STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355036	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIAN MANOR HEALTHCARE CENTER	604 ASH AVE E GLEN ULLIN, ND 58631

(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 February 18, 2014 and completed on February 20, 2014, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
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: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being possible regarding bowel function for 1 of 1 sampled resident (Resident #6) with episodes of constipation, diarrhea, and incontinence who received oral and suppository stool softeners. Failure to complete an accurate and complete bowel assessment, resulted in an increase in scheduled stool softener medication, frequent use of as needed (prn) stool softeners, incontinence of bowel, and episodes of diarrhea.	F 309	**F309:** It is the policy of Marian Manor HealthCare Center (MMHCC) to assure that all residents will have the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being possible regarding their bowel management. On February 20, 2014 the following was put in place to assure that interventions for the bowel management of all residents (which includes resident #6 from the survey sample) includes more PRN dietary measures in hopes to lessen the use of PRN bowel medication. 1. On February 20, 2014 after our exit review with the survey team, The facility's DON (director of nursing) met with the Resident Care Coordinators (RCCs) to discuss that Resident #6 of the sampled residents and all residents of MMHCC have a fully completed bowel assessment completed with admission (new residents) and/or on return from hospital, if a significant change in physical status and/or in bowel function occurs and with annual MDS (Minimum Data Set) (Copy of DON's written notes from that meeting are enclosed).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Loretta Dewsnup RN-Director of Nursing		03-20-14

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 309	Continued From page 1 Findings include: Review of the facility's policy and procedure, "Bowel Management - (Routine)", occurred on 02/20/14. This undated document stated "Objective: 1. To regulate bowels routinely. Important Points: . . . 3. Encourage roughage in diet, as indicated. Consult Dietary Supervisor as necessary. Nursing Action: . . . 8. Check Bowel Movement list daily. a. 2 No's [no bowel movement in 2 days] - laxative as indicated or rectal check and treat as indicated according to resident's needs. . . . b. 3 No's [no bowel movement in 3 days] - do rectal check and treat as indicated with either suppository or enema. . . . 9. Chart method used and results . . ." Review of the facility's "Bowel Management Protocol", occurred on 02/20/14. This undated protocol identified use of laxative, suppository, or enema, as necessary, and then consider dietary interventions "if concerns continue." The facility's Bowel Management protocol indicated the primary intervention is the use of medications instead of dietary measures. - Review of Resident #6's medical record occurred on February 18-20, 2014. The facility admitted the resident in December 2013 after a fall and fractured pelvis at home. The resident then experienced a fall and fractured hip in the facility in January. The facility re-admitted the resident after hospitalization for surgical repair of the hip fracture. Current diagnoses included constipation. The resident's current Minimum Data Set (MDS), dated 01/27/14, identified the resident required extensive assistance of two or more persons for transfers, walking did not occur, required set-up and supervision for eating,	F 309	2. The facility's "Bowel Management Protocol" (BMP) was revised by the DON to include PRN (when every necessary) dietary measures as the initial interventions instead of PRN bowel medication for residents who are going into a second day without a bowel movement and PRN bowel medication intervention will only be offered on the third day of not having a bowel movement. The facility's Dietary Supervisor and facility's Consulting Dietician were included in the revising of the BMP. The final updating/changes of the BMP were completed on 03/18/14 (Copy of revised BMP is enclosed & copies of highlighted areas on BMP also enclosed). Nursing was in-serviced on the changes of our BMP on 03/19/14 with the March Nurses' in-service. At the CNA (certified nurse assistant) March in-service on 03/19/14 the CNAs were also in-serviced on their role of bowel management for our residents. (Copy of the 03/19/14 in-service notes for the nurses and CNAs and the Roster of attendance enclosed).	

