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 _____	08/04/2011

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on August 1, 2011 and completed on August 4, 2011 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 six (6) additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. Use of Resident #5 torso support clarified in the Care Plan. Care Plan clarification, citation, identification and reporting procedures according to our Abuse Prevention Plan were presented and reviewed at staff meetings on August 31st, and September 6th, minutes posted. 2. All residents have potential to be affected. 3. Education completed at the staff meetings on August 31st, and September 6th by LSW on the importance of following the Care Plan and also on our abuse/neglect policy. An addition has been placed to the 72 Hour Fall Monitoring form to note if Care Plan was followed and if not to notify DON/ADON. All potential neglect will be reported and investigated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT / CEO — (X6) DATE: 9-20-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to report and investigate a fall for 1 of 1 sampled residents (Resident #5) who experienced a fall/injury as a result of staff not following the resident's care plan. Failure to investigate and report to the State survey and certification agency all incidents of potential neglect does not allow the facility to determine causative factors of the incidents and places residents at risk for neglect. Findings include: Review of the facility policy titled "Abuse Prevention Plan" occurred on 08/04/11. The policy, dated 06/024/08, stated, ". . . Definitions . . . 8. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Failure to carry out resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to residents, or failure to carry out resident services through careless oversight. . . . Prevention . . . Staff are educated to individual resident care needs	F 225	4. Corrected September 13th. 5. QI monitor will be placed to monitor proper use of torso support devices and any falls for not following Care Plan that could be potential neglect reporting monthly times three than re-evaluated at the quarterly QI. DON responsible.	9-13-11

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F 225	Continued From page 2 through care plans, shift reports, and communication boards. Monitoring and assessment is the responsibility of the management personnel. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, osteoporosis, and dementia. Resident #5's Minimum Data Set (MDS), dated 04/12/11, identified a Brief Interview for Mental Status (BIMS) score of 14 (indicating cognitively intact), usually makes self understood and understands others, extensive assistance from one person for transfers, did not walk in room or corridor, and functional range of motion impairment to bilateral lower extremities. Resident #5's "Interdisciplinary Care Plan Conference" notes, dated 01/20/11, stated the following: ". . . Requires torso support for her postural support because she leans forward. . . ." Resident #5's physician orders and treatment administration record both prior to and after the fall stated, "Torso support for positioning on when up in w/c." Resident #5's care plan prior to and after the fall stated, "Torso support on in w/c." A form in Resident #5's chart titled "72 Hour Fall Monitoring," dated 04/02/11, stated, ". . . Brief explanation of event: Resident was in w/c in her room - reached for something [and] fell forward out of the w/c to the floor. Landed on her [left] side. Hit her [left] forehead near her eye - twisted glasses. [left] fingers 2nd, 3rd, 4th are bruised. Bruise to [left] knee. . . . Pain: [left] forehead [and] [left] hand . . . New orders: To ER . . . Involved Persons . . . unwitness [sic] . . ."	F 225		

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F 225	Continued From page 3 A nurses' note dated 04/02/11 stated the following: "10:30 [a.m.] . . . Found resident on the floor lying on the left side - pt awake [and] answers appropriately. . . . Abrasion [and] bruise noted to [left] temple area just above eye - glasses are twisted. Bruises noted to [left] hand on the 2nd, 3rd, [and] 4th fingers. . . . States 'head hurts a little' . . . [11:30 a.m.] To ER via w/c. . . . [12:00 p.m.] Resident returns from ER - No new orders . . ." A note dated 04/08/11, stated, ". . . Fall Mtg. [meeting]: On 4-2-11 Res. [resident] had fall from w/c with minor injuries noted. Torso support not in place, staff reminded needs to be on when up in w/c [secondary to] excessive trunk [flexion]. . . ." During an interview on the morning of 08/03/11, a supervisory nursing staff member (#7) stated they did not report or investigate the incident because they "did not feel it was neglect. It wasn't intentional." She further stated Resident #5 did not want the vest on at that time; however, Resident #5's medical record, fall monitoring form, and care plan failed to identify this information. Resident #5's physician's orders and care plan state the resident is to have the torso support in place when she is in her wheelchair. The facility failed to provide further information related to the fall. During an interview on the morning of 08/04/11, a supervisory nursing staff member (#7) stated staff sometimes left the torso support off while Resident #5 "did her make-up." She further stated, "She likes it [the torso support]. It makes her feel safe."	F 225		

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F 225	Continued From page 4 Resident #5's care plan failed to include instances when it would be appropriate for staff to leave the resident unattended in her wheelchair without her torso support in place. Resident #5's medical record also lacked evidence of any assessment by staff to determine if Resident #5 could safely sit in her wheelchair without the support in place. The facility identified Resident #5 required the torso support for positioning when she sat in her wheelchair. The resident experienced a fall from her wheelchair after staff failed to ensure it was in place. Failure to report and investigate this incident as possible neglect placed Resident #5 and all facility residents at risk for neglect.	F 225		
F 241 SS=D	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, record review, and staff interview, the facility failed to provide care in a manner and environment that enhances dignity for 1 of 1 sampled resident (Resident #4) observed in bed without pants. This practice fails to maintain and enhance a resident's sense of self-esteem and self-worth. Findings include:	F 241	1. Resident #4 Care Plan will reflect her choice with dignity to be in her room with the pants off in bed at times. When she does choose to lie down without her pant the privacy curtain will be pulled. Staff meetings held on August 31st, and September 6th to educate staff and minutes posted. 2. All residents who choose to lie down without pants can be affected. 3. All residents who choose to lie down without pants will be assured privacy by pulling the privacy curtain. Care Plans will reflect preference.	

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F 241	Continued From page 5 Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left-sided cerebrovascular accident, aphasia, anxiety, and depressive disorder not elsewhere classified (NEC). Resident #4's current Minimum Data Set (MDS), dated 05/09/11, identified long-term and short-term memory problems, rarely/never makes self understood or understands others, and severely impaired daily decision making skills. The MDS also identified extensive assistance from two or more people for transfers, bed mobility, and toilet use. Observation on 08/01/11 at 11:25 a.m. and 3:17 p.m. showed Resident #4 lying in bed with the top sheet folded back, exposing her incontinence brief. The door to her room was open and staff failed to pull the privacy curtain, exposing Resident #4 unnecessarily to anyone who walked by her room. At these times, observation showed Resident #4's pants folded over the back of her wheelchair. Observation on 08/02/11 at 8:56 a.m. showed Resident #4 sitting on the edge of her bed without pants on, exposing her incontinence brief and lower body. Observation showed Resident #4's pants folded over the back of her wheelchair. The door to her room was open and observation showed two residents and a staff member passed by. An unidentified housekeeping staff member alerted a supervisory nursing staff member (#7) who covered the resident with a sheet and obtained assistance from two certified nursing assistants (CNAs) (#14 and #15). At that time, the two CNAs (#14 and #15) put the resident's pants on and transferred her to a wheelchair. An interview occurred during this observation with a	F 241	4. Completed September 13, 2011. 5. QI monitor monthly on resident #4 to monitor if privacy maintained and Care Plan reflective of her preference and any other resident identified who choose to have pants off in bed, monthly times three than re-evaluate at quarterly QI. DON responsible.	9-13-11

