STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 10/19/15 and completed on 10/22/15, the sample included five (5) residents for complete review, 12 residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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 complete a Significant Change in Status Assessment (SCSA) within 14 days of the resident's discharge from Hospice services for 1 of 3 sampled residents (Resident #1) receiving Hospice services. Failure	F 274	1. For Resident #1, MDS coordinator for that neighborhood was educated to complete significant change status assessments (SCSA) upon initiation or revocation of hospice benefits, 10/19/15. The missed SCSA when hospice was discontinued caused no adverse outcome for the resident. The hospice benefit was	11/26/15

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

Electronically Signed | 11/13/2015

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F 274	Continued From page 1 to complete a SCSA limited the facility's ability to accurately assess the resident's status and identify potential care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-21 and 2-22 stated, "A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [assessment reference date] must be within 14 days from one of the following: 1) the effective date of the hospice election revocation . . ." Resident #1's medical record, reviewed on all days of survey, identified a Hospice progress note, dated 04/14/15 at 12:16 p.m.: "Pt [patient] was discharged from Hospice today and nurse [name] on Acorn Lane and [name] RN [registered nurse] nurse manager were notified of this. . . ." Review of the resident's Minimum Data Sets (MDSs) failed to identify a SCSA completed within 14 days of the resident's discharge from Hospice. During an interview on 10/20/15 at 4:20 p.m., an MDS coordinator (#5) confirmed a SCSA was not completed within 14 days of the resident's discharge from Hospice services on 04/14/15.	F 274	again initiated 43 days after being discontinued and a new SCSA was completed at that time. 2. Any resident electing to initiate or revoke hospice benefits has the potential to be affected. 3. All MDS coordinators have been re-educated on the required completion of an SCSA upon initiation or revocation of hospice benefits (Chapter 2 in the RAI Manual). 4. A QA tool has been developed and will be completed by assigned licensed staff monthly x 3 months and quarterly thereafter (tool attached). The QAPI manager will review the findings and report to the QAPI committee for review and potential further action.	
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		11/26/15

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F 278	Continued From page 2 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 the Minimum Data Set (MDS) accurately reflected the resident's status for 6 of 17 sampled residents (Resident #2, #4, #5, #6, #11, and #12) coded for constipation. Failure to code the MDS correctly does not provide an accurate	F 278	1. For identified residents #2,4,5,6,11, and 12, the MDS coordinators were instructed to code constipation according to the definition in the RAI manual on 10/20/15. They will also complete a modification of the most recent MDSs incorrectly coded for constipation for above listed residents.	

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F 278	Continued From page 3 assessment of the resident's current status and needs. Findings include: The Long-Term Facility RAI Manual, revised October 2015, page H-12, stated, ". . . CONSTIPATION: If the resident has two or fewer bowel movements during the 7-day look-back [assessment] period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements)." Review of Resident #2, #4, #5, #6, #11, and #12's medical record occurred on October 19-22, 2015. The facility coded the residents for constipation on the following comprehensive MDSs even though the bowel records indicated more than two bowel movements during the 7-day assessment period: * Resident #2 - Annual MDS, dated 04/02/15 * Resident #4 - Annual MDS, dated 01/21/15 * Resident #5 - Annual MDS, dated 10/12/14 * Resident #6 - Admission MDS, dated 07/23/15 and the Significant change MDS, dated 08/29/15 * Resident #11 - Admission MDS, dated 01/09/15 * Resident #12 - Annual MDS, dated 06/15/15 During an interview on 10/22/15 at 10:45 a.m., an administrative nurse (#6) confirmed the MDSs for Resident #2, #4, #5, #6, #11, and #12 were coded incorrectly.	F 278	2. All residents have the potential to be affected. 3. All MDS coordinators have been re-educated on the definition of, and proper coding of, constipation. (Section H of the MDS, and Chapter 3 of the RAI manual.) See also #1 above. 4. A QA tool has been developed and will be completed by assigned licensed staff weekly x one month, monthly x three months, and quarterly thereafter. The QAPI manager will review the findings and report to the QAPI committee for review and potential further action.	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		11/26/15

