterly Hospital QA Committee for further recommendations if needed.	

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F 431	Continued From page 16 * insulin pen for Resident #4 did not have a label and was stored in a plastic bag with the resident's name hand written on the bag. * Resident #4 and #11's insulin pens were found in Resident #4's plastic bag and not appropriately labeled. * 2 single unit dose nebulizer treatments were found in the nebulizer bags with residents names hand written on them but not in the original box that contained the resident information and physician order. During an interview on 10/12/16 at 1;20 p.m., a pharmacist (#13) and an administrative nurse (#3) confirmed all residents medications should be individually labeled. The facility failed to ensure patient identification labels were on resident medications and medications were stored in their original container.	F 431	5) Date of completion is November 16, 2016.	
F 441 SS=E	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	F 441		11/16/16

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F 441	Continued From page 17 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to follow infection control practices for 1 of 1 sampled resident (Resident #1) under infection control precautions and observed for 2 of 3 days. Failure to follow infection control practices related to droplet precautions has the potential to spread infections to the other residents, staff, and visitors. Findings include:	F 441	It is the intent of CHI St. Alexius Garrison Memorial Hospital Nursing Facility to provide a safe, sanitary environment and to prevent the development and transmission of infection and disease. 1) Staff were immediately educated on 10/11/16 about droplet precautions on resident #1. Staff was educated by floor nurses at report from 10/11/16 until 10/20/16 (when resident was taken off precautions) to follow droplet precautions on resident #1 and where the isolation	

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F 441	Continued From page 18 Review of the facility policy titled "ISOLATION PRECAUTIONS" occurred on 10/12/16. This policy, revised May 2015, stated, ". . . DROPLET PRECAUTIONS . . . In addition to Standard Precautions, use Droplet Precautions for a patient know [sic] or suspected to be infected with microorganisms transmitted by droplets . . . that can be generated by the patient coughing, sneezing, talking, or performing procedures. . . . Patient Placement . . . Place patient in a private room. When a private room is not available, place the patient in a room with another patient who has active infection with the same microorganism. Patient should remain in room. . . . Personal Protective Equipment . . . surgical masks should be worn when entering the room. . . . Visitors should be instructed how to protect themselves by wearing a mask when entering a room. . . . Transport . . . Limit the movement and transport of the patient from the room to essential purposes only. If transport is necessary, place a surgical mask on the patient prior to transport." Kozier & Erb's "Fundamental of Nursing Concepts, Process and Practice," 10th Edition, Pearson Education Inc., Upper Saddle River New Jersey, 2016, Page 619, stated, ". . . Droplet Precautions . . . Limit movement of client outside the room to essential purposes. Place a surgical mask on the client while outside the room. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included pneumonia. The current care plan stated, ". . . Problem . . . Returned from [local hospital] Pneumonia . . . Approaches . . . 1) Antibiotics as ordered . . . 4) Droplet Precaution - Encourage good handwashing." Resident #1 returned from	F 441	manual is located on the unit. A mandatory staff meeting was held on October 27, 2016 (Exhibit A), where staff was educated on isolation precautions and tag F 441 was reviewed. All staff was directed to information in the isolation book located at the nursing station. 2) All residents that live in this facility can be affected by this practice. 3) All staff will review new isolation precaution procedures by November 7, 2016 and will sign off on the revised policy (Exhibit T1-T9). Droplet precaution policy (Exhibit U) will also be reviewed by November 7, 2016 as this policy has also been revised. Staff will be educated on the isolation policy annually by ECRS modules. 4) A QA study of isolation practices will be done by Clinical Care Coordinator and DON on all isolation patients from October 12, 2016 - February 1, 2017 (Exhibit V). This information will be reviewed at the nursing departmental meetings as they occur and reported to the quarterly Hospital QA committee for further recommendations if needed. 5) Date of completion is November 16, 2016.	

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F 441	Continued From page 19 the hospital on 10/04/16. Resident #1 and Resident #2 shared a room and observation showed the following: * 10/10/16 at 7:40 a.m.: A droplet precaution cart outside Resident #1 & #2's room. An unidentified staff member provided care for Resident #2 inside the room without a mask or gloves. * 10/10/16 at 9:43 a.m.: an activity director (#5) entered into Resident #1 and #2's room without a mask. Resident #1 was lying in his bed. * 10/10/16 at 9:45 a.m.: a certified nursing assistant (CNA) (#2) donned a mask, entered Resident #1 and #2's room, transferred Resident #2 into bed, and removed his mask. During this observation, another CNA (#7) entered Resident #1 and #2's room without a mask and assisted Resident #1, who wore no mask and had coughed, from his bed to a standing position and into the hallway. * 10/10/16 at 12:07 p.m.: Resident #1 was in the activity room eating lunch at a table away from the other residents. An activity director (#5) was seated directly behind him sewing. Neither the resident or staff member wore a mask. * 10/10/16 at 2:44 p.m.: Resident #1 walked in the hallway with no mask on. Several unidentified staff members walked by Resident #1 and acknowledged the resident. The staff members failed to ensure Resident #1 wore a mask. * 10/10/16 at 2:52 p.m.: A CNA (#8) entered into Resident #1 and #2's room and assisted Resident #2 from the bathroom to his bed. Resident #1 entered the room without a mask. The CNA (#8) did not wear a mask. * 10/11/16 at 2:00 p.m.: An unidentified staff member assisted Resident #1 from his room to the restorative care room. The resident did not	F 441		

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F 441	Continued From page 20 have a mask on. The staff member failed to wear a mask or ensure Resident #1 wore a mask. During an interview on 10/11/16 at 5:15 p.m., an administrative nurse (#9) stated she expected staff to wear a mask and gloves when providing any cares in Resident #1's room and staff should ensure Resident #1 wore a mask when outside of his room.	F 441		