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F 241	Continued From page 6 CNA (#14). The CNA stated, "I did oral cares, washed her up, and got her ready for the day earlier this morning." Observation on 08/02/11 at 10:13 a.m. showed two CNAs (#14 and #15) assisted Resident #4 to lie down. The CNAs transferred the resident to bed using a mechanical lift, checked the resident's incontinence brief in bed, and left the resident's pants on. Staff did not ask Resident #4 if she wanted her pants on or off. Observation on 08/03/11 at 4:00 p.m. showed Resident #4 lying in bed without pants on, her pants folded over the back of her wheelchair, the privacy curtain not pulled, and the door to her room open, unnecessarily exposing her to anyone who walked by. During an interview on the morning of 08/04/11, a supervisory nursing staff member (#7) stated it was the resident's "choice" to lie in bed without pants on. She stated staff ask Resident #4 if she would like to take her pants off before she lies down, which conflicts with the observation made on 08/02/11 at 10:13 a.m. Resident #4 is identified as cognitively impaired, rarely/never makes self understood or understands others, and severely impaired daily decision making skills. She is dependent upon staff to ensure her dignity and privacy. Review of Resident #4's care plan and medical record failed to identify the resident's preference. On 08/04/11 at 3:50 p.m., a supervisory nursing staff member verified they had not care planned the preference/request.	F 241		
F 257	483.15(h)(6) COMFORTABLE & SAFE	F 257		

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F 257 SS=B	Continued From page 7 TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to maintain a comfortable temperature level on 1 of 2 units (Unit B). Failure to maintain comfortable room temperature levels can result in resident discomfort. Findings include: Observations made throughout Unit B from August 01-02, 2011 included: - On 08/01/11 at 10:45 a.m., during the initial tour of the facility, observation showed Resident #24 sitting at the edge of her bed and dressed in a long sleeve shirt. Upon entering her room, the resident stated "I am froze to death." - On 08/02/11 at 9:15 a.m., a random observation revealed an unidentified certified nursing assistant (CNA) pushed an unidentified resident down the Heritage Wing hallway in her wheelchair. Even though the resident wore a sweater, she stated, "I'm cold." - On 08/02/11 at 1:35 p.m., an unidentified CNA pushed another unidentified resident down the Liberty Wing hallway in her wheelchair. Even	F 257	1. A locking thermostat guard placed in the room of residents #24, #1 and #20 and temperature set at 73 degrees. The thermostats in the hallways in Unit B will be set at 73 degrees and maintained. 2. All residents have the potential to be affected. 3. Review of this citation will be done at staff meetings on August 31st, and September 6th and minutes posted. Staff educated on importance of maintaining comfortable temperature for the residents. The temperature will be monitored and logged by Maintenance throughout the facility and adjustments made as necessary. 4. Completed by September 13th. 5. QI monitors to monitor temperature in the rooms of residents #24, #1 and #20 along with random room and	

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F 257	Continued From page 8 though the resident wore a sweater, she stated, "It's cold in here." - On 08/02/11 at 9:32 a.m., observation showed two CNAs (#2 and #3) started giving Resident #1 a bedbath. Resident #1 made the following comments throughout the bath: "It is cold in here," "My feet are cold," "My legs are too cold," and "I'm shivering from the inside out." After the CNAs finished Resident #1's bath and transferred her into a wheelchair, one CNA (#2) looked at the thermostat and stated, "I don't know why it is that low [63 degrees Fahrenheit (F)]," and adjusted the thermostat to 74 degrees F. - Review of Resident #19's medical record occurred on 08/02/11. The admission Minimum Data Set (MDS), dated 05/12/11, identified intact cognition. During an interview on 08/02/11 at 5:00 p.m., when asked if her room temperature was comfortable, Resident #19 stated, "Yes." She also stated, "It's too cold in here for most of the residents. They're always complaining and wearing sweaters." - Review of Resident #20's medical record occurred on 08/03/11. The quarterly MDS, dated 07/22/11, identified intact cognition. During an interview on 08/03/11 at 3:30 p.m., when asked if her room temperature was comfortable, Resident #20 stated, "It's so cold in there, and in the hallways. My nose has been running the last couple of days." Air temperatures taken on Unit B, on 08/02/11 at 11:00 a.m., showed the following: * Memory Lane Wing - Room 14 - 70 degrees Fahrenheit	F 257	hallway temperatures will be done daily times one month then weekly times two months and re-evaluated at quarterly QI. Maintenance staff responsible.	9-13-11

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F 257	Continued From page 9 * Unit B Nurses' Station - 70 degrees Fahrenheit * Liberty Wing Hallway - 70 degrees Fahrenheit * Heritage Wing Hallway - 70 degrees Fahrenheit During an interview on 08/03/11 at 10:30 a.m., a managerial staff member (#1) stated, "Each room has it's own control. Staff like it turned down when they're working."	F 257		
F 278 SS=E	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		

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F 278	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instruction (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to accurately complete the Minimum Data Set (MDS) Section P - Restraints for 3 of 15 sampled residents (Resident #5, #6, and #14); Section G - Functional Status for 1 of 15 sampled residents (Resident #12) and 1 closed record (Resident #17); and Section K -Swallowing/Nutritional Status for 1 of 15 sampled residents (Resident #12). Failure to accurately complete portions of the MDS for these residents does not allow each resident's comprehensive assessment to reflect care provided, consistent with their individual needs and problems. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .," and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process	F 278	1. Residents #5, #6 and #14 MDS section P will reflect restraints, OT evaluation were completed to address torso support vs restraint. Resident #12 and #17 (closed) MDS section G functional status will be addressed with new awareness of input error. Resident #12 MDS Section K swallowing/nutritional statuses were addressed by the dietician and aware of error. Resident #17 coding of toileting as 8 was incorrect and staff made aware of inputting error. 2. All residents have potential for assessment error. 3. Information continuously reviewed by MDS staff to minimize future coding errors. It will be documented in the Care Conference notes that the MDS reviewed for accuracy. 4. Corrected September 13th.	

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F 278	Continued From page 11 * the quality measures used for public reporting * research and policy development . . ." - Review of Resident #6's medical record occurred on all days of survey. Resident #6's diagnoses included Alzheimer's dementia and Parkinson's disease. A physician's order dated 02/23/10, stated "Torso support [a vest placed around the trunk and secured to the wheelchair with Velcro] on at all times when up in w/c [wheelchair] every shift." Review of Resident #6's "Restraint Consent," form included this definition of a physical restraint as "any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." Resident #6's family signed the consent form on 02/25/10, indicating the use of a "Torso support when up in w/c fastened in back." The "reason" listed on the consent form for use of this physical restraint stated, "Leans forward in w/c - to prevent him from falling forward out of chair - [he] removes torso support per self when fastened in the front- Is restless at times [and] forgets to ask for help." Observations of Resident #6 on 08/01/11 at 3:15 p.m. and on 08/02/11 at 9:15 a.m., showed Resident #6 seated in his wheelchair with a torso support placed on his upper body/trunk. Observation showed the torso support secured in place at the back of the resident's wheelchair, which limited Resident #6's free movement and access to his upper body/trunk. These	F 278	5. QI monitor to monitor accuracy of MDS will be done on residents #5, #6, 12 and #14 quarterly and on all residents quarterly and annual MDS. MDS Coordinator responsible.	9-13-11

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	355037	A. BUILDING _____ B. WING _____	08/04/2011

