STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

(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 August 20, 2015 and completed on August 23, 2015, the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 160	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed to the residents' responsible parties/designees within 30 days for 1 of 1 closed resident record reviewed (Resident #17) and 2 of 2 supplemental residents (Resident #19 and #20) reviewed. Findings include: Review of conveyance of funds following death occurred on 08/20/15 at 11:20 a.m. with a business office staff member (#27). The resident trust account information identified the following: * Resident #17 expired on 04/14/15. The facility issued a check for the remaining balance of	F 160	1. Staff educated on the Conveyance of Personal Funds upon Death/Discharge on September 9, 2015. 2. All residents who have a personal fund deposited with the facility have the potential to be affected. 3. The policy on trust funds was reviewed with the staff of the Business office in a meeting September 9, 2015. 4. September 23, 2015 5. QI monitor of resident trust fund transfer after resident leaves the facility will be done weekly for one month, monthly for three months and quarterly for one year and report to QI committee at monthly scheduled meetings.	9/23/15

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

Electronically Signed | 09/11/2015

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F 160	Continued From page 1 $100.08 on 07/23/15, 100 days later. * Resident #19 expired on 04/14/15. The facility issued a check for the remaining balance of $38.37 on 07/23/15, 100 days later. * Resident #20 expired on 03/17/15. The facility issued a check for the remaining balance of $21.35 on 04/22/15, 36 days later. During an interview on 08/20/15 at 11:30 a.m., staff member (#27) agreed the facility failed to refund residents' funds within 30 days of expiration.	F 160		
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, resident interview, and staff interview, the facility failed to provide care for 3 of 12 sampled residents (Resident #4, #6, and #8) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality and failed to provide dignity during 2 of 2 breakfast meals. Failure to ensure the use of a privacy curtain during cares (Resident #4), failure to close the resident's bathroom and room door during toileting (Resident #8), failure to knock on doors prior to entering residents' rooms (Resident #4 and #6), and providing paper plates for dining during breakfast does not promote residents' dignity, self esteem, self worth, or	F 241	1. Staff was reminded to provide privacy for residents #4, #6 and #8 Unit meetings on September 3rd and September 10th and minutes posted. Styrofoam plates at breakfast were discontinued and glass plates were implemented on August 29th. 2. All residents have the potential to be affected. 3. Staff was inserviced on maintaining privacy at nurse's and unit meetings September 3rd and September 10th. Policy on proper entrance to the room was reviewed and providing privacy with curtain and closing of doors. Minutes and policies were posted. Dietary	9/23/15

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F 241	Continued From page 2 enhance their quality of life. Findings include: PRIVACY Review of facility policy "C.N.A. (Certified Nursing Assistant) SKILLS" occurred on 08/20/15. The policy, dated 09/15/08, stated, ". . . Provides for client's privacy during procedure with curtain, screen, or door . . ." Observation on 08/18/15 at 3:40 p.m. showed two CNAs (#3 and #4) provided toileting assistance for Resident #4 at the bedside. The staff allowed the privacy curtain to remain open two feet down from the head of the bed while Resident #4's roommate rested in his bed during cares. Observation on 08/19/15 at 9:50 a.m. and 1:20 p.m. showed two CNAs (#5 and #6) provided toileting assistance for Resident #4 at the bedside. The privacy curtain remained opened two feet down from the head of the bed while Resident #4's roommate rested in his bed during cares. During an interview on 08/20/15 at 10:45 a.m., a nursing supervisor (#1) stated the expectation is for staff to close the privacy curtain during resident cares. - Observation on 08/18/15 at 4:37 p.m. showed Resident #8 on the toilet and the CNA (#7) in the bathroom with the resident. The room door and the bathroom door remained open the entire time the CNA (#7) assisted the resident on and off the	F 241	discontinued Styrofoam plates at breakfast and implemented glass plates on August 29th. 4. September 23, 2015. 5. QI monitor implemented by Social Services weekly for one month, monthly for three months and then quarterly for one year and reported to the QI committee at scheduled meetings.	

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F 241	Continued From page 3 toilet. During an interview on 08/20/15 at 11:40 a.m., a nursing supervisor (#1) stated she expected staff to close the bathroom door during cares. KNOCKING/ANNOUNCING SELF PRIOR TO ROOM ENTRY - Observation on 08/18/15 at 3:40 p.m. showed two CNAs (#3 and #4) transferred Resident #4 from the bed to his wheelchair with a Hoyer lift when a CNA (#8) opened the door to Resident #4's room without knocking. - Observation on 08/18/15 at 5:20 p.m. showed a CNA (#8) opened the door to Resident #6's room without knocking. - The group interview occurred on 08/19/15 at 1:00 p.m. with 11 residents, identified by the facility as interviewable. When asked about privacy, Resident F stated staff knock on the door before entering her room, but do not always wait for permission to enter. Other residents agreed with Resident F. During an interview on 08/20/15 at 10:45 a.m., a nursing supervisor (#1) stated the expectation is for staff to knock on the resident's door and wait for a response from the resident before entering into the resident's room.	F 241		
F 248	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests	F 248		9/23/15

