STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI-ACRES MANOR NURSING CTR	1300 2ND PL NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey, started on 03/01/10 and completed on 03/04/10, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 2 residents added to verify specific concerns during the survey.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies and procedures, and staff interview, the facility failed to develop and implement individualized activity programs to respond to the residents' interests and capabilities for 6 of 13 sampled residents (Resident #2, #5, #9, #15, #20, and #21) requiring assistance to attend activities. Findings include: Review of the facility policy "Activity Standard of Care" occurred on 03/04/10. The undated policy stated, "1. Complete Leisure Assessment within MDS [Minimum Data Set] assessment period. 2. Offer assistance to group activities as needed. 3. Introduce to other residents. 4. Provide large Print Monthly Calendar in room. 5. Provide Activity	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gary M. Riffe — TITLE: Administrator/President — (X6) DATE: 3/24/10

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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Calendar Monthly. 6. Offer Chatterbox monthly. 7. Remind of activities through visits and announcements. 8. Individual visits PRN [as needed]. 9. Orientate to monthly calendar and daily activity board upon admission and PRN. 10. Morning Greeting Monday - Saturday."

Review of the facility policy "Sensory Stimulation Programs" occurred on 03/04/10. The undated policy stated, "Stimulation of senses occurs daily with many activities, such as music and baking. Most of the scheduled activities provide some form [sic] stimulation. However when a resident's cognitive awareness is impaired to the point that regular activities do not meet their needs, a sensory program is implemented. This is determined by the care team and indicated on the care plan. Sensory programming at Hi-Acres includes: 1. Small Group activities with sensory approaches. 2. 1-1 [one to one] visit with sensory approaches. 3. 'SPA' Sensory stimulation with bathing.
Scheduled Sensory visits and small groups are provided Monday - Saturday through the Activity Department.
Documentation: Small Group and 1-1 visits will be documented on the sensory stimulation form. The staff person assigned for the day is required to document approaches and responses as indicated on the form.
'SPA' sensory is provided during the resident's usual bathing time. Sensory stimulation is [sic] provided during the bath time may include aromas, music, and use of scented lotions.
Documentation: bath aides are to document on the 'SPA' sensory stimulation form the approached [sic] and responses. . . . "

- Resident #5's medical record, reviewed on

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F 248	Continued From page 2 March 02-04, 2010, identified diagnoses including dementia and depression. A quarterly MDS, completed on 01/10/10, identified the resident with a short term memory problem, moderately impaired in daily decisions, and sometimes understands others. The MDS identified Resident #5 exhibited indicators of depression, anxiety, or sad mood up to five days a week: negative statements, repetitive questions, repetitive verbalizations, persistent anger with self or others, self deprecation, expressions of unrealistic fears, recurrent statements that something terrible was about to happen, as well as sleep-cycle issues, and a sad, apathetic, anxious appearance. The resident also exhibited verbally and physically abusive behaviors and socially inappropriate behaviors 4 to 6 days of the last 7 days, not easily altered. The MDS also indicated Resident #5 required extensive assistance with transfers and locomotion off the unit, and limited assistance with locomotion on the unit. Resident #5's current care plan, dated 10/03/06, identified "Needs reminders and enc. [encouragement] to attend Act [activities]." Approaches to the problem included, "Follow activity standard of care, in-room Programming, pictures in room, TV in room, Plays cards: Crazy 8's, Kings in the Corner with daughter, Invite resident to the following group activities of interest: Socials, music pro [program], devotions, chapel services." The goal for the problem, dated 01/07/10, stated, "Resident will attend devotions 2 x/wk [two times per week]." The care plan identified no small group, 1-1, SPA, or sensory visits planned for Resident #5. An Activity Quarterly Progress Note, dated	F 248	Additional small group activities have been added to the care plans of the identified residents #5, 9, 2, 20, 21, and 15. Small group activity will be provided five (5) times a week. These additional small groups began on 3/09/10. In addition to these small group activities the following has been completed: • Resident #5 – Activity staff will monitor her activity attendance and change activity plan to accommodate her activity needs in her room when unable to attend activities out of her room. • Resident #9 – Activity staff will monitor and document awake and asleep cycles and adjust activity plan to provide meaningful activity during awake periods. • Resident #2 – Staff are given reminders daily of activities that are of interest to Resident #2. • Resident #21 will be encouraged and assisted to activities of interest as identified on the care plan. • Resident #15 will be assisted to activities of interest and activity staff will monitor for outbursts. Sensory programming of small group, sensory spa, and 1-1 activity has been implemented.	