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F 278	Continued From page 12 observations showed Resident #6 was incapable of removing the torso support himself. Resident #6's quarterly MDSs dated 04/27/11; and annual MDS, dated 7/27/11; failed to indicate the use a physical restraint when out of bed. During interview on 08/03/11 at 10:00 a.m., a therapy staff member (#24) stated the torso support used by Resident #6 is an "enabler" and "positioning device." This staff member stated she failed to consider that the torso support, which is secured in place at the back of the resident's wheelchair, may also be a physical restraint for Resident #6. - Review of Resident #14's medical record occurred on August 03-04, 2011 and identified diagnoses including dementia and Parkinson's. A physician's order dated 04/26/11 indicated a torso support when up in wheelchair. Review of an admission Minimum Data Set (MDS), dated 04/11/11, identified Resident #14 utilized a trunk restraint daily and the quarterly MDS, dated 07/05/11, indicated no trunk restraint. A "Restraint/Safety Device Assessment" form, dated 04/14/11, stated, ". . . Reason for initiation: Attempts to get up unassisted unaware limitations requires assist . . . Restraint/Safety Device used and when: seatbelt in w/c . . . " The form indicated the family notified, consent signed and physician order received. Random observations of Resident #14 on 08/04/11, showed the resident sitting in his wheelchair in his room and attending an activity.	F 278		

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F 278	Continued From page 13 Both observations showed the torso support in place which limited Resident 14's forward movement. Facility staff implemented the torso support to prevent Resident #14 from getting up from the wheelchair due to his unawareness of his limitations and risk for falls. Facility staff secured the torso support in the back of his wheelchair to prevent Resident #14 from removing the torso support himself. Failure to accurately assess the device does not allow for individual care planning, an accurate assessment and coding of the MDS for this device. - Review of Resident #12's medical record occurred on August 03-04, 2011. Resident #12's Minimum Data Sets (MDS) revealed the following: * 01/04/11 Significant Change MDS - Section K - weight of 133 pounds * 03/15/11 Quarterly MDS - Section G - supervision/set up only for locomotion, and independent/one person assist with toileting; - Section K - weight of 127 pounds * 06/14/11 Quarterly MDS - Section G - extensive assistance of one person for locomotion on unit, and extensive assistance of one person for toilet use; - Section K - weight of 118 pounds During an interview on 08/04/11 at 11:15 a.m., a nursing staff member (#9) stated, "These [03/15/11 Quarterly MDS Section G entries] were input errors." The above interview indicates a contradiction between the resident's actual status (extensive	F 278		

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F 278	Continued From page 14 assistance required for locomotion on unit and toileting) and the status coded on the MDS (supervision/set up only for locomotion, and independent/one person assist with toileting). During an interview on 08/04/11 at 11:15 a.m., a dietary staff member (#10) stated, "I look at three months. She [Resident #12] went from 127 to 118 [pounds]. That's seven percent. Seven [percent] is less than the seven and one half [percent] that is needed. The dietician increased her supplements. I didn't look back two [MDS assessment periods]." She went on to explain that the dietary staff use the resident's actual weight (with no rounding) to determine weight loss/gain. Resident #12's "Dietary Notes" indicated the following: * 01/05/11: ". . . Weight - 132.6 . . ." * 03/17/11: "Weight - 126.9 . . ." * 06/16/11: ". . . Wt [weight] 117.7 . . . 3.1% wt loss last 30 days, 7.2% wt loss last 90 days, 9.7% wt loss last 6 months . . ." The facility failed to identify Resident #12 lost 11.2% of her body weight in a 6 month period (January-June) which indicated a significant weight loss. The above interview and supporting documentation indicate a contradiction between the resident's actual status (significant weight loss) and the status coded on the MDS (no weight loss). - Review of Resident #5's medical record occurred on August 02-04, 2011. The resident's	F 278		

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F 278	Continued From page 15 annual MDS, dated 07/12/11, and quarterly MDS, dated 04/12/11, failed to identify the use of any restraints. Observations throughout the survey showed Resident #5 in her wheelchair with a vest-type device secured around the back of the wheelchair with Velcro. Observation showed the resident was unable to remove the vest independently. During an interview on the morning of 08/04/11, a supervisory nursing staff member (#7) stated staff did not code Resident #5 for a trunk restraint because it is used as a positioning device. - The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page G-8 states, ". . . Activities of Daily Living (ADL) Assistance . . . Toileting would be coded 8, activity did not occur: only if elimination did not occur during the entire look-back period. . . . Review of Resident #17 closed medical record occurred on 08/04/11, and identified diagnoses included anoxic brain and bowel and bladder incontinence. Review of the following MDSs, dated 10/07/10 and 04/07/11, indicated "toilet use - how resident uses the toilet room, . . . changes pad . . ." as 8 -the activity did not occur. During an interview on the morning of 08/04/11, a nursing staff member (#9) confirmed the coding was incorrect.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 16 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 2 of 12 sampled residents (Resident #9 and Resident #12), received the necessary care and services while eating. Failure to adequately assess and provide appropriate positioning during meals may affect the residents overall swallow safety, placing them at risk of aspiration and limiting their nutritional intake. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, pages 15-16,125 and the educational handouts state the following: * "Neurological causes [of dysphagia]: . . . Stroke . . . Dementia . . ." * "What are some signs of dysphagia?: Signs of oral phase dysphagia include . . . loosing food or liquid out the front of the mouth . . . Signs of pharyngeal dysphagia are coughing or choking during a meal . . ." * "Appropriate Seating: During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle,	F 309	1. OT evaluation obtained for resident #9 and #12 for positioning during meals. Staff educated at staff meetings on August 31st, and September 6th and minutes posted on assisting resident #9 and #12 up in wheelchair for all meals unless they are unable or unwilling to get up. If unable or unwilling to get up, assist with meal and position bed at the proper elevation. Assist #9 and #12 to eat as necessary. Reposition #12 when having difficulty with coughing during meal and see if this will help. 2. All residents needing assistance with eating have potential. 3. OT will evaluate all residents with quarterly MDS and prn with requested screens for positioning with eating when resident needs assistance. This will be added to the Physical and Occupational quarterly screen for MDS "positioning during meals". Staff educated at staff meetings on August 31st, and September 6th on	

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F 309	Continued From page 17 whether in a bed or in a chair. . . . This position must be maintained during and following the meal. Repositioning is frequently required during the meal. " * "Why is it important for patients to sit at 90 degrees when eating?: Many patients with dysphagia have decreased back of tongue control. This condition allows food or liquid to fall over the back of the tongue with risk of it entering the airway. Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue." - Resident #9's medical record, reviewed August 01-04, 2011, identified diagnoses including cerebral vascular accident (CVA) [stroke] with dysphagia [swallowing disorder] and anorexia. The resident's admission Minimum Data Set (MDS), dated 06/23/11, identified severely impaired cognitive skills, extensive assist of one person for eating, difficulty/pain with swallowing, and mechanically altered diet. Her Nutritional Status Care Area Assessment (CAA) revealed, "Current BMI [body mass index] is below the standard weight range at 13.3. She receives a mechanically altered diet, mechanical soft with ground meats. . . . Her meal intake is poor, she consumes an average of 20% . . . she eats slow and very little amounts . . . encourage adequate meal [and] supplement intake, and provide extensive assist with meals (help with part of meal) . . ." Resident #9's "Alteration in Nutrition" plan of care, dated 06/27/11, identified, ". . . Approaches: . . . Provide Mechanical Soft Diet with ground meats as ordered, small portions . . . Requires extensive assist for all meals (help with part of meal) . . .	F 309	importance of proper bed evaluation when resident eats in bed and proper positioning in wheelchair when having difficulty eating. Hand out from Nurse Aide skills January 2011 on FEEDS CLIENT WHO CANNOT FEED SELF given. 4. Corrected September 13th. 5. QI monitor to assess resident #9 and #12 along with 10% of all residents for proper assistance and positioning during meals monthly times three then re-evaluated at quarterly at QI meeting. DON responsible.	9-13-11

