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 _____	11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE 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 The Standard Medicare/Medicaid recertification started on 11/19/19 and concluded on 11/21/19.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		12/26/19

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

Electronically Signed | 12/10/2019

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F 582	Continued From page 1 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to provide the CMS (Centers for Medicare and Medicaid Services) 10123 Notice of Medicare Noncoverage (NOMNC) and failed to assure a completed CMS 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) for 1 of 2 residents (Resident #7) discharged from Medicare Part A and remained in the facility. Failure to provide the required Medicare noncoverage notices limited the resident's/legal representatives ability to exercise their rights in regard to Medicare Part A services. Findings include: On the afternoon of 11/20/19, a review of the	F 582	1. It is the intent of CHI St. Alexius Garrison Nursing Facility to ensure that Medicare required notices 10123 Notice of Medicare Non-coverage (NOMNC) is completed at the time of Medicare A being discontinued and to assure the completion of the form 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage. 2. All residents that have Medicare A have the potential to be affected by this deficient practice. 3. The form 10123 was revised to add information that is pertinent for resident/representative. Social Services and Utilization Review	

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F 582	Continued From page 2 Medicare Part A letters/notices for Resident #7 showed the facility failed to provide the NOMNC (Form CMS 10123). The SNFABN returned by the legal representative failed to identify their choice of option for Medicare Part A. The facility failed to contact the resident's legal representative to clarify their option for Resident #7 who remained in the facility. During interview on the morning of 11/21/19, an administrative nurse (#7) confirmed the facility failed to assure completion of the SNFABN and provide the NOMNC to Resident #7's legal representative.	F 582	Coordinator/discharge planner reviewed the new form and are the individuals that will be responsible to make sure that appropriate forms are given to the resident/representative, and are completed as required. Discharge planner and a nurse called son on 12/9/19 to review the document 10055 and explain what was missing on the document; he agreed per this conversation that option 2 was what he would have checked. This conversation was signed off and witnessed by 2 staff nurses. 4. A QA study will be completed for one year by Social Services starting on 12-4-2019, on all residents that are to be issued these forms 10123, and 10055 for correct completion. 100% review will be completed on all 10123 and 10055 forms for one year. The results of the study will be reviewed by the hospital QA committee on a quarterly basis, for further recommendations needed. 5. Date of completion will be Dec. 26, 2019	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		12/26/19

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F 609	Continued From page 3 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify and report to the State Survey Agency a potential incident of abuse for 1 of 1 sampled resident (Resident #20) who made allegations of abuse. Failure to report the allegation of abuse to the State Agency places all residents at risk of potential abuse. Finding include: Review of the facility policy titled, "Abuse, Neglect, and/or Exploitation" occurred on 11/21/19. This policy, revised August 2016, stated, ". . . Long Term Care . . . The Director of Nursing / designee shall inform the Administrator	F 609	1. It is the intent of CHI St. Alexius Hospital Garrison Nursing Facility to ensure that appropriate reporting of alleged abuse allegations are reported in the appropriate time frames as set forth by Federal and State Regulations. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. The Abuse policy was updated to reflect the time frames for reporting of alleged abuse and/or abuse that results in serious bodily harm. It identifies when and how nursing is to report the initial	

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F 609	Continued From page 4 of incident and findings from investigation, report to the State Health Department immediately or at the latest within 24 hours of impending investigation. . . . All allegations will be reported to the department within 24 hours by telephone [phone number for State Health Department, Division of Health Facilities], after business hours a message will be left on the ND Department of Health's voice mail. The report of the investigation and results will be mailed or faxed within five working days to [fax number for State Health Department, Division of Health Facilities] the ND Department of Health . . ." Review of Resident #20's medical record occurred on all days of survey. The progress notes stated the following: * 08/31/19 at 3:27 a.m., "about 0200 (2:00 a.m.) res. (resident) wanted to go to br. (bathroom) put gait belt on and escorted to br. as soon as she was in the br. she started to yell "get away from me" and "get out of here" Other staff came and tried to help. I left trying to diffuse the situation but said the same things to other staff member was showen [sic] br. across the hall from room. res did use but wouldn't come out. Was offered wheelchair to sit down refused offer said we would put her somewhere and take advantage of her. called [sic] for female assistance from 2nd floor." * 08/31/19 at 4:27 a.m., "female staff came from 2nd floor and tried to give order from [physician's name] for 50 mg [milligrams] Benadryl and 2 mg Ativan IM [intramuscularly] due to combative nature only partial dose given. Dr. was notified of partial dose. Res stated that staff was trying to rape her and female staff from 2nd floor was in on it too. After shot given was escorted by 3 staff	F 609	incident in a 2 hour time frame with completion and resolution to the alleged abuse in 5 days by the VP of Nursing. An education program will be conducted on Dec. 16th, the updated policy will be reviewed with emphasis on the procedure for reporting in the 2 hour time frame, how to use the State Web site for doing the initial reporting and completion of our inhouse incident report system(IRIS). 4. A QA study will be completed on all Iris reports (incident reporting system) for a full year starting on 12-4-2019 that address alleged Abuse, Neglect, and/or Exploitation of a resident, to determine that all steps in reporting have been completed at time of alleged report. The VP of Nursing will do an audit on all IRIS reports for a full year starting on 12-4-2019. All audit information will be taken to QA committee meetings on a quarterly basis for further review and recommendations as needed. 5. This deficiency will be corrected by Dec. 26th 2019.	