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F 248	Continued From page 3 01/02/10, identified the resident as awake from 7 a.m. to noon, noon to 5 p.m., and 5 p.m. to 10 p.m., and as needing assistance to and from activities. The note identified coffee parties/socials, bingo, music programs, card games, chapel service, devotions, therapy dog visits, radio/TV, visits with others, bird aviary, and one to one visits as activities of interest. Departmental Notes, dated, 01/02/10, stated, "Resident is out of room daily. Sits in the hallways or/and wing four lounge sometimes. Likes to socialize with staff daily. When her daughter is here she likes to play cards sometimes. Resident does come out for some group act. such as: music programs, bingo, socials, and devotions. Resident is content with her act. goal of: Resident with interact with others during social act." Observations on all days of survey identified Resident #5 exhibited resistance (hitting, kicking, swearing) with cares and did not always understand staff when they conversed with her. On March 02-03, 2010, Resident #5 spent most of each morning and afternoon in her room resting in bed with her eyes closed and the TV off. At no time during the survey did observation identify the resident involved in a structured activity or seated near the aviary. On 03/02/10 at 2:30 p.m., observation identified several residents playing cards in the lounge. Resident #5 did not attend. Review of Resident #5's Activity Records identified, in January 2010, the resident attended one music program and refused to attend one. She attended religious services five times and received 1-1 visits from non-activity staff eight times. In February 2010 the resident attended	F 248	Additional stimulation in room with pictures will be provided. • Resident #20 will be assisted to activities of interest as identified on his care plan. Staff will monitor and interact with him while at activities to encourage him to stay Those residents who have difficulty interacting and/or participating in group activities are considered at risk for social isolation. Those residents identified will have their plan of care reviewed and revised as needed. An activity staff meeting was held on 3/09/10 in which activity staff were instructed on the changes to the activity programming. Activity staff were also instructed to document approaches and responses for residents with dementia and to document refusals or rationale why a resident did not attend. Activity staff were instructed to reassess the care plan when a change is noted in a resident's activity attendance. A meeting was held with activity staff on 3/16/10 to follow-up on the changes and staff were reminded to make the necessary changes to care plans.	

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F 248	Continued From page 4 one music program, one game, two religious services, and one social. She received 1-1 visits from non-activity staff on seven occasions. The activity records failed to identify Resident #5 received therapy dog visits, or played bingo and/or cards during January or February 2010. During an interview on the afternoon of 03/03/10, a licensed nurse (#10) stated Resident #5 has been spending more time in bed recently due to the need to be positioned off her coccyx. The record identified Resident #5 developed an open area on her coccyx on 12/15/09, which healed on 12/26/09 and reopened on 02/22/10. On 03/03/10 at 4:45 p.m., a social services staff member (#9) stated both Resident #5's daughters live out of state and do not visit frequently, but come about once a month. The record lacked evidence activity staff reassessed Resident #5's activity needs and revised her plan of care when she began spending more time in bed. Providing more frequent meaningful activities based on Resident #5's interests may help alleviate or decrease the frequency of her depression and anxiety symptoms and improve interaction with staff/others during cares. - Resident #9's medical record, reviewed March 01-04, 2010, identified diagnoses including schizophrenia, anxiety state, psychosis, depressive disorder, and dementia. An annual MDS, completed on 12/21/09, identified the resident with a short term memory problem and moderately impaired with daily decisions. The MDS identified Resident #9 displayed indicators of depression, anxiety, and sad mood up to five	F 248	Nursing staff were instructed on the importance of being aware of the activity schedule and assisting residents to activities that are appropriate as identified on their care plan. This instruction was/will be given at in-service training sessions on 3/08/10, 3/09/10, 3/11/10, 3/16/10, 3/17/10, 3/18/10, 3/19/10, 3/22/10, 3/23/10, 3/24/10 and 3/25/10. An activity documentation form has been put in place for nursing staff to document visits and activities. This form was in place on 3/15/10. Refer to *Resident Activity Record* (Attachment A). An activity presentation has been included in the mandatory staff in-service training held throughout the year, beginning March 30, 2010, and as scheduled for the remainder of the year. (Refer to tentative calendar – Attachment B) Quality assurance reviews of activity documentation will be implemented. The Activity Director will review 7% random sampling of charts with a minimum of six (6) charts of residents with dementia included in the sample.	