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F 309	Continued From page 18 Encourage adequate intake of meals . . . " Resident #9's "Physician Orders", dated 07/22/11, identified an order for a mechanical soft diet with ground meat. Observations revealed the following: * On 08/02/11 at 8:35 a.m., Resident #9 sat in a 30 degree reclined position in her bed. She attempted to feed herself by reaching for the toast on her breakfast tray, which was above eye level. Resident #9's menu lay on her breakfast tray with a sheet of "Swallow Recommendations" attached. The recommendations included, ". . . 1. Sit upright. . . . 8. Assistance and supervision . . ." An unidentified staff member entered the resident's room twice and encouraged her to keep eating. The staff member did not ask the resident if she required assistance, and made no attempts to reposition her during the meal. * On 08/03/11 at 8:25 a.m., Resident #9 sat in a 60 degree reclined position in her bed. She attempted to feed herself by reaching for the banana slices and toast on her breakfast tray. She demonstrated a hand tremor; stating, "I can't seem to get it from here [pointing toward her breakfast tray] to my mouth. It keeps falling [pointing towards her chest]." When asked if she would like assistance, she stated, "Yes." The surveyor located facility staff in the hallway, and asked them to assist Resident #9 with the remainder of her breakfast. * On 08/04/11 at 8:30 a.m., Resident #9 sat in her bed [at an 85 degree angle]. She attempted to feed herself by reaching for the banana slices and toast on her breakfast tray. She dunked her toast into her cereal. She made no attempt to eat her cereal with a spoon or drink her coffee/milk	F 309		

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F 309	Continued From page 19 from a mug. She demonstrated a hand tremor; stating, "I have a terrible time with my hands. I try to reach out for something and they shake like crazy." In an interview on 08/04/11 in the afternoon, an administrative staff member (#7) stated staff check on Resident #9 in the morning. She did not indicate they stayed to assist Resident #9 with her meal. She agreed sitting at 30-60 degrees was not an optimal position for swallow safety. - Resident #12's medical record, reviewed August 03-04, 2011, identified diagnoses including anxiety, dementia, diabetes with hypoglycemia, and glaucoma. The resident's quarterly MDS, dated 06/14/11, identified severely impaired cognitive skills, independent with eating following set-up, a loss of liquids/solids from the mouth when eating or drinking, and therapeutic diet. Resident #12's "Alteration in Nutrition" plan of care, dated 09/21/10, identified, ". . . Approaches: . . . Provide . . . diet as ordered with small servings . . . Requires set-up assist, cues and feeding supervision for all meals . . ." An addition, dated 06/16/11, identified, ". . . impaired vision . . ." Observation revealed the following: * On 08/02/11 at 12:20 p.m., Resident #12 sat in her wheelchair in the dining room, leaning at a 45 degree angle towards her right side. She attempted to feed herself by scooping food onto the handle of her butter knife. An unidentified CNA noticed and went to assist her. She sat next to the resident and fed her the remainder of her meal. The resident coughed three times while	F 309		

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F 309	Continued From page 20 being fed. Facility staff made no attempts to reposition the resident during the meal. The PT [Physical Therapy] Progress Note, dated 10/06/10, identified the resident ". . . sits very slumped in [her] w/c [wheelchair] . . ." In an interview at 3:45 p.m. on 08/04/11, the physical therapy staff member (#12) stated, "We addressed her sliding forward [in her wheelchair]. We did not address her lateral position. We did not observe her during a meal. We did not look at her for that. We will ask for a screen." In an interview on 08/04/11 in the afternoon, an administrative staff member (#7) agreed sitting at 45 degrees was not an optimal position for swallow safety. The facility failed to 1) ensure proper seating position during meals for swallow safety for Resident #9 and Resident #12, 2) provide assistance during meals for Resident #9, and 3) recognize Resident #12's coughing as a potential sign of aspiration. These failures placed Resident #9 and Resident #12 at risk of aspiration and reduced nutritional intake.	F 309		
F 314 SS=D	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 services to promote healing, prevent infection and	F 314		

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F 314	Continued From page 21 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of standards of practice, and staff interview, the facility failed to provide necessary treatment and services to aid in the prevention and promote the healing of pressure ulcers for 2 of 5 sampled residents (Resident #4, and #7) identified with a pressure ulcer or identified at risk for pressure ulcer development. Failure to consistently implement interventions to prevent and promote healing of pressure ulcers for Resident #4 and #7 resulted in the deterioration of Resident #4's existing facility-acquired pressure ulcer, and placed Resident #7 at risk for developing a pressure ulcer. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left-sided cerebrovascular accident, Type I diabetes, peripheral vascular disease, a history of weight loss, and a history of pressure ulcers to the right heel and coccyx. The resident's current Minimum Data Set (MDS), dated 05/09/11, identified long-term and short-term memory problems, rarely/never makes self understood or understands others, severely impaired daily decision making skills, and extensive assistance from two or more people for bed mobility. During the initial tour on 08/01/11 at 10:55 a.m., a nursing staff member (#21) identified Resident #4	F 314	1. Resident #4 ulcer is healing as of August 22nd with no open area. She remains on an AccuMax pressure redistributing pressure relieving mattress, on arginaid. Care Plan adjusted to note that resident will remove boots, heelbo devices. Resident #7 does not have a pressure ulcer on her heels. She continues to have an AccuMax pressure redistributing pressure relieving mattress, arginaid, supplements, Roho cushion and Prevalon boots for prevention measures. Staff instructed at staff meetings on August 31st, and September 6th to apply pressure relieving devices as directed. A checklist developed for C.N.A.'s to sign off on these devices and for #4 to note if removes and attempts to reapply. This will promote staff accountability. A cue to staff to apply boots/heelbo in the form of boot picture will be	

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F 314	Continued From page 22 with a Stage II pressure ulcer to her left lateral foot. She stated the ulcer was over a bony prominence and developed approximately a week ago. A physician's order, dated 07/21/11, stated, "Polymen adhesive to left lateral foot - apply skin prep prior, [after] cleansing, - change every 5 days [and] prn [as needed] - until healed . . ." A physician's order, dated 05/05/11, stated, "Bilateral heelbo sleeve (a lightly padded covering that fits over the heel) when in bed - every shift." On 08/02/11, staff changed the order to read, "Right heelbo sleeve when in bed." An occupational therapy (OT) staff member also added an order that read, "Left Prevalon boot on in bed." An OT progress note, dated 08/02/11, stated, ". . . Nursing reports [left] lateral skin issues on [left] foot. Prevalon boot implemented on when in bed. . . ." Resident #4's current care plan stated the following: ". . .Potential for impaired skin integrity . . . Heelbo sleeves bilateral when in bed . . ." A revision on 08/02/11 stated, ". . . Right Heelbo sleeve when in bed . . . Left Prevalon boot on in bed . . ." Review of Resident #4's "Weekly Wound Assessment" and "Daily Dressing Assessment" forms revealed the following: *07/20/11: "Polymen adhesive dressing to left lateral foot - red area 1.6 cm [centimeter] length x [by] 1.4 cm width. Red raised area. . . ." *07/28/11: "Has 0.3 cm x 0.3 cm wound left	F 314	placed in the resident's room to cue staff to apply pressure relieving device. 2. All residents having pressure ulcers have potential to be affected. 3. Educated staff at staff meetings August 31st, and September 6th to apply all pressure devices as directed and document on checklist. The information is on C.N.A. daily plan of care. Instructed staff on a cue being developed in the form of a boot picture that will be placed in resident's room needing devices. Instructed staff on importance of timely documentation. In addition to regularly held Unit skin meetings the QA multidisciplinary meetings will be increased to three times a week. Skin issues will be reviewed by the team for any additional preventive measures. Minutes will be taken and posted on the Units. 4. Corrected September 13th.	