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F 248	Continued From page 4 and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, group interview, and confidential resident interview, the facility failed to provide ongoing, individualized, and meaningful activities on the weekends for 14 of 15 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14, and #15). Failure to implement activity programs on the weekends may negatively affect the resident's psychosocial well-being. Findings include: The group interview occurred on 08/19/15 at 1:00 p.m. with 11 residents, identified by the facility as interviewable. When asked about activities, five of the 11 residents (Residents B, C, D, E and F) stated there were no activities on weekends except for worship services. Review of Unit A and Unit B's June 2015 activity schedule identified the following: * Saturday June 06, 13, and 20 - rosary and mass * Saturday June 27 - movie and popcorn * Sunday June 07, 21, and 28 - church service * Sunday June 14 - Lucy Ball marathon and church service Review of Unit A and Unit B's July 2015 activity schedule identified the following: * Saturday July 04, 18, and 25 - rosary and mass * Saturday July 11 - movie and popcorn	F 248	1. On August 27, 2015 an activity staff meeting was held to educate the staff on the need to provide on-going and meaningful activities on the weekends and proper documentation of attendance on weekends for residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14 and #15. An activity attendance log was created for staff and volunteers to use to document activity attendance on the weekends. 2. All residents have the potential to be affected. 3. The Activities calendar has been adjusted to address weekend activities. On August 27, 2015 a staff meeting was held to educate the staff on the need to provide on-going and meaningful activities on weekends and proper documentation for residents. An activity attendance log was created for staff and volunteers to use to document activity attendance on the weekends. At the resident council meeting on August 31, 2015, the changes to the activity calendar were presented and discussed. 4. Date of correction: September 23, 2015. 5. QI monitoring will be implemented by the Activity Director on weekend attendance. Documentation will be reviewed weekly times one month,	

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F 248	Continued From page 5 * Sunday July 05, 19, and 26 - church services * Sunday July 12 - Lucy Ball marathon and church service Review of the activity records identified no activities documented for the following dates and residents: * Saturday June 27, 2015 - Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #14, and #15 * Sunday June 28, 2015 - Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14, and #15 * Saturday July 11, 2015 - Resident #4, #5, #6, #10, #12, #13, #14 * Sunday July 12, 2015 - Resident #4, #5, #6, #10, #12, #13, #14 * Saturday July 18, 2015 - Resident #4, #5, #6, #10, #12, #13, #14 * Saturday July 25, 2015 - Resident #4, #5, #6, #10, #12, #13, #14 * Sunday July 26, 2015 - Resident #4, #5, #6, #10, #12, #13, #14 During a confidential interview, Resident B stated the facility never has any activities on Saturdays and Sundays available. She stated she has mentioned it to the facility several times and feels the facility has not done anything about it. During a confidential interview, Resident A stated she likes to keep busy and would like more activities to be available on the weekends.	F 248	monthly times three and then quarterly for one year. The results will be reported to the Director of Nursing. If concerns are identified, corrective action will be implemented. The Activity Director will submit a report on the monitoring results to the QA Committee at the scheduled meeting.	
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		9/8/15

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F 278	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 1 sampled residents (Resident #2) coded for weight gain. Failure to accurately complete portions of the MDS, Section K (swallowing/nutritional status), does not allow the resident's assessment to reflect their current	F 278	1. For resident #2, the July 26, 2015 quarterly MDS was corrected and submitted on September 8th, 2015 2. All residents have the potential to be miscoded for weight gain or weight loss. 3. The current procedure for assessing weight gain or losses is being revised. All residents will be assessed for weight gain or weight loss within seven days of admission. The admit weight will be	

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F 278	Continued From page 7 status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2014, page K-8 and K-9 stated, ". . . K0310: Weight Gain . . . Coding Instructions . . . Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician. Coding Tips: A resident may experience weight variances in between the snapshot time periods. Although these require follow-up at the time, they are not captured on the MDS. . . ." Review of Resident #2's medical record occurred on 08/20/15. The resident's admission weight on 01/26/15 was 132.5 pounds. Resident #2's weight on 02/10/15 was 173 pounds. A quarterly MDS, dated 04/26/15, identified a weight of 162 pounds and a weight gain that was not physician prescribed. A quarterly MDS, dated 07/26/15, identified a weight of 153 pounds and a weight gain that was not physician prescribed. A nurse's progress note dated 02/10/15 stated "hoyer wt [weight] obtained - 173 noted when in Bismarck [just prior to admission] wt was 178.4." A physician's progress note dated 02/11/15 stated ". . . Weight is down about 5 pounds to a present weight of 173 . . ."	F 278	compared to the first weekly weight. 4. Date of correction September 8, 2015. 5. The CDM/LRD will be responsible to monitor. The CDM/LRD will monitor to assure there is not a weight discrepancy between the admit weight and first weekly weight. Quality Assurance/monitoring will be implemented by September 8, 2015. The CDM/LRD will monitor every new admission and report quarterly to the Director of Nutritional Services. If concerns are identified, immediate corrective action will be implemented. The Director of Nutritional Services will submit a report of the monitoring results to the QA committee at each scheduled quarterly meeting.	

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F 278	Continued From page 8 During an interview on 08/19/15 at 4:55 p.m., a dietitian (#20) confirmed Resident #2's weight gain was miscoded. Failure to reevaluate a 40 pound weight discrepancy (between the physician progress note and the facility's admission weight) resulted in staff inaccurately coding Resident #2 for a weight gain.	F 278		
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a	F 279	1. Resident #4 has had a fall care plan added to his record on August 21st.	9/23/15