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F 248	Continued From page 5 days a week: negative statements, repetitive questions, repetitive verbalizations, expressions of unrealistic fears, recurrent statements that something terrible is about to happen, repetitive anxious complaints/concerns, as well as sleep-cycle issues and sad, apathetic, anxious appearance, easily altered. The MDS also identified Resident #9 as requiring extensive assistance with transfers and locomotion on the unit and total assistance with locomotion off the unit. Resident #9's care plan, dated 12/12/04, stated, "Needs encouragement and assistance to attend activities." Approaches to the problem included, "Follow activity standard of care, In-room Programming, Pictures in room, 'Spa' sen. [sensory] act with bathing as scheduled, Invite resident to the following group activities of interest: Music programs, devotions, Read newspaper to her- Jamestown Sun, Sensory stim [stimulation] 3x/week: Taste, smell, balloon volleyball, movies, walk outside." The goal for the problem stated, "Resident will verbalize and est [establish] eye contact during 1-1 sensory visits 3x/week." An Activity Quarterly Progress Note, dated 12/15/09, identified Resident #9 as awake from 7 a.m. to noon and from 5 p.m. to 10 p.m., and as needing assistance to and from activities. The note identified music programs, devotions, communion service, therapy dog visits, visits with others, one to one visits, one to one sensory visits, and sensory small group as activities of interest. Departmental Notes, dated 12/15/09, stated, "Resident is out of room daily. Resident likes to	F 248	A QA form *Activity Attendance Review* (refer to Attachment C) will be utilized. The activity care plan will be reviewed for its implementation and effectiveness and also for involvement of other departments. This will be determined by review of daily activity attendance records, staff charting, and progress notes. QA review will be weekly for two (2) weeks, then two (2) times per month for two (2) months. If compliance is noted, QA will be monthly thereafter. Quality Assurance Manager will monitor activity documentation compliance for QA monthly.	4/07/10

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F 248	Continued From page 6 socialize with staff. Resident is on the sensory list three times a week and small group one time a week. Resident seems more alert in the late afternoon. Resident does attend some group act. once in a while. Such as devotions and music programs [sic]. Resident is meeting her act goal of: Resident will verbalize and est. eye contact during 1-1 sensory visits 3x/wk." Observation on 03/01/10 at 4:30 p.m. identified Resident #9 seated in a wheel chair near the nurse's station with her eyes closed, dressed in a nightgown and robe. A licensed nurse (#11) stated the resident "may not have allowed staff to dress her." Throughout the day on 03/02/10, observation showed Resident #9 in bed resting. At 11 a.m., a Certified Nursing Assistant (CNA) (#12) stated Resident #9's pattern is to be up for 2-3 days, then to sleep for 2-3 days. On 03/03/10 at 8 a.m., observation identified Resident #9 awake and seated in a wheel chair in her room. At 2:40 p.m. observation showed the resident in the lounge actively engaged in looking at pictures of food with an activity staff member (#13).The resident smiled and laughed during the observation. Review of Resident #9's Resident Activity Records for January and February 2010 identified the resident attended two religious services in January and one in February. The record failed to identify Resident #9 participated in other activities during those months. Sensory Stimulation "SPA" documentation identified the resident received SPA with her bath	F 248		

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four times each month. Review of Sensory 1:1 Activity Documentation for Resident #9 identified the resident received 1-1 visits 10 times in January and seven times in February, with each visit averaging four minutes. Documentation identified, on two occasions each month, the resident slept during the 1-1 visit.