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F 281	Continued From page 4 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference and facility policy, and staff interview, the facility failed to ensure administration of insulin occurred within the recommended timeframe for 1 of 2 observations of insulin administration (Resident #21). Failure to administer short acting insulin at the correct time (no more than 15 minutes prior to the resident eating) may result in low blood sugar levels (hypoglycemia). Findings include: Review of the facility policy and procedure "Medication Administration" occurred on 10/22/15. The policy, dated November 2014, stated, " . . .E. The individual Primary Care Nurse assumes the responsibility for his/her own safe practice in administering medication and oversees the CMA [Certified Medication Assistant]. 1. Such responsibility involves: a. Observing the '5 Rights of Medication Administration': 1. Right Resident 2. Right Medication 3. Right Dose 4. Right Route 5. Right Time . . ." Wolters, Kluwer, Nursing 2015 Drug Handbook, Philadelphia, Pennsylvania, page 756-757 stated, "Humulin R [regular] . . . ADMINISTRATION . . . give within 15 minutes before a meal to prevent a hypoglycemic reaction. . . ."	F 281	1. The neighborhood nurse was reminded to give fast acting insulin no more than fifteen minutes prior to eating on 11/23/15. 2. Any resident receiving short-acting insulin has the potential to be affected. 3. All licensed nursing staff will be re-educated at 11/19/15 nurses meeting regarding timing of short-acting insulin administration. 4. A QA tool has been developed and will be completed by assigned staff weekly x one month, monthly x three months, and quarterly thereafter. The QAPI manager will review the findings and report to the QAPI committee for review and potential further action.	

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F 281	Continued From page 5 Observation on 10/20/15 at 7:58 a.m. showed a licensed nurse (#19) administered Levemir (a long-acting insulin) 15 units subcutaneously (SQ) in the left upper abdomen and Humulin R (a short-acting insulin) 5 units SQ in the left upper arm to Resident #21 in her room. Observation showed the resident remained in her room until 8:45 a.m. when an unidentified staff member assisted her to ambulate to the dining room. Observation showed a staff member (#20) served the resident breakfast at 8:58 a.m.(one hour after receiving her insulin). During an interview on 10/20/15 at 4:20 p.m. two administrative nurses (#5 and #16) confirmed Resident #21's should have received her insulin closer to the time she received her meal.	F 281		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of standing orders, review of facility policy, and staff interview, the facility failed to follow the bowel protocol for 2 of 7 sampled residents (Resident #8 and #11) identified with constipation. Failure to follow the facility bowel protocol to relieve constipation does not ensure regular bowel	F 309	1. Evening neighborhood nurses were re-educated on 10/20/15 and 10/21/15 to follow AMV bowel protocol and offer Milk of Magnesia (MoM)to any resident with no bowel movement for two days. 2. All residents have the potential to be	11/26/15

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F 309	Continued From page 6 evacuation and may cause the resident unnecessary discomfort. Findings include: Review of the facility "Standing Orders 2015" occurred on 10/21/15. The standing orders stated, ". . . 3. Bowel Management a. MOM [Milk of Magnesia] 30ml [milliliter] (po) [by mouth] PRN [as needed] X [times] 30 days . . . b. Biscolax Suppository (pr) [per rectum] PRN X 30 days. . . ." Review of the facility policy titled "Bowel Protocol" occurred on 10/21/15. This policy, dated October 2014, stated, ". . . 5. For Residents prone to hard stools or constipation problems the following guidelines apply: d. . . . Milk of Magnesia will be given on the evening of the second day without a bowel movement. . . . e. If the Milk of Magnesia is unsuccessful, the day nurse will insert a suppository rectally on the third day. . . ." - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included constipation. The quarterly Minimum Data Set (MDS), dated 10/02/15, indicated severely impaired cognitive skills, extensive assistance of one staff for toileting, and frequently incontinent of bowel. The care plan failed to address constipation. Physicians orders included Standing orders, Biscolax Suppository as needed for constipation, and Senna-Docusate (stool softener/laxative) 8.6-50 mg [milligrams] two times a day for constipation. Review of Resident #11 MARs (Medication	F 309	affected at some point. 3. All licensed nursing staff will be re-educated on facility bowel protocol at the 11/19/15 nurses meeting. 4. A QA tool has been developed and will be completed by assigned licensed staff. A representative sample (10%) will be monitored using the tool, weekly x one month, monthly x three months, and quarterly thereafter. The QAPI manager will review the findings and report to the QAPI committee for review and potential further action.	