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F 279	Continued From page 9 comprehensive care plan for 1 of 12 sampled residents (Resident #6) that included measurable objectives and interventions to meet the resident's medical and nursing needs related to falls. Failure to develop a comprehensive care plan based on resident specific needs does not allow staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "A PLAN OF CARE FOR EACH RESIDENT WILL BE IMPLEMENTED IN LONG TERM CARE" occurred on 08/20/15. This policy, dated 09/19/05, stated, ". . . The plan of care will be revised to reflect the resident's condition and the care provided as needs occur . . . The resident plan of care includes the daily plan of care which addresses the ADL [activity of daily living] needs of the resident . . . As new concerns and/or illness are addressed, they will be entered into the care plan . . ." Review of Resident #6's medical record occurred on all days of the survey. Review of the resident's annual Minimum Data Set (MDS), dated 02/17/15, identified the resident needed supervision with one person's assistance for transfers, and experienced one fall with no injury. The quarterly MDS, dated 05/19/15, identified the resident needed limited assist with one person for transfers, walking in the room and corridor, locomotion on the unit, and experienced two or more falls with no injury and one fall with an injury since the prior assessment. Resident #6's care plan failed to address falls.	F 279	2. All residents having had a fall have a potential to be affected. 3. All residents having had a fall will have a fall care plan in their record. All residents were reviewed by September 9, 2015. The need for a fall care plan was reviewed with the MDS staff and nurses at meetings on September 3rd and minutes posted. Care plans are reviewed with each MDS and the need for a fall care plan will be addressed. 4. Completed September 23, 2015. 5. QI monitor implemented and ADON will be responsible to monitor residents who experience falls have a fall care plan implemented, weekly for one month, monthly for three months, quarterly for one year and report to the QI committee at regularly scheduled meetings.	

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F 279	Continued From page 10 Review of Resident #6's progress notes identified the following: * 11/29/15 at 3:30 p.m.: ". . . CNA (certified nursing assistant) came to writer and said that the resident was found on his knees by the recliner . . ." * 03/17/15 at 9:30 a.m.: ". . . heard resident call out 'I fell'. Nurse walked in room and found resident sitting in front of his recliner . . . Resident stated 'I was trying to put my belt on. I had to let go of the walker and I fell back . . ." * 04/12/15 at 2:00 p.m.: ". . . CNA found resident on his knees in front of his bed . . . Resident stated he was going to go to the bathroom. 'I stood up . . . and I lost my balance' . . ." *04/12/15 at 3:06 p.m.: ". . . Staff heard a bang on Liberty Lane and tracked sound to residents room. Upon entering resident was found lying behind door of his room on his back . . . Resident stated he bumped his head . . . Bruise . . . right elbow . . . Bruise . . . back of head . . ." Review of the current comprehensive care plan identified it failed to have any measurable objectives or interventions in place to address the potential for falls. During an interview on 08/19/15 at 4:57 p.m., a staff nurse (#9) confirmed the care plan did not include the resident's risk for falls or interventions to help prevent falls.	F 279		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		9/23/15

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F 281	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to meet professional standards of quality for 1 of 2 residents (Resident #22) observed receiving insulin via an insulin pen. Failure of staff to correctly prime insulin pens may cause residents to receive an incorrect dose of insulin. Findings include: Review of the manufacturer's instructions for Lantus SoloStar occurred on 08/20/15. This insert stated, ". . . Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly . . . removing air bubbles . . . A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection . . . C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubble rise up towards needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip . . ." Observation during medication pass on 08/19/15 at 8:24 a.m. showed a nurse (#17) administered insulin to Resident #22. The nurse (#17) primed the insulin pen holding the pen in a horizontal position and pressed the injection button as she held the insulin pen in a downward position emptying the insulin into the medication cart trash can. The nurse (#17) failed to hold the needle pointing upwards, tap the insulin reservoir to expel any air bubbles, and press the injection	F 281	1. Staff education was provided to staff identified priming insulin for resident #22 on August 21st. 2. All residents receiving Lantus insulin have the potential to be affected. 3. Education was given at Nurse's Meeting on September 3rd on the priming of Lantus insulin recommended by the Lantus manufacturer, along with a visual example. Minutes and visual example were posted. 4. September 23, 2015 5. QI will be implemented with the DON responsible for observation of priming of Lantus insulin weekly for one month, monthly for three months, then quarterly for one year and report to QI committee at scheduled meetings.	

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	355037	A. BUILDING _____ B. WING _____	08/20/2015

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F 281	Continued From page 12 button to expel the insulin in an vertical position. During an interview on 08/20/15 at 10:45 a.m., an administrative nurse (#1) stated she was not aware that the insulin pens needed to be primed in a vertical position. During an interview on 08/20/15 at 1:05 p.m., a staff nurse (#17) stated she was not aware an insulin pen needed to be primed with the needle pointing up.	F 281		
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: SAFE HANDLING OF HOT LIQUIDS 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide supervision to attain the highest degree of safety possible while consuming hot liquids for 1 of 1 sampled resident (Resident #4) with safety precautions regarding hot liquids. Failure to provide hot coffee as identified in the resident's hot beverage assessment and care plan placed the resident at risk of injury. Findings include:	F 323	Gait Belt 1. Staff education was provided at Unit meetings on September 3rd and September 10th for residents #3 and #21 on proper gait belt use. 2. All residents needing assistance with use of gait belt have the potential to be affected. 3. Staff education was provided at Unit meetings on September 3rd and 10th on proper gait belt use, minutes posted. The policy on gait belt was reviewed, updated and posted. During QI monitor individual	9/23/15