The record lacked evidence activity staff considered Resident #9's pattern of staying awake for long periods, followed by sleeping for long periods, and made adjustments consistent with the resident's schedule to provide more frequent 1-1 visits and/or activities of interest during periods when she was awake and alert. Providing meaningful activities based on Resident #9's interests may assist in alleviating or decreasing the frequency of her symptoms of depression and anxiety.

- Review of Resident #2's medical record occurred on all days of the survey. Diagnoses included vascular dementia, expressive and receptive aphasia (impaired ability to communicate), and history of cerebrovascular accident (stroke). Resident #2's most recent MDS, dated 02/20/10, identified short and long term memory problems, impaired decision-making skills, rarely/never understood or understand others, and extensive assistance for locomotion off the unit. This MDS showed the resident displayed sleep-cycle issues and repetitive physical movements up to five days a week, marked as easily altered. The MDS showed the resident awake all or most of time in the morning, afternoon and evening; preferred activity settings of own room, day/activity room, and inside nursing home/off unit; and activity preference of music, reading/writing, and

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F 248	Continued From page 8 spiritual/religious activities. Resident #2's care plan, dated 11/13/09, identified "Problem/Need: Activities: Needs assistance to attend Act. Goal: Resident will part. [participate] in 1-1 sensory visits w/ [with] eye contact & a smile. Approaches: Follow activity standard of care, in-room programming, sensory stimulation programming, 1-1 visits 3 times/week - family, pictures in room, invite resident to the following group activities of interest: music programs, devotions, church services." A form titled "Departmental Notes," dated 02/11/10, stated, ". . . He needs assistance and encouragement to attend activities. Goal: Resident will attend church services 2x's [two times] a week without disruption." Resident #2's 1-1 Visitation records showed the facility failed to provide 1-1 visits three times a week on five of eight weeks between January 4 and February 28, 2010. * January 18-24: 2 visits * January 25-31: 1 visit * February 8-14: 2 visits * February 15-21: 1 visit * February 22-28: 2 visits Resident #2's activity records for 2010 showed the following: * January - active participation: 1-1 visits - twice, religious service - twice, socials - once; unable to participate: religious service - once. * February - active participation: religious service - twice; refused: sports - once. Activity notes, dated 02/11/10, noted, "[Resident #2's name] has been attending church services & responds to 1-1 visits 3x's/wk w/eye contact, smiles, & an attempt to verbalize."	F 248		

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F 248	Continued From page 9 Observation showed Resident #2 sitting quietly in the chapel for religious service on 03/02/10 at 10:00 a.m. Resident #2 frequently sat at the nurses station in his wheelchair through all days of the survey, not an identified activity of interest. The facility's failure to assist Resident #2 to attend the identified activities of interest and provide 1-1 visits as scheduled had the potential to prevent Resident #2 from reaching his highest practicable level of physical, mental, and psychosocial well-being. - Review of Resident #20's medical record occurred on March 03-04, 2010. Diagnoses included Pick's disease (frontotemporal neurodegenerative disease), dementia with behavioral disturbance, and aphasia. Review of Resident #20's most recent MDS, dated 01/27/10, identified short and long term memory problems, impaired decision-making skills, rarely/never understood, sometimes understands others, and total assist for locomotion on and off the unit. The MDS showed the resident displayed persistent anger with self or others, sleep-cycle issues, sad, pained, worried facial expressions, and crying, tearfulness up to five days a week, along with repetitive physical movements daily or almost daily, all marked as easily altered. The MDS showed wandering daily, not easily altered. The MDS showed the resident awake all or most of time in the morning, afternoon and evening; preferred activity settings of own room, day/activity room, and inside nursing home/off unit; and activity preference of music, reading/writing, spiritual/religious activities, and television (TV). Resident #20's care plan, dated 07/23/09,	F 248		