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F 309	Continued From page 2 frequently incontinent of urine, always incontinent of bowel, and received scheduled pain medications. The resident's admission MDS, dated 12/29/13, identified the resident had been occasionally incontinent of urine and continent of bowel. Resident #6's current medications included the following, the date initiated, and potential bowel effects: Pain Medications - *Tramadol (opioid pain reliever), 50 milligrams (mg), one tablet, two times each day, 01/31/14 - may cause constipation. *Extra Strength Tylenol, 500 mg, three times each day, 01/23/14. Bowel Medications - *Docusate Sodium (Dulcolax) (stool softener), 100 mg, one capsule, every morning, 12/23/13. *Sennosides Plus DDS (stool softener and laxative), one or two tablets, two times each day, 02/09/14. (Resident #6 continued to receive the Dulcolax stool softener every morning.) *Dulcolax, 5 mg, one tablet, daily, prn, 01/04/14. *Dulcolax suppository 10 mg, daily, prn, 12/26/13. Other Medications - *Crestor, 10 mg at bedtime, 12/23/13 - may cause constipation. *Ferrous Sulfate, 324 mg, one tablet, daily, 01/23/14 - may cause constipation. Resident #6's Bowel Assessment Form, dated 12/30/13, stated ". . . Resident is currently continent of bowel, Yes. No further assessment necessary at this time." No further information was assessed on the form. The medical record lacked a bowel assessment on the resident's re-admission to the facility on 01/20/14.	F 309	3. Facility's quarterly QA (Quality Assurance) meeting was held on March 13, 2014 (The deficiency report was received on 03/11/14) and at this meeting the deficiencies were reviewed. (copy of QA meeting minutes enclosed) Effective 03/17/14 a QA program was implemented by and under the supervision of the DON to assure resident #6 of the sampled residents and all residents of MMHCC have a fully completed bowel assessment completed with admission (new residents) and/or on return from hospital, if a significant change in physical status and/or in bowel function occurs and with annual MDS (Minimum Data Set). Frequency of QA monitoring: Weekly for one month-03/17/14 through 04/17/14. Monthly for three months (May-June-July 2014) and then quarterly (October 2014 & January 2015) with QA monitoring completed January 31, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff member involved). The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on 06/26/14. (copy of QA monitoring for week of 03/17/14 and completed bowel assessments enclosed)	

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F 309	Continued From page 3 The facility staff failed to identify the following items on the Bowel Assessment Form regarding Resident #6: *Required extensive assistance of two persons for transfers *Constipation *Laxative use/abuse *Inadequate/poor fluid intake *Improper diet/Low fiber intake *Receiving opiates *Dietary interventions Resident #6's current care plan, dated 01/06/14, stated "Problem, Alteration in bowel elimination manifested by constipation. Approach, Nurses - Medicate and Rx [treat] as ordered. Observe if would benefit from dietary aids. Provided with adequate fluids in an effort to maintain hydration. Monitor and record BM's [bowel movements]. Observe for s/s [signs/symptoms] that may accompany constipation, H/A [headache], anorexia, nausea, abdominal distention and cramping. Report persistent findings to Dr. [doctor] & [and] Rx as ordered. Assess bowel sounds PRN. . . . Problem, Decreased appetite . . . Inadequate intake . . . Approach . . . Monitor wt. [weight] as ordered. . . . Observe if necessary to offer nutritional supplements. Find likes/dislikes. . . ." Resident #6's care plan lacked dietary interventions to prevent constipation. Resident #6's Dietary Notes, for the period 12/24/13 to 02/19/14, showed discussions with family members regarding the resident's likes and dislikes in an effort to increase her intake. The notes included the following regarding the resident's bowel function: *01/28/14, 9:23 a.m. - 5 day Medicare Review, initialed by a dietary staff member (#4) ". . .	F 309	4. In regards to resident #6 of sampled residents: Her admission to MMHHC was 12/23/13. Since her admission and up to the survey dates, documentation of resident's behavior and frequent refusals of meals and /or supplements, meds, fluids was reviewed with the surveyors. Dietary documentation at that time was also reviewed. Her physical status was difficult to manage due to her behavior and frequently she would voice to 'let her alone, want to die'. On 02/20/14 (last day of the survey) resident's Physician reviewed resident's status and did order the appetite stimulant Megace. RCC did also visit with family member on 02/20/14 in regards to bowel management resident had when she was at home and family reported that resident's stool softeners were often adjusted at home resulting in a cycle of diarrhea/constipation. With the use of the Megace and the decreased use of pain medication (due to improvement with hip fracture) her appetite and fluid intake has improved markedly. She has had a weight (wt.) gain: her wt. on 02/20/14 was 112# and her wt. 03/20/14 was 127# (ideal body wt. range is 113-139#). 03/07/14 order to reduce the Megace was given and on 03/14/14 an order was given to discontinue the Megace in 2 weeks (03/28/14). She has not used any PRN bowel medications since 02/20/14. Another bowel assessment was completed on 03/14/14. (The following copies are enclosed: bowel assessment of 03/14/14, list of wts., meal charting for Feb. and March 2014, PRN med sheets from 02/20/14 to 03/20/14 showing no PRN bowel meds have been given, bowel output report from 02/20/14 to 03/20/14, nurses notes for 02/20/14 (which is about the visit with family about bowel function at home and order for Megace) and for 03/07/14 &03/14/14 (about Megace changes) and updated care plan problem for constipation). 3/26/14 per TC 3/25/14 DW KH	