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F 314	Continued From page 23 lateral foot. Wound bed yellow [with] 1.6 cm length x 1.4 cm width red area raised. Small amt. [amount] purulent drainage. Cleansed [with] saline [and] Polymen-Tegaderm dressing applied. Dietary slip sent to notify [and] [physician name] notified. . . . Stage II . . ." *08/01/11: "Wound cares left lateral foot. Scant amt. of serous drg [drainage] on dressing. . . . Wound bed yellow surrounded by 1.6 cm length x 1.4 cm width red raised area. . . . Prevalon boot on left foot in bed. Erythema surrounding open area is deep pink - less red than last week. . . ." The above nurses' note conflicts with the order for the Prevalon boot, which OT staff did not order until the morning of 08/02/11. The following observations show staff failed to ensure Resident #4 wore bilateral heelbo sleeves (prior to 08/02/11) or a Prevalon boot to the left heel while in bed (on 08/02/11 and 08/03/11) and also failed to provide pressure relief to the resident's feet/heels: *08/01/11 at 11:25 a.m. and 3:17 p.m.: In bed with feet/heels resting directly on the mattress, a heelbo sleeve on the right foot, and a sock on the left foot. Observation showed a Prevalon boot in the resident's recliner. *08/02/11 at 8:50 a.m.: In bed with feet/heels resting directly on the mattress, a heelbo sleeve on the right foot, and a sock on the left foot. Observation showed a Prevalon boot in the resident's recliner. *08/02/11 at 10:13 a.m.: Facility staff assisted the resident to lie down and applied a heelbo sleeve to her right foot. Staff failed to apply the heelbo sleeve or Prevalon boot to the left foot, and observation showed the resident's feet/heels rested directly on the mattress.	F 314	5. QI monitor to assess pressure relieving devices used as directed and documentation timely on resident #4 and #7 along with all residents with pressure relieving devices monthly times three then re-evaluated at quarterly QI. DON responsible.	9-13-11

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	355037	A. BUILDING _____ B. WING _____	08/04/2011

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F 314	Continued From page 24 *08/02/11 at 1:35 p.m.: In bed with feet/heels resting directly on the mattress and a Prevalon boot in the resident's recliner. *08/03/11: Throughout the morning, observation showed the resident in bed with heelbo sleeves to both feet, both heels/feet resting directly on the mattress, and a Prevalon boot in the resident's recliner. On 08/03/11 at 4:00 p.m., observation showed a small, padded dressing to Resident #4's left lateral foot directly anterior to the heel. A nursing staff member (#19) stated the resident has a "bony prominence" in that location. During an interview on the morning of 08/04/11, an administrative nursing staff member (#7) stated she did not feel it was necessary to float Resident #4's heels/feet because "She has a special mattress." During an interview on 08/04/11 at 1:30 p.m., a supervisory nursing staff member (#20) stated she delayed implementing the Prevalon boot because the resident has a "history of kicking them off in bed." Failure to off-load an area of compromised skin integrity and implement pressure ulcer interventions according to provider's orders resulted in the deterioration of a facility-acquired pressure ulcer. - Observation on 08/01/11 at 4:25 p.m., showed Resident #7 lying in bed positioned on her right side. Two certified nursing assistants (CNAs) (#22 and #23) assisted the resident to get out of bed. When the CNAs removed Resident #7's bed	F 314		

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F 314	Continued From page 25 covers, observation showed no pressuring relieving boots on the resident's feet. Observation on 08/02/11 at 1:30 p.m. showed Resident #7 lying in bed positioned on her left side. Observation showed two Prevalon boots located in a corner in front of Resident #7's closet door. Observation on 08/02/11 at 4:15 p.m., showed Resident #7 lying in bed positioned on her right side. Two CNAs (#22 and #25) assisted the resident to get out of bed. Observation showed two Prevalon boots remained located in the corner next to Resident #7's closet door. A CNA (#22) stated Resident #7 ". . . should have had them [referring to the Prevalon boots] on while she was in bed." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included right cerebral vascular accident (CVA) with left hemiplegia, insulin dependent diabetes mellitus (IDDM), coronary artery disease, chronic renal failure, congestive heart failure, peripheral vascular disease (PVD) and a history of pressure ulcers to the heels, left ankle, coccyx. The resident's current Minimum Data Set (MDS), dated 06/13/11, identified the resident with moderate cognitive impairment, requires extensive assistance of two persons for bed mobility, and requires total assistance of two persons for transfers, dressing, eating, toileting, and personal hygiene. Current physician orders for treatment modalities to promote pressure relief included a Roho cushion placed to the seat of her Horizon chair,	F 314		

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F 314	Continued From page 26 Accu Max Mattress to bed, and bilateral Prevalon boots on "when in bed - every shift." Resident #7's current care plan stated the following: ". . . Potential for impaired skin integrity R/T [related to] impaired mobility, bowel and bladder incontinence, PVD, Db [diabetes] . . . ." A revision on 05/10/11 identified an approach of "Prevalon boots on in bed." Failure of facility staff to place the Prevalon Boots to Resident #7's heels when she is in bed and failure to consistently off-load Resident #7's heels places her at risk for development of recurrent pressure ulcers to her heels and left ankle.	F 314		
F 323 SS=E	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: Based on record review and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #5) who experienced a fall which required emergency medical assessment. Failure to implement Resident #5's positioning device (a torso support) resulted in Resident #5 falling from her wheelchair; receiving minimal injuries with the	F 323		

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F 323	Continued From page 27 potential for more than minimal harm. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, osteoporosis, and dementia. Resident #5's Minimum Data Set (MDS), dated 04/12/11, identified a Brief Interview for Mental Status (BIMS) score of 14 (indicating cognitively intact), usually makes self understood and understands others, extensive assistance from one person for transfers, did not walk in room or corridor, and functional range of motion impairment to bilateral lower extremities. An occupational therapy (OT) progress note, dated 10/13/08, stated the following: ". . . Pt. [patient] seen this date w/c [wheelchair] positioning consult. . . . OT to trial . . . chest harness to [increase] upright positioning. . . ." A note, dated 11/03/08, stated, ". . . Have been trialing [with] chest harness or torso support to [decrease] trunk [flexion] when up in w/c. Positioning much improved [with] torso support . . ." A nurses' note dated 04/02/11 stated the following: "10:30 [a.m.] . . . Found resident on the floor lying on the left side - pt awake [and] answers appropriately. . . . Abrasion [and] bruise noted to [left] temple area just above eye - glasses are twisted. Bruises noted to [left] hand on the 2nd, 3rd, [and] 4th fingers. . . . States 'head hurts a little' . . . [11:30 a.m.] To ER via w/c. . . . [12:00 p.m.] Resident returns from ER - No new orders . . ."	F 323	1. Use of resident #5 torso support clarified in the Care Plan. Care Plan reviewed along with the citation at staff meetings on August 31st, and September 6th and minutes posted. 2. All residents wearing torso supports have potential to be affected. 3. Education done at the staff meetings on August 31st, September 6th on torso supports and the need to follow the Care Plan. In addition to regularly held fall meetings that are done to address falls, will increase QA meetings that include all disciplines to three times a week. Falls will be reviewed by the team for any additional preventive measures. Minutes will be taken and posted on Units. 4. Corrected by September 13th. 5. QI monitor will be placed to monitor proper use of torso support devices and any falls involving residents with torso	