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identified "Problem/Need: Activities: Potential for social isolation due to confusion. Goal: Resident est. [establish] eye contact during sensory visits 3x/week. Resident will spend time out of room daily. Approaches: Follow activity standard of care, in-room programming, sensory stimulation programming: 1-1 visits 3 times/week: approaches, music, reading, pictures, touch, doll, pail of manipulative items; small group activity, as tol. [tolerated], offer reading material - preference: looks at newspaper at times, pictures in room, invite resident to the following group activities of interest: music as tolerated, dev [devotions], socials, as tol., TV in room, VCR [videocassette recorder]." A form titled "Departmental Notes," dated 01/21/10, stated, ". . . He sits and watches people in the lounge at times. . . . He attends group act as able. He occasionally attends music programs or devotions in the lounge. He watches TV in his room daily. He has a bucket of items in his room to have when he gets restless. . . ."

Resident #20's Sensory 1:1 Activity Documentation record, for the months of January and February, 2010, listed, "Approaches: music, pictures, reading and touch. Goal: Res will est. eye contact during sensory act." The record identified the resident received 1:1 visits three times weekly lasting an average of three to four minutes each. Resident #20 also received "SPA" sensory stimulation twice weekly in January and February. A comment on the form each month stated, "Doesn't like whirlpool."

Resident #20's activity records for 2010 showed the following:
* January - active participation: 1-1 visits - twice, music program - twice, religious service - once, sports - once, TV/radio - daily.

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F 248	Continued From page 11 * February - active participation: 1-1 visits - three times, music program - twice, religious service - once, socials - once, TV/radio - daily; refused: music program - once. Activity notes, dated 02/23/10, noted, "[Resident #20's name] continues to spend much of the day out of his room. He wheels in the hall & sits in the lounge at x's [times]. He participates in sensory visits [with] eye cont. [contact], smiles & some attempts to verbalize. He can be easily redirected most of the time. . . . 02/24/10 - Walked [with] the Res. holding his hand to the music prog. [program], he really enjoyed it evidence [sic] by his smiles, laughter & verbalization, he kept the beat to the music & clapped appropiately [sic]." Observation on 03/03/10 from 12:50 p.m. to 5:00 p.m., showed Resident #20 in his wheelchair in the hallway next to the nurses station, often with his head hanging down. At 1:35 p.m., a staff member wheeled Resident #20 to the nurses station, sat next to him for 10 minutes, talked with the resident and other staff members, and gave him a snack. The resident did not respond verbally. The facility's failure to assist Resident #20 to attend the identified activities of interest and provide 1-1 visits for more than a few minutes at a time had the potential to prevent Resident #20 from reaching his highest practicable level of physical, mental, and psychosocial well-being. - Review of Resident #21's medical record occurred on March 03-04, 2010. Diagnoses included Alzheimer's dementia, anxiety state, and auditory hallucinations. Resident #21's most recent MDS, dated 01/21/10, identified short and long term memory problems, impaired decision-making skills, sometimes understood,	F 248		

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	355078	A. BUILDING _____ B. WING _____	C 03/04/2010

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F 248	Continued From page 12 sometimes understands others, walked independently, but required limited assistance with transfers. The MDS showed the resident displayed repetitive questions and verbalizations, persistent anger with self or others, sleep-cycle issues, and sad, pained, worried facial expressions up to five days a week, all marked as easily altered. The MDS showed the resident awake all or most of time in the morning, afternoon and evening; preferred activity settings of own room, day/activity room, and inside nursing home/off unit; and activity preference of cards/other games, music, reading/writing, spiritual/religious activities, TV, and talking or conversing. Resident #21's care plan, dated 10/14/09, identified "Problem/Need: Activities: Needs reminders & direction to attend Act. Short attn [attention] span interferes [with] some act. participation. Goal: Resident will attend 1 gr. [group] act/wk. Continue to spend time out [of] room daily. Approaches: Follow activity standard of care; in-room programming; offer newspaper - Jamestown Sun; TV in room or lounge; offer reading material - preference - Lg. [large] print - mysteries; cards - Pinochle - PRN; pictures in room; invite resident to the following group activities of interest: Mass, Rosary, devotions, music programs, socials; pet visits as available; 1/12/10 all staff offer her picture books that will be at Wing 1." A form titled "Departmental Notes," dated 01/08/10, stated, ". . . She needs assistance to attend group and her short attention span interferes at times as she talks to herself during activities or leaves early. . . . She had attended mass at times, but tried to get up or talks to herself. She receives visits from Catholic volunteers when she doesn't attend Mass. . . ."	F 248		