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F 323	Continued From page 13 The facility policy titled "Burn Prevention from Hot Liquids," dated 06/26/15, stated, ". . . OT [Occupational Therapy] will assess all residents on admission and with their MDS [Minimum Data Set] for their ability to handle hot liquids and noted [sic] on therapy MDS assessment . . . Recommendations will be implemented as per OT assessment . . . Nurses will place on the Care Plan and the daily plan sheets . . . Dietary will be notified . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia. A quarterly MDS, dated 08/12/15, identified severely impaired cognition, sometimes able to understand others, and extensive assist of one person for eating. The resident's care plan, dated 05/21/15, stated, ". . . Focus . . . Dining Safety . . . Goal . . . minimize risk of negative incidence when consuming hot liquids . . . Interventions . . . Serve hot liquids in covered mug . . . Focus . . . Alteration in nutrition . . . Interventions . . . Provide from set-up to extensive assist with meals . . ." An Occupational Therapy note, dated 07/09/15, stated, ". . . Hot beverage screen: Res [resident] screened for safety with hot beverage. Rsd [sic] to get lid cup/mug at all meals to help prevent spills due to his dementia. Will monitor as needed . . ." Resident #4's Nutrition Assessment, dated 05/14/15, stated, ". . . Dining . . . 1. Supervision . . ." A progress note, dated 07/28/15 at 11:40 a.m., stated, "CNA [certified nursing assistant] notified nurse to [sic] resident spilling hot coffee on his	F 323	education will be provided as needed by the restorative nursing supervisor 4. September 23, 2015. 5. QI monitor implemented with restorative nursing supervisor responsible to monitor weekly times one month, monthly times three months and quarterly for one year and report to QI committee at scheduled monthly meetings. 1. Resident #4 was assigned to a restorative dining program and to the restorative dining room and will be supervised and assisted as needed with hot liquids. 2. All residents needing supervision/assistance with hot liquids have the potential to be affected. 3. Staff education was provided at Unit meetings on September 3rd and September 10th on burn prevention policy for hot liquids. Minutes were posted. The burn prevention policy from hot liquids was reviewed and updated. When OT assesses residents with each MDS they will alert staff of any change needed with dining assistance with hot liquids. 4. September 23, 2015. 5. QI monitor implemented with restorative nursing supervisor responsible to monitor weekly times one month, monthly times three months, then quarterly for one year and report to QI committee as scheduled meeting.	

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F 323	Continued From page 14	F 323		

lap during breakfast. At 0817 [8:17 a.m.] resident was taken to his room. Area assessed. Slight pink noted to upper left thigh. Cold compress applied. Resident denies any pain . . . Resident was screened to use a special cup while drinking hot fluids. Cup was not in place per dietary . . ."

Observation on 08/19/15 at 8:14 a.m. showed Resident #4 sitting in his wheelchair at the dining room table. The resident removed the lid from the coffee cup and poured the coffee into an empty glass. A staff nurse (#17) approached Resident #4 and poured the coffee back into the cup, added milk, recovered the coffee cup, and left the resident. The resident mixed his coffee with other liquids in an uncovered glass. The resident drank from the glass and the surveyor alerted an unidentified CNA. The unidentified CNA approached the resident's table and removed the glass and the coffee cup. Staff failed to adequately supervise the resident with hot liquids.

The facility failed to provide the necessary supervision/assistance to ensure the safety of Resident #4 regarding hot liquids. This failure placed Resident #4 at risk for a coffee burn.

GAITBELT USE

2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate assistive devices (gait belt) for 1 of 6 sampled residents (Resident #3) and one supplemental resident (Resident #21) requiring staff assistance during pivot transfers. Failure to ensure staff properly used a gait belt placed the residents at risk for accident and/or

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F 323	Continued From page 15 injury. Findings include: Review of the facility policy titled "Gait Belt" occurred on 08/20/15. This policy, dated 03/13/02, stated, ". . . To use gait belt: a. Place gait belt securely around resident's waist. b. Grasp gait belt with an underhand grasp to provide support for the resident. c. Assist resident to transfer or ambulate . . ." - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . Focus: Impaired mobility and ADL [activities of daily living] deficit related to tramatic [sic] brain injury. Potential for falls related to impaired standing balance and seizure disorder. . . . Interventions . . . Transfers with gaitbelt and assist . . ." Observation on 08/18/15 at 3:55 p.m. showed two CNAs (#22 and #23) transferred Resident #3 from her bed to the wheelchair. Both CNAs held onto the gaitbelt with one hand and lifted under Resident #3's axilla with their other hand. - A random observation in the dining room on 08/19/15 at 1:00 p.m. showed a CNA (#19) applied a gait belt around Resident #21's waist and assisted her to stand with one hand under the resident's right axilla, pulling her to a standing position. Observation showed the staff member did not grab the gait belt to assist the resident to stand.	F 323		
F 327	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327		9/23/15

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F 327	Continued From page 16 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide fluids during cares to 5 of 7 sampled residents (Resident #3, #4, #5, #6, and #7) at risk for insufficient fluid intake and/or dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included traumatic brain injury. A quarterly MDS, dated 08/07/15, identified extensive assistance of one person needed for eating. The current care plan stated, ". . . Focus: Resident has potential for dehydration due to Inadequate fluid intake, Dx [diagnosis] of Dysphagia . . . Interventions . . . Encourage & monitor fluids at meals & between meals . . . Provide fluids with meals and between meals according to preference . . ." Observation on 08/18/15 at 3:55 p.m. showed two CNAs (#22 and #23) provided personal cares for Resident #3 and failed to offer fluids before or after providing those cares. Observation on 08/19/15 at 10:45 a.m. showed two CNAs (#25 and #26) provided personal cares for Resident #3 and failed to offer fluids before or after those cares.	F 327	1. Staff education provided at Unit meetings and Nurse's meetings on September 3rd and September 10th on need to offer fluids with cares for residents #3, #4, #5, #6 and #7 and minutes posted. 2. All residents needing assistance with fluids have the potential to be affected. 3. Policy on hydration/fluids updated. Policy reviewed and staff education provided at Unit meetings and Nurse's meetings on September 3rd and September 10th. Education on need to offer fluids with cares, minutes posted During QI monitoring, individual education will be given to staff as needed on offering fluids during cares. 4. September 23, 2015. 5. QI monitor implemented with DON/ADON to be responsible to monitor staff offering fluids to residents needing assistance with cares weekly for one month, monthly for three months and quarterly for one year and report to QI committee at scheduled meetings.	

