STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(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 09/28/15 and completed on 09/30/15, the sample included 4 residents for complete review, 9 residents for focused review, and 3 closed records for review.	F 000		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		11/3/15

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

Electronically Signed | 10/16/2015

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and review of the RAI [Resident Assessment Instrument] User's Manual, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 13 sampled residents (Resident #5 and #6). Failure to accurately code active diagnoses (pressure ulcers) and urinary continence does not allow the residents assessment to reflect their current status/needs and may result in inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2014, page I-3 stated, "I: Active Diagnoses in the Last 7 days . . . This section identifies active diseases and infections that drive the current plan of care . . . 1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state license laws) in the last 60 days . . . 2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses . . ."	F 278	The MDS dated 6-23-15 for resident #5 was modified on 10-1-15 under section H: Bladder and Bowel H0300 was coded "9" reflecting "unable to determine". The MDS dated 8-29-15 for resident #6 was modified on 10-13-15 to include Pressure area as an active diagnosis in section "I". The nurse managers were educated in coding the MDS sections "H" and "I" 10-15-2015. A review of the most recent MDS for all residents with indwelling catheters and/or pressure ulcers will be reviewed for coding accuracy in sections "H" and "I". Beginning 10-19-15, QA will be completed weekly for accuracy of scoring of the MDS under sections H & I under the direction of the MDS coordinator until 100% compliance has been achieved. Nurse Managers will complete peer audits on section "H" & "I" weekly until compliance has been achieved. After compliance has been achieved, periodic QA studies, not less than monthly, will be completed to assure compliance has been maintained.	

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F 278	Continued From page 2 Review of Resident #6's medical record occurred on all days of survey and showed staff identified two Stage II pressure ulcers to Resident #6's coccyx and right gluteal fold on 08/26/15. An annual MDS, dated 08/29/15, failed to identify a pressure ulcer as an active diagnosis during the 7-day look-back period. The Long-Term Care Facility RAI Manual, revised October 2014, page H-2 stated, "Section H: Bladder and Bowel . . . H0100: Appliances . . . Check next to each appliance that was used at any time in the past 7 days . . . H0100A, indwelling catheter . . ." Page H-8 stated, "H0300: Urinary Continence . . . Coding Instructions . . . Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter . . . for the entire 7 days. . . ." - Review of Resident #5's medical record occurred on all days of survey and identified the facility admitted the resident with an indwelling catheter in place. The annual MDS, dated 06/23/15, identified the resident had an indwelling catheter and was continent of urine (the MDS should be coded as "9" - unable to determine).	F 278		
F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		11/3/15

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F 314	Continued From page 3 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary treatment and services to promote the healing of a pressure ulcer for 1 of 3 sampled residents (Resident #6) with a pressure ulcer. Failure to implement established treatment and interventions has the potential to delay the healing of a pressure ulcer. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included a pressure ulcer to the coccyx and multiple sclerosis. The annual Minimum Data Set (MDS), dated 08/29/15, identified Resident #6 required extensive assist of two or more persons for bed mobility, dressing, personal hygiene, and total assistance of two or more persons for transfers. The current care plan stated, ". . . Stage III pressure area to coccyx . . . Pressure Ulcer Risk Assessment . . . Interventions to Reduce the Risk of Pressure Ulcers . . . Reposition q2hrs [every 2 hours] when in bed Reposition q2hrs when in chair . . ." Observations on 09/29/15 showed the following: * 7:41 a.m.: Sitting in wheelchair in her room * 8:48 a.m.: Sitting in wheelchair in her room * 10:23 a.m.: Sitting in wheelchair in activity room * 10:55 a.m.: Sitting in wheelchair in her room * 11:34 a.m.: Certified Nursing Assistant (CNA)	F 314	QA studies completed by the Director of Nursing, or her designee, for resident #6 began on 9-30-15 to assure staff were following the repositioning schedule. A memo was posted on 9-30-15 for all nursing staff directing them to follow all repositioning schedules. Direct care nursing staff have been instructed through in-service training on 10-13-15 regarding repositioning schedules for residents that have a pressure area and/or are care planned for repositioning every two hours. Professional nursing staff had the in-service training on 10-15-15. All residents that have pressure ulcers, will have their cares observed for compliance with their repositioning plan of care. QA studies will be completed weekly on all residents with pressure areas and repositioning schedules under the direction of the DON or her designee until 100% compliance has been achieved for two consecutive weeks. QA studies will then be completed monthly until 100% compliance is achieved for two consecutive months and then quarterly for one year.	