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F 309	Continued From page 7 Administration Record) for August, September and October 1-21 2015, identified the resident received a Biscolax Suppository nine times without first attempting a less invasive medication such as MOM. During an interview on 10/21/15 at 4:26 p.m. a nurse manager (#5) confirmed she expected staff to administer MOM before a suppository as per facility policy. - Review of #8's medical record occurred on all days of survey. The significant change MDS, dated 03/02/15, identified extensive assist of two or more persons for toileting, and constipation present. Physicians orders included Miralax (a laxative) power 17 grams one time per day and Senna-Ducosate 8.6-50 mg one tablet two times a day as needed for constipation. Review of the bowel record during the seven day look back period showed Resident #8 without a bowel movement between the dates of 2/24/15-03/01/15. The MAR showed on 02/28/15, Senna-Ducosate 8.6-50 mg given for constipation. The facility failed to follow the bowel protocol resulting in Resident #8's lack of a bowel movement for five days.	F 309		
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.	F 323		11/26/15

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and assistance to prevent accidents for 1 of 14 sampled residents (Resident #8) identified with a fall. Failure to implement measures to prevent falls may result in avoidable falls and/or injury. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses include hereditary and idiopathic (unknown origin) neuropathy, and chronic low back pain. A quarterly MDS, dated 08/23/15, identified the resident as requiring extensive assist of two or more persons for transfer, and functional limitation in range of motion to the lower extremities on one side. Resident #8's current care plan stated, "At risk for falls r/t [related to] hx [history] of falls with major injury. . . Per family request, unplug recliner while resident is in it. Date initiated: 06/24/15 . . ." A progress note dated 10/18/15 at 16:23 stated, "Type: AMV [Ave Maria Village] fall . . . Description of Incident: res found on floor in front of recliner chair . . . educated staff to unplug recliner chair when res is in it. . . ." Observation on 10/20/15 at 11:07 a.m. showed Resident #8 asleep in the recliner chair, leaning	F 323	1. Dakota Lane staff were reminded on 10/20/15 and 10/21/15 to unplug recliner when resident #8 is sitting in it. 2. Any resident that has been identified as needing their lift chair unplugged as a safety measure has the potential to be affected. 3. All staff will be re-educated on following resident individual interventions on routine care sheets and care plans which have been implemented as a safety measure. This was done at the CNA meeting on 10/30/15, and at neighborhood meetings held for Acorn Lane on 11/2/15 and Bison Lane 11/9/15. It will also be covered at the Cottonwood Lane meeting on 11/16/15 and Dakota Lane meeting on 11/23/15, and again at CNA meeting on 11/25/15. 4. Any resident identified as needing their lift chair unplugged for safety reasons as identified on the care plan and routine care sheet will be monitored weekly x four weeks, monthly x three, and quarterly thereafter. The QAPI manager will review the findings and report to the QAPI committee for review and potential further action.	