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F 327	Continued From page 17 - Review of Resident #4's medical record occurred on all days of the survey. Diagnoses included dementia. A quarterly MDS, dated 08/12/15, identified Resident #4 with severely impaired cognition and required extensive assistance of one person for eating. Resident #4's comprehensive care plan, dated 05/21/15, stated, ". . . Focus . . . resident has potential for dehydration due to Inadequate fluid intake, Receives a diuretic, Dx of Dementia . . . Interventions . . . Assist with fluid intake as needed . . . encourage & monitor fluids at meals & between meals . . . Provide fluids with meals and between meals . . ." Observation on 08/18/15 at 3:40 p.m. showed two CNAs (#3 and #4) provided personal cares for Resident #4 and failed to offer fluids to the resident before or after cares. - Review of Resident #5's medical record occurred on all days of the survey. Diagnoses included dementia. A quarterly MDS, dated 07/08/15, identified Resident #5 with moderately impaired cognition and required supervision of one person for eating. Resident #5's comprehensive care plan, dated 07/15/15, stated, ". . . Focus . . . Resident has a potential for dehydration due to Inadequate fluid intake, Receives a diuretic . . . Interventions . . . Assist with fluid intake as needed . . . Encourage & monitor fluids at meals & between meals . . . Provide fluids during activities . . . Provide fluids with meals and between meals . . ." Observation on 08/19/15 at 10:25 a.m. showed a CNA (#16) provide cares for Resident #5. The	F 327		

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F 327	Continued From page 18 CNA failed to offer fluids to the resident before or after providing the cares. - Review of Resident #6's medical record occurred on all days of the survey. Diagnoses included dementia. Resident # 6's comprehensive care plan, dated 05/27/15, stated, ". . . Focus . . . Resident has potential for dehydration due to Inadequate fluid intake, Receives a diuretic, Dx [diagnosis] of Dementia . . . Interventions . . . Encourage & monitor fluids at meals & between meals . . . Provide fluids during activities . . . Provide fluids with meals and between meals . . ." Observation on 08/18/15 at 5:20 p.m. showed a CNA (#4) provide Resident #6 personal cares and failed to offer fluids to the resident before or after the cares. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia. The quarterly Minimum Data Set (MDS), dated 06/15/15, indicated limited assistance of one person for eating. The care plan stated, ". . . Resident has potential for dehydration due to Inadequate fluid intake . . . Assist with fluids as needed, encourage & monitor fluids at meals & between meals . . ." Observation on 08/18/15 at 3:58 p.m. showed two certified nursing assistants (CNAs) (#12 and #13) assisted Resident #7 into bed. The CNA's failed to offer fluids to the resident before or after providing cares.	F 327		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	F 363		8/26/15

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F 363	Continued From page 19 Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and review of facility menus, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes in 2 of 2 dining rooms (Unit A and Unit B). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight changes and/or inadequate nutritional intake for all residents. Findings include: Review of the policy titled "Small and Large Portions" occurred on 08/20/15. This policy, dated 08/04/13, stated, "POLICY: Small and large portion sizes are available for patients and residents. PROCEDURE: 1. Small portions . . . Scoop size/portion size will vary according to menu item. 2. Large portions . . . Scoop size/portion size will vary according to menu item." - Observation of tray line occurred in the Unit B dining room on 08/19/15 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents:	F 363	1. No resident identified. Staff educated on the need to use proper size serving utensils for all meals when serving the residents according to the menu. 2. All residents eating at the facility have the potential to be served with incorrect serving size utensils. 3. CDM informed Dietary staff of use of proper serving size utensils on August 26, 2015. 4. Corrective action has taken place as of August 26, 2015. 5. A QI monitor on using the proper serving size utensils will be performed weekly for one months and then monthly for one quarter and then quarterly for one year and the results will be reported quarterly to the QI committee at regularly scheduled meetings by the CDM.	

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F 363	Continued From page 20 *Peas served with a 2 ounce (oz.) scoop. The menu identified 4 oz. *Glazed carrots served with 1 oz spoodle (cross between a spoon and ladle) and a 3 oz. spoodle. The menu identified 4 oz. *Mechanical soft pork (ground) served with a regular spoon (no measurement). The menu identified 3 oz. *Carrots RC (server identifed "RC" as reduced calorie) served with a regular spoon (no measurement). - Observation of tray line occurred in the Unit A dining room on 08/19/15 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Mashed Potatoes served with a 3 oz. scoop. The menu identified 4 oz. *Mixed vegetables served with a 2 oz. scoop. The menu identified 4 oz. - Observation of tray line occurred in Unit B dining room on 08/19/15 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Peas/Carrots served with a 2 oz. scoop. The menu identified 4 oz. cup. *Mechanical soft (ground) chicken fillet sandwich served with a regular spoon. The menu identified "one each." *Broccoli served with a 3 oz. scoop. The menu identified 4 oz. - Observation of tray line occurred in the Unit A	F 363		