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F 609	Continued From page 5 to res. bed. shot [sic] was given about 0415 [4:15 a.m.]" The facility completed an investigation into Resident #20's abuse allegation but failed to report the rape allegation within 2 hours and their findings within five days to the State Survey Agency. During interview on 11/21/19 at 12:05 p.m., an administrative nurse (#7) confirmed the facility failed to notify the State Survey Agency of the allegation made by Resident #20 and agreed the facility should have reported the incident and the investigation.	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		12/26/19

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F 623	Continued From page 6 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 7 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide residents or their representatives and the State Long Term Care	F 623	1. It is the intent of CHI St. Alexius Garrison Hospital and Nursing Facility to ensure that the Ombudsman is notified	

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F 623	Continued From page 8 (LTC) Ombudsman a written notice of transfer as soon as practicable for 2 of 3 sampled residents (Resident #7 and #18) transferred to the hospital from the facility. Failure to provide notices of transfer does not allow residents to make informed decisions or inform the Ombudsman of all transfers. Findings include: - Review of Resident #18's medical record occurred on all days of survey. The record showed the facility transferred Resident #18 to an acute care hospital on 07/29/19. The record lacked evidence the facility completed a transfer form and/or sent copies to the Ombudsman. - Review of Resident #7's medical record occurred on all days of survey. The record showed the facility transferred Resident #7 to an acute care hospital on 05/28/19. The record lacked evidence the facility completed a transfer form and/or sent a copy to the Ombudsman. During an interview on 11/21/19 at 10:40 a.m., an administrative staff member (#5) confirmed the facility could not provide a copy of the transfer forms.	F 623	and proper forms are completed for the notice requirement before transfer/discharge. 2. All residents have the potential to be affected by this deficient practice. 3. The policy Discharge or Transfer of Residents has been updated to include sending a copy of the Discharge/Transfer Form to the Ombudsman. A folder will be created and placed at the nurses station with the policy and procedure for the Notice of Discharge and Transfer. Review of deficiency and training will be done at an all staff meeting on Dec. 16, 2019 by social services. The Social Worker will have a telephone meeting with the State Ombudsman concerning education on these forms. 4. A QA study will be, started on 12-4-2019 and conducted over the next 12 months by the social worker and/or designee. 100% review of all charts will be conducted for appropriate completion of all Medicare discharge and transfer forms, bed hold forms, and the notification of Ombudsman of discharge and transfer. QA information will be taken to Hospital QA Committee meeting on a quarterly basis, for further recommendations as needed. 5. Date of correction will be Dec. 26, 2019.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		12/26/19

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F 625	Continued From page 9 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon transfer to the hospital for 2 of 3 sampled residents (Resident #7 and #18). Failure to provide the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their	F 625	1. It is the intent of CHI St. Alexius Garrison Hospital and Nursing Facility to ensure that: Upon or prior to a transfer to a hospital or resident goes on therapeutic leave we will provide written information on bed hold that specifies the duration of the bed hold in which the resident is	