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F 323	Continued From page 9 to the right with right arm hanging over the arm rest, and the recliner chair plugged in.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to monitor and assess for adequate indications for use of medications for 1 of 15 sampled residents (Resident #3) receiving psychoactive medications. Providing	F 329	1. Regarding Resident #3, a gradual dose reduction was ordered by the primary care physician on 11/10/15. 2. Any resident using psychotropic	11/26/15

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F 329	Continued From page 10 psychoactive medications without appropriate monitoring, and assessing for adequate indications for their continued use resulted in the resident receiving unnecessary medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For psychopharmacological medications (other than antipsychotics and sedatives/hypnotics), a tapering of the medication should be attempted annually, unless clinically contraindicated. For antipsychotics, a GDR must be attempted annually, unless clinically contraindicated. For sedatives/hypnotics, a GDR should be attempted quarterly unless clinically contraindicated. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety disorder. Review of Resident #3's current physician's orders identified Alprazolam (an antianxiety medication) 0.5 mg at bedtime and 0.5 mg twice a day PRN for anxiety.	F 329	medications has the potential to be affected. 3. For Resident #3, a gradual dose reduction was ordered by the primary care physician on 11/10/15. Facility has engaged a new consultant pharmacist who will be in attendance at monthly medication review meetings on a regular day and time. Gradual dose reductions will be discussed, with any recommendations forwarded to the attending physician for action. Facility has developed a gradual dose reduction tracking tool which will be used ongoing, and completed by licensed nursing staff. This form will help identify when gradual dose reductions are indicated, and whether the consultant pharmacist made recommendation to physician. 4. A QA tool has been developed to monitor that gradual dose reduction tracking is completed at monthly medication review meetings. This will be performed monthly on an ongoing basis.	

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F 329	Continued From page 11	F 329		

Review of the medication administration record (MAR) showed the last PRN dose of alprazolam administered was in March 2015.

Review of Resident #3's current care plan stated, "Focus: . . . uses anti-anxiety medications r/t [related to] Anxiety disorder. . . Interventions: Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness . . ."

A significant change Minimum Data Set (MDS), dated 09/21/15, identified Resident #3 cognition intact and lacked indicators of mood and behaviors during the assessment period. A Care Area Assessment (CAA) for Psychotropic Drug use, dated 09/24/15, stated, ". . . [Resident #3's name] is on an antidepressant and antianxiety medication for depression and anxiety. She had been on both medications since her first admission and has no side effects from them. Family has indicated a concern about them and think they are making her more confused. I explained it would be better for [Resident's name] to not stop these now as it could cause more confusion and agitation. Will assess them when she is doing better. . . ."

A consultant pharmacist's medication review, dated January 2014, stated, ". . . Alprazolam 0.5 mg HS [hour of sleep]. . . . Patient had been taking current dose of alprazolam since February 2013. CMS [Centers for Medicare and Medicaid Services] guidelines require at least yearly assessment of anxiolytics for continued need and trial dose reduction. SUGGESTED COURSE OF ACTION: Consider reducing alprazolam to 0.25 mg HS and monitoring patient's response. If a

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F 329	Continued From page 12 dose reduction is not appropriate at this time, please provide clinical rationale for continuing current dose. . . . FOLLOW-UP OR ACTION TAKEN . . . Recommendation is REJECTED and the basis for this is: [the following was written and signed by the physician on 02/13/14] No - needs current dose. Occasionally will use an additional alprazolam prn [as needed] for anxiety. . ." Review of Resident #3's medical record identified the resident remained on the same dose of antianxiety medication with out adequate indications/rationale for it's continued use since February 2013.	F 329		
F 386	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the licensed healthcare practitioner (A) wrote/dictated, signed, and dated a progress note upon the completion of the residents' visits/examinations for 8 of 9 sampled residents (Resident #5, #6, #7, #9, #13, #14, #15, and #19) reviewed. Failure to ensure each	F 386	1. For identified residents, the healthcare practitioner (psychiatric clinical nurse specialist) involved was contacted in person on 11/9/15 by director of nursing, and asked to provide missing notes so that they can be placed in the respective residents' permanent medical	11/26/15