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F 363	Continued From page 21 dining room on 08/20/15 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Carrots served with a 2 oz. scoop. The menu identified 4 oz. *Peas served with a 1 oz. scoop and a 2 oz. scoop. The menu identified 4 oz. *Mechanical soft (ground) chicken served with a 2 oz. scoop. The menu identified 3 oz. For all of the observations above, staff used the same serving size for each plate served and did not vary the portion sizes.	F 363		
F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 kitchen. Failure to maintain the cleanliness of the kitchen does not ensure food is prepared and served under sanitary conditions.	F 371	1. a. Peeling paint hanging from the ceiling/vent hood above the oven and grill surfaces has been removed. Hood has been scraped and painted b. The kitchen floor will be swept twice daily by the Dietary staff, it will be mopped	9/23/15

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F 371	Continued From page 22 Findings include: Review of the facility policy titled "Kitchen Floor Cleaning" occurred on 08/20/15. This policy, revised April 2015, stated, ". . . Maintenance will be responsible for vent cleaning throughout the kitchen as needed. Maintenance will be responsible for dish room A/C [air conditioner] and fan cleaning as needed. . . ." Review of the facility policy titled "Weekly Cleaning" occurred on 08/20/15. This policy, revised March 2015, stated, " . . . The Director of Nutritional Services or supervisor will assign employees to specific cleaning duties weekly, using the cleaning list on the following pages . . . Sweep Floor: [twice a day] . . ." The dietary tour occurred on 08/20/15 at 9:30 a.m. with a dietary manager (#24). Observation during the tour showed the following: * Peeling paint hanging from the ceiling/vent hood above the oven and grill surfaces * Scattered debris on the floor throughout the kitchen * A black substance on the floor near the oven * Three fans with dust/debris build-up * Two pot holders soiled with food debris in a drawer in the baking area * A spatula with cracked edges and soiled with food debris in a drawer in the baking area During an interview on 08/20/15 at approximately 10:00 a.m., the dietary manager (#24) stated the housekeeping staff clean the floors in the kitchen three times a week and the dietary staff are responsible for cleaning the fans. The manager	F 371	three times a week by Housekeeping staff. c. Stain on floor near the oven was removed on September 9th. d. Pot holders will be placed in the dirty potholder receptacle when soiled, they will be sent to Laundry to be washed. e. Fans will be cleaned monthly by Dietary staff. f. Only use spatulas free of cracked edges. All spatulas will be thoroughly washed before placing in drawers. 2. All residents eating at the facility have the potential to be affected. 3. a. CDM (Certified Dietary Manager) informed Maintenance of peeling paint on August 27, 2015. Housekeeping staff scraped peeling paint and cleaned the hood on September1, 2015. b. CDM re-educated Dietary staff of the floor sweeping schedule on August 26, 2015. c. CDM informed Dietary staff that all soiled potholders will be put in the dirty potholder receptacle daily on August 26, 2015. e. CDM informed Dietary staff that all fans will be cleaned monthly on August 26, 2015. f. CDM informed Dietary staff that all cracked spatulas will be discarded and all utensils will be thoroughly cleaned before placing in drawers on August 26, 2015. 4. Corrective action was taken on August 26, 2015 for the debris on the floor, soiled potholders, dirty fans and cracked and	

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F 371	Continued From page 23 (#24) stated the paint has been peeling from the ceiling/vent hood for some time now.	F 371	soiled spatulas. Corrective action was taken on September 1, 2015 for the peeling paint on the hood. 5. a. A QI monitor of the hood will be performed weekly for one month, monthly for three months, quarterly for one year and results will be reported to the QI committee at regularly scheduled meetings. CDM will be responsible. b. A QI monitor on floor cleanliness will be performed weekly for one month, monthly for three months, quarterly for one year and the results will be reported to the QI committee at regularly scheduled meetings. CDM will be responsible. c. A QI monitor on the fan cleaning will be performed weekly for one month, monthly for three months, quarterly for one year and the results will be reported to the QI committee at regularly scheduled meetings. CDM will be responsible. e. QI monitor on clean potholders will be performed weekly for one month, monthly for three months, quarterly for one year and the results will be reported to the QI committee at regularly scheduled meetings. CDM will be responsible. f. A QI monitor using crack free, clean spatulas will be done weekly for one month, monthly for three months, quarterly for one year and the results will be reported to the QI committee at regularly scheduled meetings. CDM will be responsible.	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		9/23/15

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F 428	Continued From page 24 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's consulting pharmacist failed to recognize and report regimen irregularities and recommend a gradual dose reduction (GDR) for 1 of 1 sampled resident (Resident #9) on a hypnotic. Failure to identify irregularities and recommend a GDR may result in residents receiving unnecessary medications. Findings include: Review of the facility policy titled "PSYCHOACTIVE MEDICATIONS" occurred on 08/20/15. This policy, dated 07/2014, stated, "GOAL: Residents receiving psychoactive medication will be monitored for safety and appropriateness. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia, depression, and insomnia. Medications included Ambien (a hypnotic) 10	F 428	1. Hypnotic use for resident #9 was addressed/assessed by physician/Medical Director on September 9th and orders received for trial of dose reduction of the hypnotic medication. 2. All residents using hypnotics have the potential to be affected. 3. All residents using hypnotics are monitored monthly by the pharmacists. The pharmacist will make recommendations on a quarterly basis in the use of hypnotics. Residents using hypnotics will also be included in the monthly behavior meetings to be reviewed by the team for request for a quarterly recommendation. 4. September 23, 2015 5. QI monitor will be implemented with DON being responsible monthly for one year and report to QI at scheduled meetings.	