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F 309	Continued From page 4 Conditions . . . Constipation senna fruit ball o.d. [every other day] . . ." The remainder of the Dietary Notes failed to address any dietary interventions, including the senna fruit ball. Resident #6's Dietary Card failed to include any bowel interventions such as senna fruit ball or prune juice. During interview, on 02/19/14 at 3:35 p.m., a dietary management staff member (#4) reported she was not aware of any dietary interventions provided for Resident #6 or discussions with the nursing staff about the resident's constipation. The staff member (#4)'s documentation on 01/28/14, previously identified, conflicts with this statement. This staff member (#4) reported dietary staff visited with family members to increase the resident's nutritional intake, which she refused, and did not discuss bowel interventions with the family. Resident #6's Nurse's Notes and Medication Administration Record (MAR) showed the following bowel movement (BM) and medication pattern: *For the period, 12/23/13 to 01/14/14 (23 days) - PRN Dulcolax tablets - 6 days PRN Dulcolax suppository - 1 day; refused - 2 days. Received one Dulcolax tablet on 01/04/14 and two Dulcolax tablets on 01/05/14. BM - 6 in 5 days; 1 "watery" on 01/06/14. 12/27/13 - Nurse's Note identified standing orders to add 2 Senna every day and prune juice. Resident #6's Dietary Card failed to include this standing order. *Hospitalized 01/14/14 to 01/20/14. *For the period 01/20/14 to 02/16/14 (28 days) - PRN Dulcolax tablets - 8 days	F 309		

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F 309	Continued From page 5 PRN Dulcolax suppository - 2 days; refused - 1 day. Received Dulcolax tablet on 01/22/14 and Dulcolax suppository on 01/23/14. Received Dulcolax tablet on 02/09/14 and increased Senna to two times on 02/10/14. BM - 12 in 9 days; 2 "watery" on 01/24/14 and 1 "watery" on 02/10/14. *For the period 12/23/13 to 02/16/14 Resident #6 did not have a BM without a prn stool softener. The "watery" stools followed consecutive days of stool softener tablets or a suppository. Observation on February 19 and 20, 2014 showed the resident received her meals in her room at her family's request. Observation failed to show prune juice or a fruit ball on the resident's meal trays. During interview, on 02/20/14 at 10:00 a.m., a supervisory nursing staff member (#10) reported she was not aware of any dietary interventions attempted for Resident #6's bowel management, an assessment of her pain medication as a factor related to her constipation, or her pre-admission bowel patterns. This staff member (#10) was not aware of the limited bowel assessment completed on 12/30/13. The facility's Bowel Management protocol identified the staff should administer a laxative such as Dulcolax if the resident did not have a bowel movement for two days and an enema or suppository if the resident did not have a bowel movement for three days. The facility staff failed to follow the policy on 01/05/14 when the staff administered two Dulcolax tablets after administering a Dulcolax tablet on 01/04/14.	F 309		

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F 309	Continued From page 6 On 02/20/14 at 11:55 a.m., a supervisory nursing staff member (#10) reported the facility did not continue prune juice as identified in a Nurse's Note on 12/27/13. This staff member also reported she contacted Resident #6's family and learned the resident does not like prune juice and the family member "always adjusted" the resident's bowel medication. The facility's Bowel Management protocol's primary intervention of medications and secondary use of dietary measures resulted in Resident #6 receiving PRN Dulcolax tablets 14 times and PRN Dulcolax suppositories 3 times in 51 days. Resident #6 refused the suppository 3 additional days. Resident #6 did not have a bowel movement during this period without a prn medication and the facility staff failed to re-assess the resident's bowel program. Staff identified a dietary intervention, "prune juice" on 12/27/13 and "senna fruit ball" on 01/28/14. Record review identified these interventions were not implemented. Failure to identify, assess, and develop interventions to address the risk factors related to Resident #6's bowel habits resulted in continued use of stool softeners and laxatives for the resident's bowel management. Use of these medications resulted in diarrhea, placed the resident at risk of cyclical diarrhea/constipation and continued dependence on bowel medications.	F 309		
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	F 323		