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F 248	Continued From page 13 Resident #21's activity records for 2010 showed the following: * January - visitor: twice; active participation: seven 1-1 visits, games - once, music program - once, religious service - once, socials - twice, TV/radio - daily; unable to participate: religious service - five times; refused: religious service - once, and socials - once. * February - visitor: four times; active participation: eight 1-1 visits, music program - three times, reading/puzzles - once, socials - once, TV/radio - daily; unable to participate: religious service - four times. The activity record failed to show a reason why Resident #21 was unable to participate in the religious services. The facility's failure to assist Resident #21 to attend the identified activities of interest may have contributed to her increased moods and behaviors and had the potential to prevent Resident #21 from reaching her highest practicable level of physical, mental, and psychosocial well-being. In an interview on 03/04/10 at 8:45 a.m., an administrative staff member (#3) stated, "The 1-1 visits on any resident's activity record are miscellaneous visits, not necessarily care planned 1-1 visitations scheduled per the Activity Department. I would expect staff to document all [care planned] visits provided on the 1-1 [visitation or sensory] forms. 'Unable' [marked on the 1-1 form] means the resident was out of the building, had company, was sleeping, or was not up." In regard to Resident #2's 1-1 visits, this staff member indicated the resident was changed from regular 1-1 visits to sensory 1-1 visits on March	F 248		

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F 248	Continued From page 14	F 248		

1st as felt they would benefit him more.

- Review of Resident #15's medical record occurred on 03/03/10. Medical diagnoses included cerebral vascular accident (CVA) with left hemiplegia in 2004, vascular dementia with depression, bipolar disorder, mental disorder, and epilepsy.

Resident #15's quarterly MDS, dated 02/25/10, identified short term and long term memory problems, severely impaired in daily decision making, totally dependent on staff for all activities of daily living (ADL's), some time involved in activities, preferred activity settings in room, day/activity room, inside nursing home/off unit, and general activity preferences listed are music and spiritual/religious activities.

Resident #15's current care plan, dated 06/09/08, updated 02/25/10, stated;
* "Problem: Activities: Potential for social isolation due to confusion. Needs total assistance to attend group activities."
* Goal: "Resident will respond with eye contact to 1-1 visits, Resident will attend Mass weekly 2 x [times] mo [month]."
* Approaches: "Follow activity standard of care, in-room programming, pictures in room, we will provide visits from Catholic Volunteers on Friday following Mass, when he is unable to attend, 1-1 visits 3 times/week-topics of interest - read to him, take out of room, Sen [sensory] approaches, touch, read, music, pictures, out of room as tolerated, invite and assist to the following group activities, as tolerated: Mass on Fridays, weekly Rosary, music programs, as tolerated."

Review of Resident #15's 1-1 Visitations record

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F 248	Continued From page 15 showed the facility failed to provide 1-1 visits three times a week on six of the six weeks between January 4 and February 14, 2010. * January 4-10: 2 visits * January 11-17: No visits * January 18-24: 2 visits * January 25-31: 2 visits * February 1-7: 2 visits * February 8-14: 2 visits * February 15-28: No visits documented in the chart." Resident #15"s activity records for 2010 showed the following: * January-active participation: 1-1 visits-once, religious service-four times,unable to participate: religious service-twice, TV/ radio-31 times. * February-1-1 visits-none listed, Religious service-active (participated) four times, unable to participate-religious service-twice, TV/radio-28 times. Activity notes, dated 02/20/10, noted, "[Resident #15's name] continues to spend time out of his room daily. He sits in the hall or in the lounge. He needs total assist once to attend gr [group] act [activities]. . . . He participates in 1-1 visits with eye cont. [contact] some smiles and some verbalization. He yells out at times and is difficult to calm." On 03/02/10 at 8:00 a.m., observation showed Resident #15 sitting in his Geri-chair in the hallway outside of his room. Resident #15 remained sitting in this location until 11:30 a.m., when a staff member moved him to his room for the noon meal. On 03/02/10 at 1:00 p.m. observation showed Resident #15 laid in bed with his eyes open.	F 248		