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F 428	Continued From page 25 milligrams at bedtime (re-started 01/23/2015). Resident #9's nursing progress notes stated the following: * 01/26/15 "BEHAVIOR MANAGEMENT MEETING-Resident and family requested Ambien be restarted related to poor sleep pattern with trial of trazadone . . . (trazadone d/c 1/11 and ambien restarted on 1/23) Resident related sleep improved with restart of Ambien." * 04/14/12 "QUARTERLY PROGRESS NOTE: . . . [Resident #9] daughter, [daughter name] has requested [Resident #9] no longer be seen by RMH [Rural Mental Health] routinely." During an interview on the afternoon of 08/19/15, an administrative nurse (#1) verified Resident #9's medical record lacked evidence of a GDR attempt quarterly since the drug was restarted on 01/23/15. During a phone interview on 08/20/15 at 1:47 p.m. the consulting pharmacist (#2) stated she reviews the resident's medications monthly. The pharmacist did not recommend a GDR after the failed attempt at the end of December as the resident and family requested this medication and the resident is seen by RMH.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		9/23/15

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F 431	Continued From page 26 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide locked and secure storage of medications for 1 of 2 medication carts on Unit A. Failure to lock medication carts may result in accidental ingestion of medications by residents. Findings include:	F 431	1. No resident was affected. Staff involved with medication cart that was not locked were reminded to keep cart locked when not in view at Nurse/CMA meeting on September 3, 2015 and minutes were posted. 2. All medication carts have the potential to be unlocked. 3. All nurses and CMAs were reminded	

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F 431	Continued From page 27 Review of facility policy titled "Medication Administration" occurred on 08/20/2015. This policy, dated May 01, 2012, stated, ". . . .5. The medication cart is used for medication pass. It is locked when not visualized. . . ." Observation on 08/20/2015 from 1:01-1:05 p.m. showed an unlocked medication cart outside the medication room on Unit A without a nurse present or in sight of the cart. During an interview on the afternoon of 08/20/2015, an administrative nurse (#1) stated she would expect the medication cart to be locked when a nurse is not present.	F 431	of the need to keep the medication cart locked at all times when not in view at Nurse/CMA meeting on September 3, 2015. Policy was reviewed and posted. 4. September 23, 2015. 5. QI monitor implemented and DON/ADON are responsible to monitor medication carts for being locked weekly for one month, monthly for three months and quarterly for one year and report to QI committee at scheduled meetings.	
F 441	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	F 441		9/23/15

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F 441	Continued From page 28 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 8 of 12 sampled residents (Resident #1, #2, #3, #4, #7, #8, #11, and #15) observed during personal cares. Failure to follow infection control practices has the potential to cause or spread infection within the facility. Findings include: Review of the policy titled "Hand Hygiene" occurred on 08/20/15. This policy, dated June 2014, stated, "POLICY: Hand hygiene continues to be the primary means of preventing the transmission of infection. PROCEDURE: The following is a list of some situations that require hand hygiene. . . . 2. Before and after resident	F 441	1. Staff education provided at Unit and Nurse's meetings on September 3rd and September 10th with review of hand hygiene policy and perineal care policy for residents #1, #2, #3, #4,#7, #8, #11 & #15. Meeting minutes posted. 2. All residents have the potential to be affected. 3. Staff education provided at Unit and Nurse's meetings on September 3rd and September 10th with review of hand hygiene and pericare policy. Checklist for hand hygiene and pericare developed and reviewed to remind staff and to use with monitoring. Policy, checklist, minutes posted. In addition, the Infection Control nurse will do individual education to staff as needed during her QI monitoring.	

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F 441	Continued From page 29 contact (for which hand hygiene is indicated by acceptable professional practice.) . . . 5. Before and after assisting a resident with personal care (e.g. oral care, bathing). . . . 11. After contact with a resident's mucous membranes and body fluids or excretions. 12. After handling soiled or used linens, dressings, bedpans, catheters and urinals. . . . 14. After performing personal hygiene actions. 15. After removing gloves . . . The following situations require that hands be washed with soap and water. . . . 4. Before and after assisting a resident with toileting. 5. After contact with a resident with infectious diarrhea (including, but not limited to infections caused by . . . c. difficili [clostridium difficile]). . . ." Review of the policy titled "Clostridium Difficile" occurred on 08/20/15. This policy, dated May 2010, stated, "POLICY: To provide guidelines for the prevention of disease transmission for patients diagnosed or suspected of having Clostridium Difficile. . . . INFECTION PREVENTION: . . . Gloves: all persons entering the room should wear gloves. . . . Remove the gloves after caring for the resident and wash hand with an antibacterial soap. . . . Hand Hygiene: Strict adherence to hand hygiene protocols must be maintained. Staff should wash their hands with an antibacterial soap after resident/patient care. . . . " - Review of Resident #11's medical record occurred on all days of survey. Medical diagnoses included intestinal infection with c. difficile, and the record identified the resident currently receiving Vancomycin (an antibiotic) for the infection.	F 441	4. September 23, 2015. 5. QI monitor implemented with Infection Control nurse or DON responsible to monitor hand washing and perineal care weekly for one month, monthly for three months and quarterly for one year. Report to QI Committee at scheduled meeting.	