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F 323	Continued From page 7 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, review of manufacturer's product information, and staff interview, the facility failed to ensure 2 of 3 sampled residents (Resident #4 and #6) transferred with a stand lift, received adequate supervision, and appropriate use of the stand lift to prevent accidents. Failure to properly place Resident #4's knees at the knee pads on the lift placed her at risk of pain and injury. Failure to limit weight bearing on Resident #6's right lower extremity placed her at risk of increased pain and delayed healing. Findings include: Review of the E-Z Stand manufacturer's internet site, invacare-cc.com, occurred on 02/20/14. The Stand-Up Patient Lift User Manual, revised January 2010, stated ". . . Section 4. Lifting the Patient . . . 3. Ensure the following: A. The patient's knees are secure against the knee pad. . . ." Illustrations included in the manual show the patient's knees on each side of the knee pad divider. Review of the facility's policy and procedure, "E-Z Stand Operating", occurred on 02/20/14. This undated document stated "Objective: To provide safe transfers. . . . Procedure: . . . 7. Have	F 323	**F 323:** It is the policy of MMHCC to assure that residents receive adequate supervision and assistance devices to prevent accidents. This tag had two different transfer concerns with the EZ stand. On February 20, 2014 the following was put in place to assure that residents requiring EZ stand use for transfers are transferred safely (this includes Residents #6 and #4 from the survey sample). 1. A note was placed in the CNA and nurses dept. communication notebook on February 20, 2014 after our exit review with the survey team addressing the EZ stand transfers (copy of the 02/20/14 note is enclosed). 2. Facility's quarterly QA (Quality Assurance) meeting was held on March 13, 2014 (The deficiency report was received on 03/11/14) and at this meeting the deficiencies were reviewed (copy of QA meeting minutes enclosed). The evening of 02/20/14 the DON observed transfers of residents #6 and #4 of survey sample and did observations with these two residents	

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F 323	Continued From page 8 resident place feet (help resident if needed) on platform and position their shins into the shin forms. . . ." - Review of Resident #6's medical record occurred on February 18-20, 2014. The facility admitted the resident in December 2013, transferred her to an acute hospital for surgical repair of a fractured right hip in January 2014, and re-admitted the resident on January 20, 2014. The physician's orders limited the resident to "toe-touch weight bearing" on the right. Current diagnoses included dementia and fractured pelvis (December 2013). The significant change Minimum Data Set (MDS), dated 01/27/14, identified the resident required extensive assistance of two or more persons for transfers, walking did not occur, the resident had functional limitation in range of motion in one lower extremity, received a scheduled pain medication, and did not express any pain. Resident #6's ADL [Activities of Daily Living]/Functional Rehabilitation Care Area Assessment (CAA), dated 01/28/14, identified the resident was transferred with the stand lift and a block under the left foot to ensure no or toe touch weight bearing on the right lower extremity. Resident #6's current care plan, dated 01/06/14, stated "Problem, Potential for falls . . . Manifested by: . . . hip fracture, Approach . . . Nurse Aide - see current ADL's for transfers and mobility . . ." During interview, on 02/20/14 at approximately 9:30 a.m., a certified nursing assistant (CNA) (#6) reported the facility keeps residents' "ADL sheets" in a binder on each unit and the "sheets" are available for staff review regarding the care needs of each resident. The CNA (#6) also	F 323	through 03/13/14 (copy of those handwritten observations are enclosed). DON observed transfer on resident #4 before QA meeting on 03/13/14 but not on resident #6 because the EZ stand transfers were discontinued on resident #6 on 03/13/14 as she was able to bear wt. as tolerated and do pivot transfers (copy of OT notes enclosed). Effective 03/17/14 a **formal** QA program was implemented by and under the supervision of the DON to assure residents requiring EZ stand transfers are done safely and correctly. Frequency of QA monitoring: Weekly for one month-03/17/14 through 04/17/14. Monthly for three months (May-June-July 2014) and then quarterly (October 2014 & January 2015) with QA monitoring completed January 31, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff member involved).	