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F 323	Continued From page 28 A form in Resident #5's chart titled "72 Hour Fall Monitoring," dated 04/02/11, stated, ". . . Brief explanation of event: Resident was in w/c in her room - reached for something [and] fell forward out of the w/c to the floor. Landed on her [left] side. Hit her [left] forehead near her eye - twisted glasses. [left] fingers 2nd, 3rd, 4th are bruised. Bruise to [left] knee. . . . Pain: [left] forehead [and] [left] hand . . . New orders: To ER . . . Involved Persons . . . unwitness [sic] . . ." Review of "Interdisciplinary Care Plan Conference" notes, dated 01/20/11, stated the following: ". . . Requires torso support for her postural support because she leans forward. . . ." A note dated 04/08/11, stated, ". . . Fall Mtg. [meeting]: On 4-2-11 Res. [resident] had fall from w/c with minor injuries noted. Torso support not in place, staff reminded needs to be on when up in w/c [secondary to] excessive trunk [flexion]. . . ." Resident #5's physician orders and treatment administration record both prior to and after the fall stated, "Torso support for positioning on when up in w/c." Resident #5's care plan prior to and after the fall stated, "Torso support on in w/c." During an interview on the morning of 08/04/11, a supervisory nursing staff member (#7) stated staff sometimes left the torso support off while Resident #5 "did her make-up." She further stated, "She likes it [the torso support]. It makes her feel safe." Resident #5's care plan failed to include instances when it would be appropriate for staff to leave the resident unattended in her wheelchair without her torso support in place. Resident #5's medical record also lacked evidence of any assessment by staff to determine	F 323	supports, monthly times three than re-evaluated at quarterly QI. DON responsible.	9-13-11

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F 323	Continued From page 29 if Resident #5 could safely sit in her wheelchair without the support in place. Failure to provide adequate supervision and/or implement an assistive device (torso support) resulted in Resident #5 experiencing an avoidable accident with related injuries. 2. Based on observation, record review, review of product labels, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 2 of 2 units (Unit A and Unit B). This practice placed residents with memory loss and/or wandering behaviors at risk of exposure to hazardous chemicals. Findings include: On 08/02/11 at 9:10 a.m., a random observation revealed Resident #23 ambulating in the hallway on the Memory Lane Wing [Unit B]. Resident #23 took an opened pudding cup from the top of the medication cart parked in the hallway. No facility staff were present at the time. Resident #23's care plan, reviewed on 08/02/11, stated, "Problem: . . . Alteration in behavior evidenced by wandering up and down hallways. . . Objective: Resident will continue to wander throughout the unit . . ." On 08/02/11 at 3:00 p.m., observations of the environment revealed the following: * The unlocked soiled utility room on Unit A contained two spray bottles of Super HDQ Neutral One Step Germicidal Detergent and Deodorant Liquid, a spray can of Tefla Lube -	F 323		

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F 323	Continued From page 30 Lubricating Penetrant with Teflon, and spray can of WD40 in an unlocked cupboard above and to the left of the counter. Keys hung directly to the right of the cupboard. Three residents sat in the commons area directly outside the soiled utility room. * The activity area/dining room on Unit B contained a bottle of Spar Creme - Liquid Creme Cleanser in an unlocked cupboard under the sink. Seven residents sat in the activity room. On 08/03/11 at 10:30 a.m., observations of the environment revealed the following: * The chemicals listed above remained unsecured in the soiled utility room on Unit A. Keys hung directly to the right of the cupboard. Two residents sat in the commons area directly outside the soiled utility room. After viewing the unsecured chemicals, a managerial staff member (#1) stated, "That's not good. The keys are hanging right there." The product labels stated the following: * Spar Creme - Liquid Creme Cleanser: ". . . causes eye and skin irritation, may be harmful if swallowed, contains respiratory crystalline quartz which can cause cancer if inhaled. . . ." * Super HDQ Neutral One Step Germicidal Detergent and Deodorant Liquid [white cap & green liquid]: ". . . causes eye damage and severe skin irritation . . . harmful if swallowed. . . ." * Super HDQ Neutral One Step Germicidal Detergent and Deodorant Liquid [blue cap & clear liquid]: ". . . causes irreversible eye damage . . . corrosive . . . causes skin burns . . . harmful is swallowed, inhaled or absorbed through the skin. . . ."	F 323		

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F 323	Continued From page 31 * Tefla Lube - Lubricating Penetrant with Teflon: ". . . vapor harmful . . . call physician immediately. . . ." * WD40: ". . . harmful or fatal if swallowed . . . call physician immediately. . . ." During an interview on 08/03/11 at 10:30 a.m., a managerial staff member (#1) agreed there are wandering residents within the facility and the chemicals should be stored in secured locations.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 32 (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 facility policy, staff interview, and review of the facility's infection control logs from February-July 2011, facility staff failed to follow proper infection control practices for 6 of 10 sampled residents (Resident #1, #3, #6, #7, #8, #9) observed during perineal cares and failed to analyze all resident infections, implement corrective action, and maintain an accurate infection control log. Failure to follow infection control procedures related to perineal care, hand hygiene, glove usage, and disinfecting of resident care equipment has the potential for cross contamination and the spread of infection to occur to other residents, staff, and visitors. Failure to maintain an active infection control program limits the facility's ability to reduce and prevent the development and transmission of infections. Findings include: Review of the following facility policies occurred	F 441	Hazardous Chemical A keyless lock placed on the door of Unit A Soiled Utility Room and a lock placed on the cupboard under the sink in the Dining Room/Activity Room on Memory Lane. Staff instructed at staff meetings on August 31st and September 6th to keep all chemicals locked and minutes posted. Posters hung for reminders to keep chemicals locked. All residents have potential to be affected. All doors storing chemicals to be locked and staff instructed at staff meetings August 31st and September 6th and minutes posted. Posters displayed for reminders. Completed September 13th. QI monitor placed to check chemicals being locked in the Memory Lane Dining/Activity Room, Unit A Utility Room and all areas where stored, to be done weekly times four then monthly times two and re-evaluated at the quarterly QI. DON responsible.	9-13-11

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F 441	Continued From page 33 on 08/04/11. The facility policy titled "Hand Hygiene," dated 05/12/10, 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 contact (for which hand hygiene is indicated by acceptable professional practice.) . . . 5. Before and after assisting a resident with personal care (e.g. [such as] oral care, bathing). . . . 9. Upon and after coming in contact with a resident's intact skin (e.g. when taking a pulse or blood pressure and lifting a resident). . . . 11. After contact with a resident's mucous membranes and body fluids or excretions. . . . 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. . . ." The facility policy titled "Perineal Care," dated 09/19/08, stated, "Policy: To cleanse the perineum, prevent infection and odors. Procedure: *Wash hands before contact with client. . . . *Put on gloves . . . *Washes entire perineal area with disposable wipe, moving from front to back. *Turns client on side *Removes wet incontinent pad or protective linen. *Cleanse the buttocks and peri-anal area without contaminating perineal area . . . Remove soiled gloves at this time. . . . *If ointments or scheduled sprays or medications are needed, place clean glove on and apply as directed. *Remove glove after application *Use of hand gel or washing of hands after each glove removal after resident is in a safe position with privacy secured . . . *Disposes	F 441	Infection Control Program: 1. Residents #1, #3, #6, #7, #8, #9: staff meetings held on August 31st, and September 6th and minutes posted. Review of hand hygiene and peri-care in relation to these residents and citation reviewed with staff. Policy developed for use of CAVI wipe to clean any shared razor. Instructions on whirlpool sanitizing reviewed to follow manufacturer's specifications and let solution remain on surfaces as directed for 10 minutes. Infection Control logs revised along with a policy on its use. It will include all infections, signs and symptoms of infections, all organism information identified from culture reports (this would include no growth), infections that are not treated with antibiotics and eye infections. A color designated graph has also been developed to cue staff on different infections on the unit and their	