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F 625	Continued From page 10 readmission rights. Findings include: - Review of Resident #18's medical record occurred on all days of survey and identified a hospital admission on 07/29/19. The record lacked evidence the facility completed a bed hold notice and /or provided Resident #18 and or his legal representative with the information. - Review of Resident #7's medical record occurred on all days of survey and identified a hospital admission on 05/28/19. The record lacked evidence the facility completed a bed hold notice and /or provided Resident #7 and or his legal representative with the information. During interview on 11/21/19 at 10:40 a.m., an administrative staff member (#5) confirmed the facility failed to provide the bed hold notices.	F 625	permitted to return and resume residence in the nursing home. 2. All residents have the potential to be affected by this deficient practice. 3. The current policy and procedure for the Bed Hold Notice is being reviewed at a meeting for nursing staff on Dec. 16, 2019. A folder will be created and placed at the nurses station with the policy and process regarding the Bed Hold Notice. 4. The social worker/designee will be responsible to complete an audit starting on 12-4-2019. The social worker/designee will monitor to assure the Notice of Transfer for Hospitalization and bed hold are being completed on all residents transferred to the hospital. A QA study will be conducted over the next 12 months by the social worker and/or designee. 100% review of all charts will be conducted for a full year, to ensure appropriate completion of all Medicare discharge and transfer forms, bed hold forms, and notification of ombudsman of discharge and transfers. The social worker/designee will report all QA findings to the Hospital QA on a quarterly basis, for further recommendations and further actions. 5. Date of correction will be Dec. 26, 2019.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		12/26/19

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F 658	Continued From page 11 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/31/18 Based on observation, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice for 3 of 12 sampled residents (#5, #6 and #7). Failure to prime an insulin pen as recommended (Resident #6 and #7) has the potential for residents to receive an inaccurate dose of insulin, and failure to follow physician orders regarding weights (Resident #5) may result in delayed assessment/treatment of the resident and their condition. Findings include: INSULIN PENS Review of the NovoLog FlexPen manufacturer's guidelines occurred on 11/20/19. The guidelines stated, " . . . Prime your pen: Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. . . ." Review of the facility policy titled, "Insulin Pen Use" occurred on 11/20/19. This policy, dated January 2010, stated, " . . . Remove the safety cap from needle. Turn dose selector to select 2 units. Hold pen with needle pointing up. . . . press	F 658	1. It is the intent of CHI St. Alexius Garrison Nursing Facility to ensure that services provided by the facility will meet professional standards of quality. 2. All diabetic residents that receive insulin have the potential to be affected by the deficient practice if improperly priming an insulin pen. All residents that have an order for daily weights or other scheduled weights other than the weekly weights done by the facility as a standard of care, have the potential to be affected by the deficient practice of not having their daily weights done and documented. 3. An educational meeting will be set up for all nursing staff that administer Insulin using an insulin pen on 12-16-19. The demonstration of the correct procedure for priming an insulin pen will be done by the Unit Manager, with a complete review of the policy. When a provider order is received for a daily weights (or other increments other than weekly) the unit manager will make an adjustment to Matrix that will not allow nursing to sign off on the daily weight until they actually put the daily weight into	

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F 658	Continued From page 12 the push button all the way in until the dose selector returns to 0. A drop of insulin should be visible at top of needle. . . ." Observation on 11/20/19 at 8:05 a.m. showed a licensed nurse (#1) prepared Resident #6's insulin pen for injection. After placing the needle on the insulin pen and with the shield in place, the nurse primed the insulin pen and was unable to visualize a drop of insulin from the needle. Observation on 11/20/19 8:41 a.m. showed a licensed nurse (#1) prepared Resident #7's insulin pen for injection. After placing the needle on the insulin pen and with the shield in place, the nurse primed the insulin pen and was unable to visualize a drop of insulin form the needle. WEIGHTS Review of Resident #5's medical record occurred on all days of survey. Diagnosis included chronic obstructive pulmonary disease and chronic kidney disease stage 4. The physician order dated 10/25/19 to 11/06/19 stated, "Daily weight. If has gained 2 pounds overnight or 5 pounds in one week notify (doctor name)." Review of Resident #5's weekly weights showed the following: * 10/25/19 - 139.5 pounds (#) * 10/26/19 - no weight documented * 10/27/19 - no weight documented * 10/28/19 - 140.2# * 10/29/19 - 141# * 10/30/19 - 135.8# * 10/31/19 - 140.2# (4.4# weight gain over night) * 11/01/19 - no weight documented	F 658	Matrix. A review of the policy will be done at the 12-16-19 meeting with instructions for putting orders into Matrix Care. 4. A QA study will be completed on both of these practices, by the Unit Manager/designee: " Insulin Pens: 3 times per week times 1 month ¿ weekly times 3 months ¿once every other week 2 months ¿ then randomly every month for 6 months, on all shifts " Weights, will monitor : 3 times per week for proper charting times 2 months ¿ weekly times 1 month ¿ every other week times 3 months ¿then randomly times 6 months All information will be reported at the quarterly hospital QA meeting for further recommendations or corrective actions. 5. Date of completion 12-26-19	