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F 323	Continued From page 9 reported the staff may carry the "sheets" with them as a reference and also are in each resident's bathroom. Resident #6's "ADL sheet", dated 02/18/14, reviewed on 02/20/14, stated "TRANSFERS, EZ Stand with block under left foot to keep right foot as no weight bearing with total assist of two." Observation on 02/19/14, 10:05 a.m. showed two CNAs (#7) and (#8) assisted Resident #6 to transfer with the E-Z Stand from her bed, to the bathroom, then to a wheelchair. The CNAs placed the block under the resident's right lower extremity, placing full weight on the extremity instead of maintaining no weight bearing. During interviews, on 02/19/14, facility staff reported the following E-Z Stand transfers with the block under Resident #6's right lower extremity. *12:15 p.m. - CNA (#7) and (#8) reported the resident declined toileting and the CNAs transferred the resident from the wheelchair to her bed. *3:20 p.m. - CNA (#9) reported transferring the resident from her bed to her wheelchair with the assistance of an unidentified CNA. Placement of the block under Resident #6's right foot placed all full weight bearing on that extremity during the transfers. Failure to place the block under the left foot as care planned placed Resident #6 at increased risk of pain and delayed healing of her fractured right hip. - Review of Resident #4's medical record occurred on February 18-20, 2014. The facility admitted the resident in October 2007. Current	F 323	The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC. These findings will be presented at the quarterly QA meeting on 06/26/14 (copy of QA monitoring for week of 03/17/14 enclosed). 3. Nurses and CNAs in-service was held on 03/19/14 were the EZ stand transfer procedure was reviewed (copy of procedure enclosed). After the All staff meeting on 03/19/14 the nurses and CNAs had an in-service with the facility's Occupational Therapist (OT) who reviewed "How to care for a resident with a hip fracture and how to transfer a resident with a hip fracture using the EZ stand(a copy of the OT's outline for her presentation is enclosed.) Two things were done to help the aides determine left and right on the EZ stand and on the block that needs to be used for a resident with a hip fracture and requiring EZ stand transfers with no wt. bearing for one leg.	

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	355036	A. BUILDING _____ B. WING _____	02/20/2014

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F 323	Continued From page 10 diagnoses included chronic pain related to osteoporosis and history of right femur fracture (2007). The quarterly MDS, dated 12/25/13, identified the resident required extensive assistance of two or more persons for transfers, walking did not occur, the resident did not express pain, and the resident received scheduled pain medication. Resident #4's current care plan, dated 08/01/12, identified transfers with assistance of one or two persons. Observation on 02/18/14 at 4:43 p.m. identified a CNA (#9) assisted Resident #4 from her wheelchair to the bathroom with a E-Z Stand lift. The CNA placed the resident's feet on the platform, applied the thoracic strap and lifted the resident from the wheelchair. As the resident came to a standing position, she stood with her feet on the platform and both knees were observed to be on the same side of the knee pad, placing her hips and pelvis in a position rotated to the right. The CNA (#9) did not re-position the resident and continued to transfer her to the toilet. After toileting, the CNA used the E-Z Stand to return Resident #4 to the wheelchair. The resident's knees were properly positioned on the knee pad during the transfer from the toilet to the wheelchair. Resident #4 did not express pain during this transfer. During interview, on 02/20/14 at 10:00 a.m., a supervisory nursing staff member (#10) stated it is the facility's expectation that staff place the block under Resident #6's left foot to limit weight bearing on her right lower extremity and staff should maintain the residents' knees on each side of divider of the knee pad during E-Z Stand	F 323	The shin pads on the EZ stands have been labeled with left and right (picture of that is enclosed). The block that will be left in the resident's room to use with the EZ stand will also be labeled with the resident's name and which foot the block is to go under (picture of that is enclosed). As of today 03/20/14 there are no residents in house that require the use of the block and when needed OT will do the labeling of that block. 3/26/14 per TC 3/25/14 DON	

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F 323	Continued From page 11 transfers.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their 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.	F 441	**F441:** It is the policy of MMHCC to assure that the Infection Control Program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. On February 20, 2014 the following was put in place to assure those residents requiring Whole Blood Glucose Monitoring (WBGM) that the meter used is disinfected after each use as well as the receptacle that the meter is placed in so the possibility of the transmission of blood-borne pathogens between residents will be prevented. 1. A note was placed in the CNA and nurse's dept. communication notebook on 02/20/14 after our exit review with the survey team addressing concern about disinfecting the WBGM meters and receptacles (a copy of that note is enclosed).	