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F 314	Continued From page 4 (#12) emptied Resident #6's catheter bag while she sat in her wheelchair and transported her to the dining room. * 12:13 p.m.: Sitting in wheelchair in her room * 1:50 p.m.: Received a bath * 2:00 p.m.: A nurse (#13) changed Resident #6's pressure ulcer dressing while she laid in bed. Two CNAs (#14 and #15) then transferred Resident #6 from the bed to her wheelchair. * 4:16 p.m.: Sitting in wheelchair in her room * 5:12 p.m.: Sitting in wheelchair in her room * 5:46 p.m.: Sitting in wheelchair in dining room During an interview on 9/29/15 at 2:21 p.m. two CNAs (#4 and #12) stated they transferred Resident #6 to bed around 1:00 p.m. (over five hours in the wheelchair without repositioning). During an interview on 09/29/15 at 5:46 p.m. a CNA (#16) stated Resident #6 was in her wheelchair since her bath (over three hours in the wheelchair without repositioning). Review of Resident #6's turning/repositioning log, dated 09/29/15, showed staff repositioned Resident #6 at 10:00 a.m. (conflicts with observation), 1:00 p.m., and 2:00 p.m. There was no documentation to indicate the resident was repositioned from 5:00 p.m. to 10:59 p.m., a span of approximately six hours. Observations on 09/30/15 showed the following: * 7:50 a.m.: Sitting in wheelchair in her room * 8:15 a.m.: Sitting in wheelchair in dining room * 10:07 a.m.: Sitting in wheelchair in chapel * 11:11 a.m.: Sitting in wheelchair in her room * 12:34 p.m.: Sitting in wheelchair in her room * 1:03 p.m.: Two CNAs (#17 and #18) transferred	F 314		

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F 314	Continued From page 5 Resident #6 from her wheelchair to the bed. One CNA (#17) verified Resident #6 sat in her wheelchair until transferred to bed at 1:03 p.m. (over five hours in the wheelchair without repositioning). Review of Resident #6's turning/repositioning log on 09/30/15 at 1:50 p.m. showed staff only repositioned Resident #6 at 5:00 a.m. There was no documentation to indicate the resident was repositioned for a span of approximately nine hours. Failure to reposition Resident #6 every two hours as care planned placed the resident at risk for delayed healing of a current pressure and at risk for the development of new pressure areas.	F 314		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 08/28/14. TRANSFERS AND ASSISTIVE DEVICES 1. Based on observation, record review, review of	F 323	Resident #5 was evaluated by a COTA on 9-22-15 and continues to meet the sit to stand mechanical lift requirements as written in our "Sit/Stand Mechanical Lift" policy. A memo was posted on 9-30-2015 for all nursing staff instructing them on them on use of the sit to stand lift. More	11/3/15