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	355082	A. BUILDING _____ B. WING _____	10/22/2015

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F 386	Continued From page 13 resident's medical record contained progress notes from the licensed healthcare practitioner limited the facility's ability to ensure the provisions of care and services are communicated to all members of the interdisciplinary team and other licensed healthcare practitioners. Findings include: Review of Resident #5, #6, #7, #9, #13, #14, #15, #16, and #19's medical records occurred on October 19-22, 2015 and identified the following: - The licensed healthcare practitioner (A) examined Resident #6 on 08/13/15. The medical record failed to contain a progress note related to this visit. - During an interview on 10/22/15 at 10:45 a.m., an administrative nurse (#6) stated the licensed healthcare practitioner (A) examined Resident #7 on 10/23/14, 03/15/15, 05/21/15, 07/02/15, 07/14/15, 08/13/15, and 10/12/15. The resident's medical record only contained a progress note for the visit on 10/12/15. - During an interview on 10/22/15 at 10:45 a.m., an administrative nurse (#6) stated the licensed healthcare practitioner (A) examined Resident #14 on 05/19/15, 05/22/15, 06/18/15, 07/02/15, 08/13/15, and 08/27/15. Review of the medical record revealed the licensed healthcare practitioner (A) may have examined the resident on 06/02/15, 06/30/15, and 07/20/15 as well. The medical record only contained a progress note for the visit on 08/27/15.	F 386	record. 2. Any resident who had received services provided by said health care practitioner had the potential to be affected. 3. Health care practitioner involved has taken a new position in Fargo and will no longer be following residents at this facility. 4. Facility is searching for a new psychiatric services provider. Nurse managers will educate new provider regarding regulatory compliance guidelines dealing with timing of documentation following resident visits.	

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F 386	Continued From page 14 - Review of Resident #5's medical record identified the licensed healthcare practitioner (A) examined the resident on 06/18/15 and 08/27/15. The medical record lacked a progress note related to the above visits. - Review of Resident #13's medical record identified the licensed healthcare practitioner (A) examined the resident on 03/12/15 and adjusted Resident #11's medications. The medical record lacked a progress note related to this visit. - Review of resident #9's medical record identified the licensed healthcare practitioner (A) examined Resident #9 on 01/29/15, and 02/26/15. The medical record failed to contain a progress note related to the visits. - Review of Resident #15's medical record identified the licensed healthcare practitioner (A) examined Resident #15 on 08/13/15. The medical record failed to contain a progress note related to this visit. During an interview on 10/22/15 at 10:45 a.m., an administrative nurse (#6) stated the licensed healthcare practitioner (A) also examined Resident #15 on 08/27/15, 09/28/15, and 10/02/15. The resident's medical record only contained a progress note for the visit on 10/02/15. - Review of Resident #16's medical record identified the licensed healthcare practitioner (A) examined Resident #16 on 06/18/15. The medical record failed to identify a progress note for the visit on 06/18/15.	F 386		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		11/26/15

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F 428	Continued From page 15 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 failed to ensure the consulting pharmacist reviewed the drug regimen for 17 of 17 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17) at least monthly and recommend a gradual dose reduction (GDR) for 1 of 6 sampled resident (Resident #3) on an antianxiety medication. Failure to review the drug regimen, identify irregularities, recommend a GDR, and report the findings to the attending physician and the director of nursing in a timely manner may result in residents experiencing adverse consequences related to current medications. Findings include: Review of the facility policy titled "Pharmacy consultant" occurred on 10/22/15. This policy, dated 10/2014, stated, ". . . 5. Perform a monthly utilization review of each resident's drug regimen. . . 11. Make recommendations regarding drug	F 428	1. Consultant pharmacist did review drug regimens monthly for all identified residents. However, she failed to send recommendations to facility in a timely manner. For identified resident #3, a gradual dose reduction was ordered on 11/10/15 by the attending physician. 2. Any resident using psychotropic medications has the potential to be affected. 3. As stated, resident #3 had a gradual dose reduction completed on 11/10/15. Facility has engaged a new consultant pharmacist who will be in regular attendance at monthly medication review meetings, where gradual dose reductions will be tracked. Facility medical director will contact all attending physicians explaining regulatory compliance guidelines and the importance of detailed	