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F 441	Continued From page 34 of linen and incontinent pad in proper containers . . . Washes hands." Observations of facility staff failing to follow proper infection control practices during the performance of perineal care include: - On 08/02/11 at 8:40 a.m., observation showed a certified nursing assistant (CNA) (#26) donned gloves to complete frontal perineal cares while Resident #7 was positioned on her back. The CNA (#26) wiped from the front to back down Resident #7's labia, rotated the washcloth, and wiped from the anus to the vagina using a single motion. - On 08/02/11 at 1:45 p.m., observation showed a CNA (#8) assisted Resident #9 into the bathroom. The CNA donned gloves, pulled down the resident's pants and pad, and assisted her to sit on the toilet. Observation showed the brief as dry. After the resident voided, the CNA (#8) assisted the resident to stand and provided pericares using a pre-soaked wipe. The CNA cleansed the resident's perineum from the pubis to the rectum three times without turning the wipe to a clean area. The CNA (#8) failed to use a different area of the cleansing wipe or to obtain a fresh wipe when cleansing the resident's perineum. The CNA applied a barrier cream to the resident's coccyx, adjusted the resident's clothing, removed her gloves, and assisted the resident to bed. The CNA (#8) lifted the resident's legs, removed her shoes, rolled the resident onto her left side, placed a pillow behind her, covered her with a blanket, and raised the head of her bed. The CNA then straightened up the resident's room. The CNA failed to wash her hands after removing her gloves and assuring the resident's safety.	F 441	location. 2. All residents have the potential for being affected. 3. Staff meetings August 31st, and September 6th held and education given on hand hygiene and peri-care. Reminded staff to perform as instructed, perform hand hygiene after removing gloves, when leaving the room, and having resident wash hands after toileting. Handouts were given. Policy on cleaning shared razors reviewed and posted. Laminated MEMO on need to leave disinfectant solution on surface for 10 minutes presented and posted. Infection Control nurse presented. Policy on the Infection Control Log has been developed along with a color designated graph to cue staff on infections and locations of infections occurring on the Units. A QI/Staff Development Nurse position has been implemented for 16 hours a week to monitor compliance. This will include	

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	355037	A. BUILDING _____ B. WING _____	08/04/2011

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

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F 441	Continued From page 35 During an interview on the afternoon of 08/04/11, an administrative staff member (#7) agreed facility staff should use separate quarters of the cleansing wipe each time when completing perineal cares. - On 08/02/11 at 1:45 p.m., observation showed a CNA (#29) donned gloves, transferred Resident #6 from his wheelchair to the toilet, lowered the resident's pants and incontinent product, and assisted the resident to sit on the toilet. Resident #6 used his right hand to position his penis in the toilet and voided. The CNA (#29) assisted the resident to stand and raised his incontinent product and pants. The CNA (#29) failed to prompt Resident #6 to wash his hands after the resident touched his penis during toileting. Observations of facility staff failing to perform hand hygiene include: - On 08/01/11 at 3:05 p.m., observation showed two CNAs (#16 and #17) provided pericares to Resident #8 after she toileted. The CNA (#17) assisted Resident #8 with a transfer from the bathroom to her bed. The CNA then moved the resident's walker, covered the resident with a blanket, offered her water, and left her room. The CNA failed to perform hand hygiene prior to leaving the resident's room. - On 08/01/11 at 3:10 p.m., observation showed a CNA (#16) assisted Resident #9 with a transfer from her wheelchair to her bed. The CNA then lifted the resident's legs, removed her shoes, covered her with a blanket, removed her glasses, and left her room. The CNA failed to perform hand hygiene prior to leaving the resident's room.	F 441	direct observation/surveillance of staff performing perineal cares, hand washing and/or placement of urinary catheters. 4. Completed September 13th. 5. QI monitor place for all residents needing assistance with toileting and peri-care for proper peri-care and proper hand washing monthly. QI monitor on staff hand washing compliance done monthly. QI of proper whirlpool cleaning done monthly. Review of results at quarterly QI. Infection Control nurse responsible.	9-13-11

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F 441	Continued From page 36 - On 08/01/11 at 4:16 p.m., observation showed two CNAs (#4 and #5) checked and changed Resident #3 incontinent product. One CNA (#4) removed the brief, soiled with urine and stool, and provided pericares. This CNA removed her gloves, placed a new brief and pulled the resident's pants up. The CNA failed to wash her hands before putting on Resident #4's shoes, assisting him to transfer, assisting him to clean his hands with a wet wipe, handing him a glass of water, and buckling the wheelchair seatbelt. - On 08/02/11 at 8:40 a.m., after completing perineal cares for Resident #7, observation showed a CNA (#26) needed assistance to reposition Resident #7 on her back. The CNA removed her gloves, took out her walkie talkie, and summoned another CNA to the room. The CNA (#26) failed to perform hand hygiene prior to using the walkie talkie. A second CNA (#27) arrived and the CNAs (#26 and #27) washed their hands, donned gloves, and positioned Resident #7 on her side. The CNAs needed another towel and washcloth and one CNA (#27) removed her gloves and left the room to obtain these additional supplies. Observation showed this CNA (#27) failed to perform hand hygiene prior to exiting the room. Upon completion of the above cares and with the same gloved hands, the CNA (#26) touched Resident #7's bed control, removed the garbage liner, and gathered the dirty linen. The CNA (#26) exited Resident #7's room with the dirty linen and garbage, placed these items in the receptacle bins located in the hallway, and removed her	F 441		

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F 441	Continued From page 37 gloves. While in the hallway, another resident could be heard asking for assistance to use the bathroom. The CNA (#26) entered this resident's room and observation showed she failed to perform hand hygiene upon removal of her gloves and prior to entering the second resident's room. - On 08/02/11 at 9:00 a.m., observation showed a CNA (#17) assisted Resident #8 into the bathroom. After the resident voided, the CNA cued the resident to stand, donned gloves, and performed pericares. She then changed her gloves, adjusted the resident's clothing, cued the resident to wash her hands, and assisted her to bed. The CNA (#17) removed her gloves and prepared to give the resident a bath. The CNA failed to perform hand hygiene after removing her gloves and assuring the resident's safety. - On 08/02/11 at 10:00 a.m., observation showed a CNA (#8) assisted Resident #9 into the bathroom. The CNA (#8) donned gloves, pulled down the resident's pants and pad, and assisted her to sit on the toilet. After the resident voided, the CNA (#8) assisted her to stand and provided pericares. She then applied a barrier cream to her reddened buttocks, adjusted her clothing, removed her gloves, and assisted the resident into her recliner. The CNA (#8) then straightened up the resident's room. The CNA failed to perform hand hygiene after removing her gloves and assuring the resident's safety. - On 08/02/11 at 9:32 a.m., observation showed two CNAs (#2 and #3) bathed Resident #1 in bed, starting with the lower half of her body. One CNA (#2) removed the resident's saturated brief and performed pericares. Both CNAs removed their	F 441		

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F 441	Continued From page 38	F 441		

gloves, placed a new brief, socks, pants, and shoes on the resident. The CNAs donned new gloves, continued to bathe Resident #1's upper body, and finished dressing her. The CNAs removed their gloves, assisted the resident to transfer from the bed to the wheelchair. One CNA (#2) handed the resident a wet cloth for her face, cleaned and handed the resident her glasses, and placed a personal alarm on the resident. The CNA (#2) failed to complete hand hygiene after completing pericares, after removing gloves, and before leaving the room.