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F 323	Continued From page 6 facility policy, resident interview, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 3 of 9 sampled residents (Resident #3, #5, and #12) who required staff assistance for transfers. Failure to properly use a sit-to-stand mechanical lift (Resident #5) and gait belt (Resident #3 and #12) increased the risk for falls, pain, and injury to residents. Findings include: Review of the facility policy titled "Sit/Stand Mechanical Lift" occurred on 09/30/15. This policy, dated November 2009, stated, ". . . a resident should possess at least 30% to 60% weight-bearing status and the ability to hold on with at least one hand, or two hands if a simple band harness is used . . . Ability to hold on to the lift . . ." Review of the facility policy titled "Gaitbelts For Transfers" occurred on 09/30/15. This policy, revised September 2002, stated, ". . . 3. Apply belt around resident waist. . . D. Ensure belt is snug but allow enough room for your hand to comfortably grasp it . . . 5. To transfer: A. Assist resident to a standing position by grasping belt at the waist from underneath. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included muscle weakness. A quarterly Minimum Data Set (MDS), dated 09/19/15, identified extensive assist of two or more people for transfers. The current care plan stated, ". . . TRANSFERS/MOBILITY . . . Volaro stand aid lift with assist of 1 and foot plate in highest position.	F 323	in-depth instructions on using the sit to stand mechanical lift were given to the direct care staff on 10-13-15. Professional nursing staff had an in-service training on 10-15-15. Clarification was given to direct care staff assigned to resident #12 on 9-30-15 on how to use a gait belt with all transfers. Clarification was given to direct care staff assigned to resident #3 on 9-30-15 on proper gait belt positioning and transfer procedure. More in-depth instructions on using the gait belt was given to the direct care staff on 10-13-15. Professional nursing staff had an in-service training on 10-15-15. A memo was posted on 9-30-2015 for all nursing staff instructing them on the use of the gait belt. The Gait Belt policy was reviewed on 10-13-15 along with instructional education on proper forms of transfers using gait belts. Professional nursing staff had an in-service training on 10-15-15. All residents requiring a gait belt or sit to stand mechanical lift for transfers could potentially be affected by not following said policies. Observation of transfers utilizing the Sit to Stand Mechanical Lift or the Gait Belt will be completed by the nursing staff. A minimum observation of one staff per shift/per unit will completed 4-5 days a week until a majority of the staff has been	

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F 323	Continued From page 7 . . ." Observation on 09/29/15 at 11:35 a.m. showed a certified nursing assistant (CNA) (#19) transferred Resident #5 from her wheelchair to the toilet using a sit-to-stand mechanical lift. During the transfer from the toilet back to the wheelchair, Resident #5 let go of both handle bars and bent her knees, unable to stand and bear full weight. The sling raised up and rested under the resident's axilla, extending her shoulders upward. The CNA (#19) failed to provide Resident #5 with physical guidance and cueing to ensure a safe transfer. - Review of Resident #12's medical record occurred on 09/30/15. A quarterly MDS, dated 08/12/15, identified limited assist of one person for transfer and toileting. Observation on 09/30/15 at 11:20 a.m., showed a CNA (#3) moved Resident #12's wheelchair next to the bed and, without applying a gait belt, assisted the resident to transfer into the wheelchair. During an interview on 09/30/15 at 1:00 p.m., a CNA (#3) stated, "they do not use a gait belt on [Resident #12]." On the afternoon of 09/30/15, after providing care to Resident #12, a CNA (#4) stated, she "helped [Resident #12] to the bathroom and back to her bed." When asked if she used a gait belt, the staff member (#4) stated, "no." On the afternoon of 09/30/15, during an interview with Resident #12, she stated "they want me to	F 323	observed. Beginning 10-19-15, QA studies will be completed weekly on transfers requiring gait belts and sit to stand mechanical lifts under the direction of the DON or her designee until 100 % compliance has been achieved for two consecutive weeks. QA studies will then be completed monthly until 100% compliance is achieved for two consecutive months and then quarterly for one year. Key pad door knobs have been installed on all janitor closet doors. Environmental staff will be reminded on 9-30-15 of the need to keep all janitor closet doors closed at all times. More in depth training will occur during in-service on 10-20-15. All residents could potentially be affected by open janitor closet doors. Beginning 10-21-15, QA studies will be completed under the direction of the Maintenance Supervisor or his designee, daily to assure janitor closet door are closed when not in use until compliance is achieved for two consecutive weeks. QA studies will then be completed monthly until 100% compliance is achieved for two consecutive months and then quarterly for one year. If problems are identified, the administrator will be informed and corrective action will be taken.	