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F 428	Continued From page 16 usage according to regulatory guidelines." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety disorder. Review of Resident #3's current physician's orders identified Alprazolam (an antianxiety medication) 0.5 milligrams (mg) at bedtime. A consultant pharmacist's medication review, dated January 2014, stated, ". . . Alprazolam 0.5 mg HS [hour of sleep]. . . . Patient had been taking current dose of alprazolam since February 2013. CMS [Centers for Medicare and Medicaid Services] guidelines require at least yearly assessment of anxiolytics for continued need and trial dose reduction. SUGGESTED COURSE OF ACTION: Consider reducing alprazolam to 0.25 mg HS and monitoring patient's response. If a dose reduction is not appropriate at this time, please provide clinical rationale for continuing current dose. . . . FOLLOW-UP OR ACTION TAKEN . . . Recommendation is REJECTED and the basis for this is: [the following was written and signed by the physician on 02/13/14] No - needs current dose. Occasionally will use an additional alprazolam prn [as needed] for anxiety. . ." A review of Resident #3's drug regimen reviews failed to identified the consultant pharmacist recommended a GDR annually since the physician declined a GDR of Resident #3's alprazolam on 02/13/14. - Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17's pharmacy summary reports from January through September 2015 (nine months) occurred	F 428	rationale when responding to consultant pharmacist recommendations. 4. See plan of correction for F 329.	

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F 428	Continued From page 17 on 10/21/15. These summary reports identified the pharmacist completed the monthly reviews on the following dates: * February - Not completed until April 08, 09, and 10, 2015 * April - Not completed until June 22, 24, and 25, 2015 * May - Not completed until June, 22, 23, 26, 28, and 29, 2015 The pharmacist failed to complete the drug regimen reviews in a timely manner for six of the nine months reviewed. During an interview on the afternoon of 10/21/15, an administrative nurse (#16) stated she expected the pharmacist to complete the resident's drug regimen reviews monthly.	F 428		
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	F 441		11/26/15

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F 441	Continued From page 18 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: CONTACT PRECAUTIONS 1. Based on observation, record review, review of facility policy, review of professional reference, review of Material Safety Data Sheet (MSDS), and staff interview, the facility failed to provide a safe, sanitary environment and adhere to infection control practices for 1 of 1 sampled resident (Resident #10) with clostridium difficile (C. difficile). Failure to perform proper hand hygiene, use appropriate disinfectant, and maintain contact precautions may result in spreading the infection within the facility. Findings include:	F 441	1. (a) All Dakota Lane staff were educated on 10/20/15 and 10/21/15 to perform hand hygiene using soap and water, the correct procedure for donning and doffing personal protective equipment, and proper procedure for double bagging garbage when removing from room of any resident on isolation for C. difficile. The use of Oxivir Tb wipes has been discontinued for this application, and facility has begun using Clorox Germicidal Health Care Wipes, which are effective against C. diff. Specifically the Clorox wipes will be used in resident's room to clean in-room surfaces, and	