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F 441	Continued From page 30 Observation on 08/18/15 at 4:40 p.m. showed a certified nurse aide (CNA) (#11) provided personal cares after Resident #11 had an episode of incontinent stool. After the CNA (#11) completed the cares, she removed her gloves and sanitized her hands with an alcohol based hand rub prior to leaving the room. The CNA (#11) failed to wash her hands with soap and water. - Observation on 08/18/15 at 3:40 p.m. showed two CNAs (#3 and #4) donned gloves and provided perineal cares for Resident #4 who was incontinent of stool. The CNA (#3) removed his gloves, the CNAs transferred the resident from the bed to his wheelchair and then the CNA (#3) transferred the resident to the lounge area. The CNA (#3) failed to perform hand hygiene after completing perineal cares and prior to completing other tasks. - Observation on 08/18/15 at 3:55 p.m. showed two CNAs (#22 and #23) provided perineal care for Resident #3 who was incontinent of urine. The CNAs removed their gloves, transferred the resident with a gaitbelt from the bed to her wheelchair, put Resident #3's glasses on, combed her hair, and made the bed before washing their hands. The CNAs (#22 and #23) failed to perform hand hygiene after completing perineal cares and prior to completing other tasks. - Observation on 08/18/15 at 4:18 p.m. showed two CNAs (#22 and #23) provided perineal cares for Resident #2 who was incontinent of bowel and bladder. A CNA (#22) cleansed the frontal perineal area and the other CNA (#23) cleansed	F 441		

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the rectal area. The CNAs (#22 and #23) placed a full body mechanical lift sling under Resident #2. One of the CNAs (#22) then performed hand sanitization. The CNAs (#22 and #23) transferred the resident from the bed to her wheelchair and then the CNA (#23) washed her hands. The CNAs (#22 and #23) failed to perform hand hygiene after completing perineal cares and prior to completing other tasks.

- Observation on 08/18/15 at 4:37 p.m. showed Resident #8 on the toilet and the CNA (#7) in the bathroom with the resident. After the resident voided, the CNA (#7) donned gloves and performed perineal care on the rectal area. Using a clean wipe and the same gloves, the CNA then performed perineal care on the frontal area.

- Observation on 08/19/15 at 9:50 a.m. showed two CNAs (#5 and #6) provided perineal cares who was incontinent of stool. The CNA (#5) offered Resident #4 the urinal to void, assisted the resident with placement of the urinal, and removed the urinal after the resident voided. The CNA (#6) used a single wipe to clean the resident's groin area, wiped the front side of the penis from the base to the top, and then cleansed the rectal area. The CNA (#6) failed to retract the foreskin to thoroughly clean the penis tip and failed to follow the standard of practice for basic perineal care for males.

- Observation on 08/19/15 at 12:47 p.m. showed two CNAs (#14 and #28) provided perineal care for Resident #1 who was incontinent of urine. One of the CNAs (#14) removed the resident's glasses, applied a blanket, put the bedside table next to the bed, pulled the window shade up, and

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F 441	Continued From page 32 left the room. The CNA (#14) failed to perform hand hygiene after completing perineal care and prior to completing other tasks. - Observation on 08/19/15 at 2:30 p.m. showed a CNA (#14) and a nurse (#15) donned gloves and assisted Resident #7 onto the toilet in the bathing room. The CNA removed Resident #7's wet brief, performed perineal cares, removed her gloves, and assisted the resident into the wheelchair. The CNA (#14) handed Resident #7 a tissue and left the bathing area. The CNA (#14) failed to perform hand hygiene after completing perineal care and prior to completing other tasks. - Observation on 08/20/15 at 1:25 p.m. showed two CNAs (#14 and #23) provided perineal care for Resident #15 who was continent of urine. The CNA (#23) cleansed the rectal area, however failed to perform frontal perineal cares. During interview on 08/18/15 at 5:15 p.m,, an administrative nursing staff member (#1) confirmed staff should wash hands with soap and water after completing personal cares/ prior to leaving the room. During an interview on 08/20/15 at 11:40 a.m., an administrative nursing staff member (#1) stated she expected staff to perform hand hygiene after perineal care once the resident is safe and before leaving the room. She also stated she expected staff to do frontal perineal care first.	F 441		
F 469	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests	F 469		9/2/15

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F 469	Continued From page 33 and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, group interview, and staff interview, the facility failed to maintain an effective pest control program for 2 of 4 days of survey (August 19-20, 2015). Failure to ensure the facility remains free of pests placed residents at risk for insect bites. Findings include: - Observation on the afternoon of 08/19/2015 showed a spider crawling on the floor of Unit A Harmony Lane. An unidentified certified nursing assistant (CNA) confirmed it was a spider. - During group interview on 08/19/2015, Resident A stated visitors have seen ants and spiders in her room. Resident B stated she saw a bug in her bedding the previous day. - The environmental tour occurred on 08/20/2015 at 8:15 a.m. with an administrative staff member (#19). During the tour, observation showed a spider crawling on the floor in a resident's room. The staff member (#19) stated the facility sprayed for pests last week. When asked how often they spray, he stated as needed.	F 469	1. No resident was identified. 2. All residents have the potential to be affected. 3. The Maintenance staff sprayed Tempo (an insecticide) around the outside of the facility on August 21, 2015 and August 28, 2015. On September 2, 2015 a contract was signed with Ecolab to do a monthly pest control program for insects that mirrors the contract already in place for rodents. The entire facility will be included under the contract, as they will spray inside and outside the building. 4. September 23, 2015 5. The Director of Plant Operations will implement a QI monitor for pest control. Will monitor weekly for one month, monthly for three months and quarterly for one year and report at regularly scheduled QI meetings.	