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F 441	Continued From page 12 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 infection control practices for 1 of 1 sampled resident (Resident #6) and 1 of 1 supplemental resident (Resident #17) observed during blood glucose monitoring. Failure to disinfect blood glucose meters after each use may result in the transmission of blood-borne pathogens between residents. Findings Include: Review of the facility policy titled "Cleaning and Disinfecting Guidelines" occurred on 02/20/14. This undated policy, stated, ". . . It is [blood glucose meter brand name] policy to advise healthcare professionals to clean and disinfect meters between each test to avoid cross-contamination issues. . . ." - Observation of Resident #6's glucose monitoring occurred on 02/20/14 at 9:15 a.m. After completing the blood test, the nurse (#1) took the glucose meter to the medication cart, opened the top drawer, and without disinfecting the glucose meter placed it into it's case. When asked, the nurse (#1) identified the glucose meter is a facility glucose meter used with multiple residents. The nurse (#1) stated she would clean the glucometer when she cleaned the medication cart, as Resident #6 is the last glucose meter check she had at this time. The nurse (#1) stated, "Maybe I should clean it in case I need it for another resident," and proceeded to clean the	F 441	2. Facility's quarterly QA (Quality Assurance) meeting was held on March 13, 2014 (The deficiency report was received on 03/11/14) and at this meeting the deficiencies were reviewed (copy of QA meeting minutes enclosed). Effective 03/17/14 a QA program was implemented by and under the supervision of the DON to assure WBGM meters and the receptacle that it is stored in is disinfected properly to prevent possible cross contamination. Frequency of QA monitoring: Weekly for one month-03/17/14 through 04/17/14. Monthly for three months (May-June-July 2014) and then quarterly (October 2014 & January 2015) with QA monitoring completed January 31, 2015. If concerns are noted with the monitoring immediate corrective action will be taken (e.g. teaching with staff member involved). The DON will submit a report of the monitoring results to the QA Committee at each scheduled quarterly meeting. In the absence of the DON and monitoring is due to be conducted, it will be done by an RCC.	

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F 441	Continued From page 13 glucose meter. - Observation of Resident #17's glucose monitoring occurred on 02/19/14 at 12:07 p.m. After completing the blood test and without disinfecting the glucose meter, the nurse (#2) placed the glucometer into the case. During an interview, on 02/20/14 at 2:30 p.m., an administrative nursing staff member (#2) verified the nurses should disinfect the glucose meters after use to prevent transmission of blood-borne pathogens.	F 441	These findings will be presented at the quarterly QA meeting on 06/26/14 (copy of QA monitoring for week of 03/17/14 enclosed). 3. Nursing was in-serviced 03/19/14 on the proper cleaning of the meters and reminded what the procedure states about disinfecting meters. A notice was placed in the WBGM meter's procedure/policy book on 02/20/14 to remind nurses to disinfect meter and receptacle between residents (a copy of that notice is enclosed).	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safety equipment in 1 of 1 kitchen mop room. Failure to ensure the use of a back flow device may result in back siphonage of contaminated water into the potable water system of the facility. Findings include: Observations at 2:30 p.m. on 02/19/2014 during the kitchen tour, accompanied by a dietary management staff member (#4), showed a faucet with a Y-connector and a hose that extended to the floor drain. This faucet did not have a device	F 465	F465 It is the policy of MMHCC to assure that a safe, functional, sanitary, and comfortable environment for residents, staff and public is maintained. The faucet in the kitchen mop sink now has a back flow preventer connected to both the hot and cold water after the connection of the Y hose connector. All other such sinks have been inspected for the potential of a back siphonage of contaminated water into the potable water system and they all have back flow preventers. The maintenance department procedure manual has been updated to address this issue to prevent it from occurring in the future (copy enclosed). The Dietary department will monitor the mop sink to assure it remains in compliance thru a Quality Assurance study for a period of three months beginning March 17, 2014 (QA monitoring forms enclosed).	3/26/14 per TC 3/25/14 DON KH S 6/26/14 per TC 3/25/14 DON KH

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F 465	Continued From page 14 in place to prevent the potential back flow of contaminated water into the potable water system. Interview with a maintenance management staff member (#5) on 02/20/2014 confirmed that the mop room faucet was not equipped with a back flow device.	F 465		