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F 441	Continued From page 19 Kozier & Erb's Fundamentals of Nursing, Concepts, Process, and Practice, 9th edition, Pearson Education Incorporated, New Jersey, 2012, page 694, states, " . . . Contact Precautions: . . . Wear gloves . . . Cleanse hands immediately after removing gloves. . . . If the client is infected with C. difficile, do not use an alcohol-based hand rub because it is not effective on these spores. Use soap and water. . . ." Review of the facility policy titled "Isolation-Disease/Category Precautions" occurred on 10/20/15. This policy, dated January 2015, stated, ". . . To prevent spread of infectious diseases to residents, staff and visitors. . . . 4. Wash hands before entering and when leaving room. . . . 7. Garbage bin is to have one liner in it and double bag when emptying. . . . 9. . . . b. Wear gloves when entering room and doing cares. . . . f. 1. Gown and gloves must be worn when handling isolation laundry or garbage anticipating contamination of clothing. . . ." Review of the MSDS provided by the facility for Oxivir Tb wipes, dated 2013, stated, ". . . Oxivir Tb wipes. . . effective against. . . bloodborne pathogens, gram positive bacteria, gram negative bacteria, enveloped virus, fungicidal. . . ." Oxivir Tb wipes are not effective against C. difficile spores. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included C. difficile. The current care plan stated, ". . . C. Diff [defficile] infection . . . Infection will not be spread to other residents or staff. . . Contact isolation per facility policy and procedure	F 441	bleach-based germicidal spray will be used to clean shower equipment. Resident #10's geriatric chair had armrests replaced 11/2/15. (b) Bathing assistants were educated on 10/21/15 on protocol for cleaning bathing equipment. (c) Sharps container was overfilled with used syringes, HOWEVER, no needles were attached, as syringes had been used on a PICC line, which is a needleless system. Sharps container was replaced 10/21/15. 2. All residents have the potential to be affected. 3. Dakota Lane staff were educated 10/20/15 and 10/21/15 on proper infection control procedures. All CNAs were educated at the monthly CNA meeting on 10/29/15 regarding proper infection control procedures. Oxivir Tb wipes have been replaced with Clorox Germicidal Healthcare Wipes, which are effective against C. diff. These will be used in resident's room, and a bleach-based germicidal spray will be used to clean shower equipment. Instructions will be posted in bathing areas detailing proper cleaning techniques. Facility policy revised to reflect correct procedure. Licensed nursing staff will be educated at the monthly nurses meeting on 11/19/15 on proper protocol regarding use and disposal sharps containers. 4. QA tools have been developed to	

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F 441	Continued From page 20 . . . ." - Observation on 10/20/15 at 10:19 a.m. showed two Certified Nursing Assistants (CNAs) (#7 and #8) donned gowns and gloves and entered Resident #10's room. The CNAs checked the resident's incontinence product then transferred the resident to the recliner using a Hoyer lift. One CNA (#7) wiped down the Hoyer lift with Oxivir Tb wipes after the transfer, removed her gown and gloves in the room, performed hand hygiene with alcohol based hand rub, and exited the room with the Hoyer lift. The CNA (#7) failed to perform hand hygiene using soap and water. - Observation on 10/20/15 at 2:07 p.m. showed two CNAs (#8 and #9) donned gowns and gloves and entered Resident #10's room. The CNAs provided incontinence cares (for urinary incontinence). The CNA (#9) removed the brief then removed her gloves. The other CNA (#8) used wet wipes to perform perineal cares then removed her gloves. The CNAs (#8 and #9) placed a new brief, transferred Resident #10 to her geri-chair, combed her hair, placed pillows under her feet and legs, and opened the window shades. One CNA (#8) cleaned the Hoyer lift with Oxivir Tb wipes. The other CNA (#9) transported Resident #10 to the hallway, returned to the room, sanitized her hands with alcohol based hand rub, and removed the singled lined garbage bag containing used gowns and gloves from the room. The CNAs (#8 and #9) failed to wear gloves while providing cares, disinfect the lift with a C-difficile approved agent, double bag the garbage, and wear gowns/gloves when disposing of the garbage.	F 441	monitor (a) proper hand washing protocol, (b) bathing assistants' proper sanitizing of bathing equipment, (c) proper use of sharps containers, and(d)condition of wheelchair upholstery. All QA tools will be completed by QAPI manager or designated staff. Monitoring will be weekly x one month, monthly x three months, and quarterly thereafter.	