- On 08/02/11 at 10:22 a.m., observation showed two CNAs (#2 and #3) bathed Resident #3. One CNA (#2) removed the resident's saturated brief and provided pericares. The CNAs removed their gloves and placed a new brief and pants on the resident. The CNA (#2) failed to perform hand hygiene before putting a gaitbelt on Resident #3, assisting him to transfer, putting his shirt on, shaving him, and securing his wheelchair seatbelt.

- On 08/02/11 at 4:08 p.m., observation showed a CNA (#4) assisted Resident #1 onto the toilet. The CNA donned gloves, removed the wet brief, placed a new brief, assisted the resident to stand after she voided in the toilet, provided pericares, removed her gloves, pulled up the brief and pants, assisted the resident to wash her hands at the sink, to walk to the wheelchair, and to sit down. The CNA failed to perform hand hygiene before combing the resident's hair or placing foot pedals on the wheelchair.

Failure to perform hand hygiene after completing pericares and before performing other tasks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 39	F 441		

placed these residents at risk of the transmission of infection from staff touching and contaminating objects in the room or on the residents. Failure to perform hand hygiene before leaving the resident's room has the potential for the staff to contaminate objects throughout the facility possibly contributing to infections in other residents, staff, and visitors.

Observations of facility staff failing to follow proper infection control practices related to disinfecting resident care equipment include:
- On 08/02/11 at 10:46 p.m., observation showed a CNA (#2) shaved Resident #3. The CNA removed the razor from the resident's room and placed it in a drawer in the dining room. The CNA stated the razor is used on residents who do not have their own. When questioned regarding the cleaning technique for the razor, the CNA retrieved an alcohol prep pad and cleaned the razor's head. The CNA (#2) stated staff clean the razor between each use with peroxide or rubbing alcohol when "we feel it needs it," or when it is dirty, and clean the inside with the brush and an alcohol wipe. Another CNA (#6) stated she had never cleaned the razor and had not been shown how.

During an interview on 08/03/11 at 9:25 a.m., when asked regarding the sanitation of razors, the CNA (#18) stated, "Most [residents] have a shaver in their room . . . We also have universal shavers in the shower rooms. Anybody can use these, as long as they use the alcohol wipes. We use gloves and the wipe, so nothing gets carried over to the next resident."

During an interview on 08/04/11 at 9:15 a.m., an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 40 administrative nurse (#7) stated the razor head should be cleaned with a Cavi-wipe (a type of disinfecting wipe), not an alcohol pad. This nurse also stated staff should wash their hands after all cares are done. Failure to ensure staff knew the correct procedure to clean the razor placed all residents without their own razor at risk for infection when shaved with a possible contaminated razor. - The Disinfecting SILCRAFT tubs with the Closed Loop System "how to sheet" stated the following: * ". . . You may now use the wand to spray the interior of the tub - including whirlpool jets, overflow fitting and whirlpool inlet fitting - with disinfectant. . . . Allow disinfectant to remain in the loop for 10 minutes. . . ." During an interview on 08/03/11 at 9:25 a.m., when asked questions regarding the sanitation of the showers/tubs, a CNA (#18) stated, "I spray the cleaner [Super HDQ Neutral One Step Germicidal Detergent and Deodorant Liquid]. There is solution in the door of the whirlpool. You turn a switch and fill it with water. It says 5 minutes at least, if not longer. I read the sheet each time." During the same interview, when asked questions regarding bathing residents with infections such methicillin resistant staphylococcal aureus (MRSA) or vancomycin resistant enterococcus (VRE), the CNA (#18) stated, "If they [the infected residents] like their bath or shower later, we try to do it later. We had one lady, she liked to get it over with early. We did her early. We bleached	F 441		

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F 441	Continued From page 41 everything really good . . . we put an extra couple [questionable amount of chemical product] in between. Seemed to be okay. I mean it didn't carry over to any other residents." The product label stated the following: * Super HDQ Neutral One Step Germicidal Detergent and Deodorant Liquid [white cap & green liquid]: ". . . Let solution remain on surface for a minimum of 10 minutes. . . ." Failure to sanitize the facility's showers/tubs following manufacturer's specifications increased the potential for transmission of resident infections to occur. - Review of the facility's February-July 2011 Infection Control Logs, occurred on August 02-04, 2011. Information listed on each monthly log included the date of the infection, resident name and room number, signs and symptoms, culture site, organism, appropriate antibiotic, general description of the infection, and whether the implementation of infection control precautions occurred. Review of the infection control logs showed the information listed under the column titled "signs and symptoms" had captured the type of infection, but failed to identify the signs and symptoms of individual resident infections. The facility's infection control logs failed to identify/list an organism when the provider ordered a culture as follows: *February 2011 - obtained eight urine cultures and one sputum culture and identified organisms for two of the eight cultures. *March 2011 - obtained 11 urine cultures, one strep screen, one left groin culture, and one stool	F 441		

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F 441	Continued From page 42 culture; and identified organisms for eight of the cultures. *April 2011 - obtained six urine cultures, one sputum culture, and one stool culture; and identified organisms for five of the eight cultures. *May 2011 - obtained seven urine culture and failed to identify/list an organism for the any of the cultures obtained. *June 2011 - obtained 11 urine cultures, one strep screen, one stool culture, and one left groin culture; and identified organisms for five of the 14 cultures. At the time of the survey, the facility had not compiled the data for their July 2011 Infection Control Log. Review of the facility's infection control worksheets used to enter the data on the log, identified four resident infections for July. During interview on 08/03/11 at 8:15 a.m., the facility's infection control nurse (#30) stated the Infection Control Log only lists those residents who are treated with antibiotics and/or those with a culture and sensitivity laboratory test. This nurse stated if a resident exhibits signs/ symptoms of an infection, such as the gastrointestinal influenza, they probably will not show up on the log due to lack of treatment with antibiotics. This nurse confirmed the Infection Control Log failed to identify specific organisms. - Resident #1's medical diagnosis included urethral stenosis with placement of a urinary catheter, and a history of urinary tract infections (UTIs). Resident #1's physician treated her for five UTIs from February-June 2011. The facility's Infection Control Logs failed to include the UTI the resident experienced in April.	F 441		

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F 441	Continued From page 43 During interview on 08/03/11 at 8:15 a.m., the facility's infection control nurse (#30) stated her unawareness of Resident #1 monthly UTIs and stated she did not conduct an analysis of potential contributing factors nor direct observation/surveillance of staff performing perineal cares and/or placement of urinary catheters to ensure all staff adhere to infection control principles. - Resident #8's medical record showed the physician treated the resident for a UTI with Amoxicillin (an oral antibiotic) on 03/31/11, with Cephalexin (an oral antibiotic) on 05/10/11, and with Bactrim (an oral antibiotic) on 07/11/11. The organism Escherichia coli (E. coli) was identified on each of these urine cultures obtained for the above three infections. Review of the March, May, and July 2011 infection control data failed to identify these infections. - Resident #6's medical record showed the physician treated the resident for an eye infection with Gentamycin eye drops (an antibiotic) on 06/02/11. Review of the June 2011 Infection Control Log failed to identify Resident #6's eye infection. - Resident #12's medical record showed the physician treated the resident for an eye infection with Gentamycin eye drops on 07/11/11. Review of the facility's July infection control worksheets failed to include information pertaining to this infection. - Resident #13's medical record showed the physician ordered a urine culture on 07/05/11.	F 441		

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F 441	Continued From page 44 Review of the facility's July infection control worksheets failed to include information pertaining to this infection. Failure to collect and analyze all resident infections, perform process surveillance of proper hand hygiene, glove usage, and perineal cares, and implement corrective actions based on the analysis of the data, limits the facility's ability to reduce and prevent the development and transmission of infections.	F 441		