STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CENTER	2900 14TH AVE S GRAND FORKS, ND 58201

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 01/07/19 and concluded on 01/10/19.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide dining assistance for 1of 4 sampled resident's (Resident #61) who required assistance during meals. Failure to cue and/or assist a resident who required assistance may result in decreased intake and/or unwanted weight loss. Findings include: Review of Resident #61's medical record occurred on all days of survey. Diagnoses included dementia and late Alzheimer's disease. The current care plan identified, ". . . I need assistance with my ADL's [activities of daily living]. . . . I am able to eat independently after set-up assist . . ." The dietary progress notes identified the following: * 11/16/18 at 2:19 p.m., ". . . Assistance with meals varies - does best with cueing. Adaptive equipment: plateguard and rocker knife provided to aid self feeding. . . . Meal card used as res [resident] with difficulty making decisions per family. Wt: [weight] 115-116-117 pounds. . . ."	F 677	CNAs #1 and #2 were reeducated by the RN Care Coordinator on the standard of cueing Resident #61 during a staff huddle on 1/10/19. A visual reminder for staff to cue the resident was added to the placesetting each meal for Resident #61 on 1/10/19. All residents who require assistance with their meals have the potential to be affected by this practice. The Licensed Registered Dietitians (LRDs) will provide all nurses and CNAs education by 2/14/19 through a computer-based training module. The education will include cueing during meals, encouraging completion of the meal and/or supplements, identification and treatment of diet textures, and weight loss or gain. The LRDs or their designees will audit 10 meals per week for the first month and 20 meals per month for the next 11 months to ensure that the appropriate level of assistance is provided to residents during the meal service. The LRDs will report	2/14/19

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

Electronically Signed | 01/24/2019

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F 677	Continued From page 1 * 12/31/18 at 12:39 p.m., ". . . Res with significant weight loss over last month. Past weights: 11/18 [November 2018] 116-117 pounds; 12/18 [December 2018] 112-110-108-106 pounds. . . . Small portions provided due to small appetite. Res does need encouragement/cueing at meals. Appetite: 0-25% of meals . . . Staff encouraged to provide cueing at meals. Res does sit at table where staff assist/sit. . . ." Observations showed the following: * 01/07/19 at 6:12 p.m., Resident #61 seated in a wheelchair at the table with three other residents, a certified nurse assistant (CNA) (#1) provided dining assistance to the resident seated directly across from Resident #61. Resident #61 consumed ¾ of a glass of a liquid supplement and a few bites of french toast, then stopped eating. A full serving of eggs, bacon, milk, and a fruit cup remained on the plate. The CNA (#1) failed to cue or encourage Resident #61 to eat. At 6:19 p.m., Resident #61 appeared to be asleep at the table, staff failed to provide cueing, encouragement, or assistance. * 01/09/19 at 8:13 a.m., Resident #61 seated in a wheelchair at the table with three other residents, a CNA (#2) provided dining assistance to the resident seated directly across from Resident #61. Resident #61 consumed a half glass of milk, and a 1/4 piece of toast. A full glass of juice supplement, a bowl of oatmeal and a serving of scrambled eggs remained on the plate. The CNA (#2) failed to cue or encourage Resident #61 to eat. At 8:19 a.m., Resident #61 finished the glass of milk when the CNA (#2) stood to leave the table then the resident asked to be taken to her room. The CNA (#2) failed to cue, encourage, or assist Resident #61 to eat before being assisted	F 677	the results of the audits to the VEC Quality Review Team monthly for the next twelve months.	

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F 677	Continued From page 2 away from the table. Review of the documented meal intake percentages for the previous seven days identified the following: * 01/02/19 - Breakfast: Refused, Lunch: 25%, Supper: 0% * 01/03/19 - Breakfast: 0%, Lunch: 0%, Supper: 25% * 01/04/19 - Breakfast: 25%, Lunch: 25%, Supper: 25% * 01/05/19 - Breakfast: Refused, Lunch: 0%, Supper: 0% * 01/06/19 - Breakfast: Not Applicable, Lunch: 25%, Supper: 25% * 01/07/19 - Breakfast: 25%, Lunch: 0%, Supper: 0% * 01/08/19 - Breakfast: 75%, Lunch: 0%, Supper: 50% During an interview on 01/10/19 at 9:20 a.m., a dietary staff member (#3) stated she would expect the CNA assisting at that table to cue and encourage Resident #61 during the meal. "Best practice is for staff to cue and encourage when they see a resident not eating their food."	F 677		
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	F 880		2/14/19

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F 880	Continued From page 3	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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

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F 880	Continued From page 4 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 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, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 2 sampled residents (Resident #12) on contact isolation precautions. Failure to follow appropriate infection control practice related to isolation precautions may result in the spread of infection to all residents, staff and visitors. Finding include: Review of the facility policy titled "Clostridium Difficile" occurred on 01/10/19. This policy, updated January 2019, stated, ". . . residents with suspected or identified Clostridium Difficile will be placed on Contact Isolation Precautions when caring for residents with C. [Clostridium] difficile .	F 880	CNAs #7, #8, #9, and #10 were reeducated to follow appropriate contact precautions specific to Clostridium difficile (C. difficile) on 1/8/19. All residents within the facility have the potential to be affected by this practice. A policy change was made on 1/23/19 to allow for alternative bathing methods within the resident room when a resident has an active infection of C. difficile. All nurses and CNAs will complete an educational module by 2/14/19 which will include education on touching surfaces with soiled gloves, disinfection of contaminated surfaces and equipment, the process for body fluid spills, and cleaning hands with soap and water	