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F 441	Continued From page 21 - Observation on 10/20/15 at 4:18 p.m. showed a CNA (#13) cleaned the Hoyer lift with Oxivir Tb wipes after using it to transfer Resident #10. The CNA failed disinfect the lift with a C. difficile approved agent. - Observation on 10/20/15 at 4:18 p.m. showed Resident #10's geri-chair with tears and cracks in the armrests of the chair. The tears and cracks exposed the padding underneath the material making it an uncleanable surface. - During an interview on 10/20/15 at 11:40 a.m., an administrative nurse (#3) stated the staff are expected to wash hands after removing gloves in a room with C. difficile, and not use hand sanitizer. At 2:41 p.m. this nurse (#3) stated staff are expected to wear a gown and gloves anytime they come into contact with items in a room with C. difficile and to wash their hands every time they leave the room. CLEANING OF BATHTUBS 2. Based on observation, review of facility policy, review of daily maintenance instructions, and staff interview, the facility failed to follow accepted infection control practices for 2 of 2 resident whirlpool bathtubs (Acorn-Bison Unit and Cottonwood-Dakota Unit). Failure to follow accepted infection control practices when disinfecting the whirlpool bathtub between residents has the potential to spread infection within the facility. Findings include: Review of the facility policy "Cleaning Whirlpool"	F 441		

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F 441	Continued From page 22	F 441		

occurred on 10/21/15. The undated policy, stated, ". . . 5. During the day between resident baths, spray the chair with disinfectant and rinse after approximately 10 minutes. . . ."

Review of the "Cascade Sit-Bath System 6900 Daily Maintenance Instructions" occurred on 10/21/15. The undated instructions stated, " . . . System Cleaning (After Every Bath) Clean and disinfect the tub after every bath . . . 6. Using the long-handed brush, . . . thoroughly scrub all interior surfaces of the tub with solution . . . Let disinfectant stay on surface for 10 minutes. . . ."

- Observation on 10/21/15 at 8:34 a.m. showed a CNA (#1) in the Cottonwood-Dakota bathing area. The CNA explained she disinfects the bathtub between residents by using the disinfecting jets. She then uses a brush to scrub the entire bathtub and rinses off the disinfectant solution after five minutes.

- Observation on 10/21/15 at 9:40 a.m. showed a CNA (#2) cleaning the whirlpool bathtub in the Acorn-Bison bathing area. The CNA (#2) pushed the disinfecting jet button, used a long handled brush to scrub the sides of the bathtub, and after approximately one minute rinsed the disinfectant solution from the bathtub.

During an interview on 10/21/15 at 2:45 p.m. a nurse manager (#3) confirmed she expects staff to leave the disinfectant solution on the tub surfaces for 10 minutes per the maintenance instructions.

DISPOSAL OF USED NEEDLES

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F 441	Continued From page 23 3. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff properly disposed of used syringes/needles in 1 of 1 sharps container specifically for disposal of syringes/needles used during blood draws (Cottonwood unit lab tray). Findings include: Review of the facility policy and procedure "Universal Precautions" occurred on 10/22/15. The policy, dated July 2014, stated, "POLICY: Ave Maria Village practices Standard (Universal) Precautions with all residents when there is potential for exposure to blood . . . 2. RESIDENT SERVICES . . . C. Puncture-proof containers marked with biohazard symbol are available for disposal of syringes, needles and disposable sharps. . . . 3. When containers are at fill level, close and carry to appropriate boxes for infectious waste disposal. . . ." Observation of the Cottonwood unit medication room occurred on 10/22/15 at 10:25 a.m. with a licensed nurse (#21) and showed a sharps container used for disposal of syringes/needles used to draw blood from residents. Observation showed the sharps container over-filled. Two syringes with needles attached extended approximately three inches above the opening on the container. The placement of the syringes prevented staff from closing the container for safe disposal of the syringes/needles. During an interview on 10/22/15 at 10:52 a.m. an infection control nurse (#3) stated sharps containers should not be over-filled and should be disposed of when full.	F 441		

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