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F 658	Continued From page 13 * 11/02/19 - 140.1# * 11/03/19 - 138.4# * 11/04/19 - 138.4# * 11/05/19 - 138.8# * 11/06/19 - 139.8 # During interview on 11/21/19 at 8:43 a.m., an administrative nurse (#7) stated staff failed to obtain daily weights. During interview on 11/21/19 at 8:52 a.m., an administrative nurse (#8) confirmed the facility failed to notify the physician regarding the overnight weight gain. The facility failed to follow physician orders regarding daily weights and failed to notify the physician of a 2 pound weight gain overnight.	F 658		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		12/26/19

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F 803	Continued From page 14 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, review of facility policy, review of medical record, and resident and staff interviews, the facility failed to follow menus and diet orders to meet the nutritional needs of the residents by serving incorrect portion sizes during 2 of 2 observations of tray line (noon meal on 11/19/19 and evening meal on 11/20/19). Failure to follow recommended portion sizes as outlined in the facility's menus and diet orders may result in weight loss/weight gain, and/or inadequate nutritional intake. Findings include: Review of the facility policy titled "Small Portions" occurred on 11/21/19. This undated policy, stated, ". . . When small portions are requested it must be physician ordered and follow-up documentation should be on the nutritional assessment and/or progress notes. . . . entree or meat 2 oz [ounce] or equivalent . . . Starch or Bread choose one or 1/2 portion of each . . . Vegetable or Salad choose one or 1/2 portion of each . . . Observation of tray line on 11/19/19 noon meal	F 803	1. It is the intent of CHI St Alexius Hospital and Nursing facility to ensure that the diet ordered meets the needs of the resident by serving the correct portion sizes. 2. Every resident has a physician ordered diet, that alerts the dietary department to serve the appropriate diet and portion sizes to the resident, which would make every resident at risk for this deficient practice. 3. The policy for Meal Portions was revised and will be reviewed at a departmental meeting on 12-16-19, education will also include review of all scopes and ladles used during a meal service. Also a review of sample large and small portions. 4. A Q A audit will be conducted by the Dietary Manager/designee monitoring staff serving up meals across all three meals. The audit will be conducted daily times 1 week, 2 times per week times 3 weeks, weekly for 4 months, 2 times per	

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F 803	Continued From page 15 and 11/20/19 evening meal, showed the following inconsistencies between the amount served to residents and the portion sizes listed on the facility's menus. 11/19/19 Noon Meal Chicken and Dumpling - 6 oz (3/4 cup) ladle - Menu identified 1 cup Vegetable Medley - 3 oz (1/3 cup) ladle - Menu identified 1/2 cup 11/20/19 Supper Meal Potato Soup - 6 oz (ounce) (3/4 cup) ladle - Menu identified 1 cup Vegetable Medley - 3 oz (1/3 cup) ladle - Menu identified 1/2 cup During an interview on 11/19/19 at 10:16 a.m., Resident #21 stated he asked for smaller portions for weight loss, but stated he is getting regular portions. Resident #21 stated his weight is causing back pain and required use of a walker for ambulation. Review of Resident #21's record occurred on all days of survey. Diagnosis included Type 2 Diabetes Mellitus. Current care plan identified. ". . . Dietary to provide Diabetic diet. 10/30/19 Small portions. . . ." A Physician progress note dated 10/30/19, stated. "Today he's doing reasonably well but he said he would like to lose some weight. We had a discussion with this and we talked about decreasing calorie intake with smaller portions of food. . . . We will make his portions smaller to decrease calories. . . ." A Nursing Facility Diet Sheet dated November 2019 identified Resident #21 on a diabetic diet	F 803	month times 3 months, then randomly for 4 months. The findings will be taken to the Hospital QA committee quarterly for further recommendations as needed. 5. Date of completion will be 12-26-19	