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F 323	Continued From page 8 call for assistance since my fall." During an interview on the afternoon of 09/30/15, an administrative nurse (#2), reviewed Resident #12's care plan with the surveyor and reported that the resident needs some assistance. The staff member (#2) reported that Resident #12 had a fall and now required assistance of one with transfers. The staff member stated, "they should be using a gait belt when assisting her." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included hemiplegia. A quarterly MDS, dated 06/27/15, identified extensive assist of one person for transfers. The current care plan stated, ". . . Problem/Need: Self care deficit . . . weakness, right hemiparesis . . . Approaches . . . Transfers with extensive assist of 1 pivot transfer with gait belt. . . ." Observation on 09/29/15 at 8:37 a.m. showed a CNA (#4) assisted Resident #3 to stand by lifting under his axilla (armpit) with one hand and holding the gait belt with the other hand. Upon standing, the gait belt slid to Resident #3's axilla. CHEMICAL STORAGE: 2. Based on observation, review of facility policy and procedure, and staff interview, the facility failed to maintain an environment free of hazardous chemicals in 1 of 6 janitor closets. This failure placed cognitively impaired and wandering residents at risk for injury. Findings include:	F 323		

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F 323	Continued From page 9 Review of the facility policy and procedure "Nursing Chemical Delivery and Storage" occurred on 09/30/15. The policy, dated 04/19/13, stated, ". . . Special Considerations: . . . 2. Chemicals that may cause harm to a resident if accidental contact is made must be kept in a secure area, cabinet, etc. [etcetera]." During a tour of the environment, on 09/30/15 at 10:10 a.m., observation revealed the door to the janitor closet in the north hall on Unit 3 unlocked. Observation showed the following chemicals stored on an open shelf (all labels stated to keep out of reach of children): Clorox Urine Stain Remover Red Stain Remover Bioenzyme Spotter Enzyme Deodorant Bio Active Pre-spray Prominence floor cleaner An environmental staff member (#6), present during the tour, stated "This needs to be locked at all times." Observation on 09/30/15 at 1:35 p.m. showed the door to the janitor closet unlocked. An unidentified staff member in the hallway stated, "That's supposed to be locked." A housekeeping staff member (#7) coming down the hall with a mop bucket stated, "Oh, that was me. It will be locked." She then put the mop bucket in the janitor closet and locked the door.	F 323		
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		11/3/15

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F 441	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 441	On 9-30-15, all direct care staff assigned	

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F 441	Continued From page 11 and staff interview, the facility failed to follow standard infection control practices for 3 of 11 sampled residents (Resident #1, Resident #5, and Resident #8) observed during perineal care. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 09/30/15. This policy, dated October 2009, stated, ". . . situations that require hand hygiene: . . . before and after resident contact . . . before and after assisting a resident with personal care . . . before and after assisting a resident with toileting . . . after contact with a resident's mucous membranes and body fluids or excretions . . . after handling soiled or used linens . . . after removing gloves . . . after completing duty . . ." Review of the facility policy titled "Soiled Linens" occurred on 09/30/15. This policy, dated January 1995, stated, ". . . TRANSPORTATION OF SOILED LINEN: 1. Soiled linen should be transported in covered carts or closed bags . . ." - Observation on 09/29/15 at 7:45 a.m. identified two certified nursing assistants (CNAs) (#19 and #20) assisted Resident #5 with morning cares. A CNA (#19) donned gloves; completed perineal cares; removed the resident's brief, wet with urine; and removed her gloves. Without performing hand hygiene, the CNA (#19) placed a new brief; dressed the resident; positioned the mechanical lift sling; transferred the resident from the bed to her wheelchair; applied lotion and	F 441	to provide cares for residents #1, #5 and #8 were instructed on facility policy regarding hand hygiene, glove use, standard precautions and soiled linens. The facilities policies for hand hygiene, standard precautions, and soiled linens will be reviewed at the direct care staff in-service on 10-13-15. Professional nursing staff had the in-service training on 10-15-15. All residents could potentially be affected by not following infection control policies. Observation of infection control procedures will be completed by the nursing staff. A minimum observation of one staff per shift/per unit will completed 4-5 days a week until a majority of the staff has been observed. Beginning 10-19-15, QA studies will be conducted weekly on randomly selected residents that involve working with soiled linen and providing multiple cares at one setting under the direction of the DON or her designee until 100% compliance has been achieved for two consecutive weeks. QA studies will then be completed monthly until 100% compliance is achieved for two consecutive months and then quarterly for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	09/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12	F 441		

deodorant; combed the resident's hair; placed her glasses; and then the CNA (#19) washed her hands. During this observation, the CNA (#20) carried the resident's soiled linen out of the room while holding it against her body and without wearing gloves.