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F 880	Continued From page 5 . . steps toward prevention and early intervention to prevent transmission include . . .staff will maintain vigilant hand hygiene . . . frequent hand washing with soap and water by staff and residents . . . hand washing with soap and water is necessary for the mechanical removal of spores from hands . . . alcohol-based hand rub does not remove C. difficile spores from hands . . . wearing gloves when handling feces or articles contaminated with feces . . . disinfection of items with potential fecal soiling using a disinfecting agent recommended for C. difficile with household bleach and water solution or an EPA [environmental protection agency] registered germicidal agent effective against spores . . . and reduced sharing of dedicated medical equipment . . ." Review of the facility policy titled "Cleaning and Disinfection of Environmental Surfaces" occurred on 01/10/19. This policy, dated March 2017, stated, " . . . in areas of Clostridium difficile infection . . . 1:10 dilution of household bleach will be used for routine environmental disinfection . . . surfaces with spills of blood and other potentially infectious materials will promptly be cleaned and decontaminated . . ." Review of the facility policy titled "Isolation-Categories of Transmission-Based Precautions" occurred on 01/10/19. This policy, updated January 2019, stated, " . . . contact precautions . . . staff will avoid touching potentially contaminated surfaces or items in the resident's room . . . contact precautions will be taken during resident transport to minimize the risk of transmission . . ."	F 880	versus hand sanitizer when caring for a resident with C. difficile. The Infection Preventionist or their designee is responsible to complete observations of resident care for a resident with an active C. difficile infection. The frequency will be ten observations per month for three months and five observations per month for the next nine months. If there is no resident within the facility with an active C. difficile infection, observations of resident care with transmission-based precautions will be completed. If there are no residents with transmission-based precautions, the Infection Preventionist will test the competency of staff through educational huddles, testing knowledge, or mock demonstrations of care. The Infection Preventionist will report the results of the audits to the VEC Quality Review Team monthly for the next twelve months.	

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F 880	Continued From page 6	F 880		

Review of Resident #12's medical record occurred on all days of survey and identified a diagnosis of C. difficile on 12/30/2018. The current care plan stated, "I have C. Difficile . . . Interventions: Disinfect all equipment before it leaves the room . . ."

Observation on 01/08/19 at 10:57 a.m., showed an isolation cart outside of Resident #12's room. Two certified nursing assistants (CNAs) (#9 and #10) donned gowns and gloves and entered Resident #12's room to provide incontinence cares. As the CNAs transferred Resident #12 from the bed to the shower cart via the full body mechanical lift, stool from Resident #12 soiled the floor, shower cart, and the CNAs' shoes/clothing. The CNAs placed a towel on the floor which absorbed the stool. The shower cart wheels and the CNAs' shoes came into contact with the soiled towel. One CNA (#9) wiped stool from the resident as he/she continued to expel incontinent stool, then touched the bed, lift, shower cart, and wheelchair with soiled gloved hands. The other CNA (#10) removed his/her gloves and washed his/her hands, then proceeded with ungloved hands to touch the unsanitized lift, bed, shower cart, and transported the patient out of the room to the shower area. The CNA (#10) failed to disinfect contaminated surfaces and equipment used during cares for a resident in contact isolation.

Observation on 01/08/19 at 11:45 a.m., showed two CNAs (#9 and #10) transported Resident #12 on the shower cart from the shower room to the resident's room, leaving a visible trail approximately 50 feet in length of wet, soiled water that continued to drain from an open area

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F 880	Continued From page 7 on the bottom of the shower cart onto the carpeted floor. Continued observation showed staff transporting two residents in wheelchairs and housekeeping staff push a cart through the soiled carpet. Observation on 01/08/19 at 3:47 p.m., showed two CNAs (#7 and #8) entered Resident #12's room after they donned gloves and gowns. CNA (#7) provided cares, touched the resident's body, skin, clothing, bed, wheelchair, bedside table and plate of food/silverware. The CNA (#7) removed his/her gloves, sanitized his/her hands with personal pocket hand sanitizer, donned clean gloves, and proceeded with cares. An infection control nurse (#5) entered the room prompting the CNAs throughout their cares to handwash with soap and water, not use hand sanitizer after glove changes, and to clean equipment after use and before removing it from the room. During an interview on 01/08/19 at approximately 12:20 p.m., a charge nurse (#11) stated that all equipment must be sanitized with an approved disinfectant after use on a resident on contact isolation. During an interview on 01/10/19 at 10:03 a.m., an administrative nurse (#4) agreed that infection control policies and practices were not followed by staff in providing Resident #12's care.	F 880		