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F 803	Continued From page 16 with small portions. Observation on 11/19/19 at 12:17 p.m. identified Resident #21 received a full bowl of chicken dumpling soup, one piece of garlic bread, and a small bowl of coleslaw,. During an interview on 11/20/19 at 2:50 p.m., the facility dietary manager (#4) stated Resident #21 should have received 1/2 cup of chicken dumpling soup for the dinner meal on 11/19/19 to meet small portions, not a full bowl. Observation on 11/20/19 at 5:10 p.m., showed Resident #21 was served 3 oz vegetables and 3 oz meat and 1/2 cup (4 oz) sweet potatoes which facility considered full portion. Observation on 11/21/19 at 8:37 a.m., showed Resident #21 received a full bowl of oatmeal (approximately 1 cup), one full piece of toast, and an omelet which facility considered full portion.	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/26/19

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F 880	Continued From page 17 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 18 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 2 of 3 days of survey (November 19 and 20, 2019). Failure to follow appropriate infection control practices related to hand hygiene/glove usage during personal cares and during kitchen tasks has the potential for transmission of microorganisms to residents and staff. Findings include: PERSONAL CARES Review of the facility policy titled "Hand Hygiene" occurred on 11/21/19. This policy, dated June 2010, stated ". . . Specific Indications for Hand Hygiene . . . Before and after assisting a patient or resident with toileting . . . Before and after eating or handling food . . ."	F 880	1. It is the intent of CHI St. Alexius Hospital and Nursing Facility to ensure that to ensure that the standard for infection control to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. All staff and residents have the potential to be affected by this deficient practice. 3. Dietary will replace the practice of using a wet rag for wiping off food that is accidentally splashed onto the clean dinnerware; they will have pop up napkin dispenser on the food cart to use for wipe ups. The soiled napkins will not be reused and will be disposed of appropriately. A onetime use wet popup wipe will be also available on the cart for spills.	

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F 880	Continued From page 19 - Observation on 11/19/19 at 10:05 a.m. showed two CNAs (Certified Nurse Aides) (#2 and #6) after providing perineal cares and wearing the same gloves, one CNA (#2) opened the dresser drawer, opened a jar of barrier cream, obtained cream from the jar, and applied the cream to Resident #8's coccyx area. The CNA (#2) then removed the soiled gloves and continued cares including placing the sling and transferring the resident into the wheelchair. The CNA (#2) failed to remove gloves perform hand hygiene prior obtaining barrier cream and continuing with resident care. - Observation on 11/19/19 at 11:08 a.m. showed two CNAs (#2 and #3) donned gloves and transferred Resident #1 to the toilet using a stand lift. After toileting, one CNA (#2) provided perineal care for Resident #1 and transferred Resident #1 to his/her wheelchair. After the transfer, both CNAs removed their gloves and one CNA (#2) combed Resident #1's hair, washed her face, applied perfume, and offered fluids to the resident. The CNA (#2) failed to perform hand hygiene after removing gloves and prior to continuing cares. During interview on 11/21/19 at 12:05 p.m., an administrative staff member (#7) confirmed staff failed to preform hand hygiene appropriately after providing cares. DIETARY - Observation on 11/19/19 at 12:00 p.m. showed a dietary staff member (#9), dishing food to be served, wiped off food spilled onto the plate and the side of the bowl with a dirty rag and/or gloved	F 880	The staff person who was observed washing hands with gloves was educated one on one for proper glove usage and was done by infection control nurse on 12 -10-19. An education program will take place on 12-16-19 with a review of the policy on glove usage and hand washing by the Infection Control nurse for both 3rd floors education meeting for Nurses and CNA's and Dietary□s education meeting. 4. A QA study will be completed by the Unit Manager/designee on the nursing unit, and the Dietary Manager/designee. This will consist of watching proper donning and doffing of gloves during working hours in the kitchen and during resident cares on the nursing unit. Observations will be done 3 times per week for 3 months¿ weekly times 3 months¿ 2 times per month times 6 months. All results will be taken to the quarterly QA meeting for further recommendations as needed. 5. Date of completion will be 12-26-19	

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F 880	Continued From page 20 hand, then wiped the gloved hand on the dirty rag. The dietary staff member continued to use the same gloves throughout the whole meal service and touched ready to eat food items. - Observation during the final kitchen tour on 11/20/19 at 11:00 a.m. showed an unidentified dietary staff member washed and dried her hands while continuing to wear her gloves. The staff member continued with her kitchen tasks while wearing the same gloves.	F 880		