Observation on 09/29/15 at 11:38 a.m. showed a CNA (#19) assisted Resident #5 to the toilet. The CNA (#19) donned gloves, cleansed stool from the resident's perineal area, removed her gloves, and transferred the resident back to her wheelchair. The CNA (#19) placed the resident's footpedals and set the call light within reach, donned gloves and wiped stool from the toilet, removed her gloves, bagged the garbage, and exited the room. The CNA (#19) failed to perform hand hygiene after completing perineal cares and after wiping stool from the resident's toilet.

- Observation on 09/29/15 at 5:15 p.m. showed a CNA (#21) assisted Resident #1 from his wheelchair to the toilet using a mechanical lift. The resident's brief was wet with urine and soiled with stool. The CNA (#21) donned gloves, completed perineal cares, removed her gloves, and transferred the resident back to his wheelchair. Resident #1 stated he wanted to lay down, so without performing hand hygiene after perineal cares, the CNA (#21) transferred the resident from his wheelchair to his bed. The CNA (#21) covered the resident with a blanket, exited his room, returned with fresh water, gave the resident a drink, removed his glasses, bagged the garbage, and exited the room. The CNA (#21) failed to complete hand hygiene after completing perineal cares and prior to exiting the resident's room on two occasions.

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F 441	Continued From page 13 Observation on 09/30/15 at 9:25 a.m. showed a CNA (#22) transferred Resident #1 from his wheelchair to the toilet. The resident had a small bowel movement in the toilet. The CNA (#22) donned gloves, completed perineal cares, removed her gloves, and transferred the resident back to his wheelchair. Without performing hand hygiene, the CNA (#22) brushed the resident's hair, placed his glasses, donned gloves, brushed his dentures and placed them in the resident's mouth, removed her gloves, and took the resident to the dining room. The CNA (#22) failed to perform hand hygiene after completing perineal cares and prior to performing other tasks. During this observation, the CNA (#22) carried the resident's soiled linen out of his room and down the hall against her clothing and without wearing gloves. During an interview on 09/30/15 at 1:50 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene after removing their gloves and after completing perineal cares. - Observation on 09/29/15 at 3:45 p.m., showed a CNA (#5) assist Resident #8 to the toilet. The CNA donned gloves, removed the resident's incontinent product wet with urine, and disposed of it in the garbage can in the bathroom. Without removing her gloves, the CNA pulled the curtain on the bathroom doorway, opened a cabinet and obtained a clean incontinent product and wipes. After providing perineal cares, the CNA removed her gloves and performed hand hygiene. During an interview on 09/30/15 at 2:30 p.m., an administrative nurse (#1) stated, "the CNA should	F 441		

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F 441	Continued From page 14 have removed her gloves," after she disposed of the soiled product.	F 441		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure essential equipment remained in safe operating order for 1 of 4 facility suction machines. Failure to ensure all components of the suction machine were immediately available placed residents requiring suction at risk of injury or death. Findings include: Observation of the Unit One suction machine occurred on 09/30/15 at 12:40 p.m. with two administrative nurses (#8 and #9) and showed the machine located in a utility room. Observation revealed no suction catheter available with the machine or in the utility room. Further observation showed the port on the canister which connects to the suction unit broken off and stuck in the connecting tubing. The nurses (#8 and #9) stated their expectation for the suction machines is that catheters are available and canisters are in working order.	F 456	The port on the suction machine on Station 1 was replaced on 9-30-15. A suction catheter was added on 9-30-15. Education was provided on checking suction machine to professional nursing staff on 10-15-15. All suction machines in the facility have been inspected for physical damage. A suction catheter is immediately available to each machine. Beginning 10-16-15, QA studies will be conducted daily on the suction machines under the direction of the DON or her designee until 100% compliance has been achieved for two consecutive weeks. QA studies will then be completed monthly until 100% compliance is achieved for two consecutive months and then quarterly for one year.	11/3/15