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F 248	Continued From page 16 Observation showed no pictures hanging on the wall, no music playing, and the curtains to the window closed. During an interview on 03/03/10 at 3:00 p.m., when asked concerning Resident #15's morning activity, a staff nurse (#5) stated, "Resident #15 was up in his geri-chair and taken to the lounge for an activity, but taken out because he was noisy. He was then taken to the end of the hallway to watch outside for awhile then put to bed after his noon meal." During an interview on 03/04/10 at 8:30 a.m. an administrative staff member (#4) agreed Resident #15 did not have any personal items in his room or pictures on the walls and would possibly benefit from some religious items on the walls. The administrative staff member (#4) stated she knew the resident and his wife were very active in their church and attended mass regularly. During an interview on 03/04/10 at 8:45 a.m., an administrative staff member (#3) agreed the "Resident Activity Record" lacked documentation for Resident #15's activities. The staff member did not know why Resident #15 no longer attended the sensory program. The record lacked evidence activity staff reassessed Resident #15's activity needs when he had outbursts and did not attend activities. The staff failed to provide Resident #15 with 1-1 visits as identified in the care plan. Failure to engage resident in activities and the provide ongoing, meaningful activities has the potential to minimize their highest practicable quality of life and overall well being.	F 248		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 17 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. (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.	F 441		

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F 441	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow infection control procedures for handwashing and glove usage for 1 of 3 sampled residents (Resident #14) observed receiving staff assistance with bowel incontinence. Failure to follow proper hand hygiene has the potential to contaminate clean surfaces and clothing and spread infection to residents, visitors, and staff. Findings include: Review of the facility policy and procedure titled "Perineal Care" occurred on 03/04/10. This policy, dated 11/04/09, stated "Procedure: . . . Wash hands. . . . Do pericare . . . Don a new pair of gloves. . . . Spread the ointment evenly on peri area. . . . Remove gloves. . . . Wash hands. . . ." Observation on 03/02/10 at 8:55 a.m., showed the certified nurses aide, (CNA) (#1), provided pericares for Resident #14. The CNA removed her gloves and washed her hands. The CNA re-gloved and applied ointment to the resident's perineal area, removed her gloves, and exited the resident's room without washing her hands. The CNA (#1) proceeded to the food service area, opened a drawer with her hand, removed a clothing protector, and placed it on a resident awaiting breakfast. An interview with an administrative nursing staff member (#2) occurred on 03/04/10 at 10:25 a.m. This staff member agreed, and stated the nursing staff member (#1), should have washed her hands after removing her gloves and prior to exiting Resident #14's room.	F 441	Both CNAs who were working at the time of the finding were re-educated in both the handwashing and perineal care policy. All residents who require assistance with personal hygiene and toileting are considered potential residents at risk. Certified nursing assistants have had or will have in-service training on 3/08/10, 3/09/10, 3/16/10, 3/17/10, and 3/22/10 to review the procedures for proper perineal care and handwashing. Nurses had in-service training on 3/11/10 regarding the need for continued monitoring for staff adherence to procedures for perineal care and handwashing. Perineal care will be observed on 18 residents per month. Additionally, 36 observations of handwashing will be completed monthly. Those staff members found to be noncompliant will be re-educated and the disciplinary process will be utilized for continued noncompliance. QA will monitor for continued compliance monthly. (Refer to Attachment D and E).	4/07/10

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F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		