STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/11/2020

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GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 02/09/20 and concluded on 02/11/20.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/17/20

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

Electronically Signed | 03/06/2020

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview the facility failed to provide care and services, in a manner that maintained and enhanced, each resident's dignity during 2 of 2 noon meals observed. Failure to serve all residents at the same table at the same time (Resident #1, #7, #20, and #22), and provide assistance (Resident #10, #13, and #31) during meals does not promote the residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Dining Service Standards" occurred on 02/11/20. This policy, dated, September 2017, stated, "Take into consideration each resident's individual needs . . . Employees will provide meals based on available resident information and requirements for the level of care (eg., resident choice/preferences, tray/diet cards, reports/lists, menu documents). . . . Resident's will receive assistance from employees. . . ." - Observations during the noon meal on 02/09/20 showed the following: *11:50 a.m.: Resident #10 shouted out "Let's go!" An unidentified certified nursing assistant (CNA)	F 550	1) Residents #1, 7, 20, 22 will be served at the same time, if at the same table. Resident #10□s care plan will be updated to reflect need for cueing, encouragement or assistance while in dining room. Staff will ensure Resident #10 will be given assistance in the dining room when needed. Resident #13□s care plan will be updated to reflect the preference to eat food with fingers and that he prefers to feed himself. Staff will ensure resident #13 will be clean and tidy when he leaves the dining room. Resident #31□s care plan will be updated to reflect he will eat food with hands, at times, as to encourage independence. 2) All residents have the potential to be affected by this deficient practice. Resident care plans will be updated as needed to reflect dietary assistance needs as well as assistance preferences. Staff will monitor all residents to ensure dignity while eating is provided. 3) All staff will be educated on resident dignity while eating, including serving residents at the same table at the same time, providing assistance when needed, residents are kept clean and neat in the	

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F 550	Continued From page 2 placed Resident #10's meal on the table and walked away. Resident #10 took a few bites, spilled food on the table, and pushed the remainder of the food around on the table with the spoon. Staff failed to offer assistance or cuing. *11:56 a.m.: A staff nurse (#11) served Resident #13's meal of pureed food. The staff nurse (#11) stood and talked to another resident as Resident #13 used his fingers to push the food onto the spoon. Resident #13's fingers became covered in food. Staff failed to assist the resident to wipe/clean his hands. Resident #13 finished eating, removed the clothing protector, and propelled his wheelchair from the dining room, spreading food onto the wheelchair. *At 12:00 p.m.: Resident #7 had not received a meal. Staff had served all the residents seated at the table, and they were finished eating. At 12:17 p.m., Resident #7 received his meal. *At 12:23 p.m.: Resident #31 ate a piece of pumpkin pie with his fingers; staff failed to offer assistance/cuing. Observation of the noon meal on 02/10/20 showed the following: *11:38 a.m.: Resident #1, #20, and #22 sat together at a table. A CNA (#12) served Resident #20's meal and assisted him to eat. At 12:03 p.m., staff served Resident #22's meal; and at 12:05 p.m., staff served Resident #1's meal (27 minutes after Resident #20). *12:00 p.m.: Resident #13 used his fingers throughout the meal to push pureed food onto the spoon; staff failed to assist Resident #13 to wipe/clean his hands. During an interview on 02/11/20 at 4:30 p.m., an	F 550	dining room and upon exiting. In addition, care plans are updated to reflect dietary assistance needs and preferences. 4) The Director of Nursing Services or designee will administer audits which ensure resident dignity is intact while in the dining room, including providing assistance when needed, serving residents at the same table at the same time, residents are kept clean and neat in the dining room and upon exiting. In addition, care plans are updated to reflect dietary assistance needs and preferences. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F550. These audits will be administered weekly for two months, every two weeks for two months and monthly for two months. 5) The corrective action will be completed by March 17, 2020.	

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F 550	Continued From page 3 administrative nurse (#3) stated she expected staff to assist residents during meals.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584		3/17/20

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F 584	Continued From page 4 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of committee meeting report/minutes, and staff interviews, the facility failed to provide maintenance services necessary to maintain a comfortable/homelike environment in the resident common area. Failure to ensure maintenance completed routine repairs to walls and ceilings does not provide a comfortable/homelike area for all residents, visitors, and staff. Findings include: Observations on all days of survey showed the following: *The lower half of all the walls surrounding the resident commons area contained scuff marks, scratches/gouges and areas of paint scrapped/chipped off. *The lower part of the wall on the outside of the ward clerk office, adjacent to the resident commons area, contained scuff marks and areas of paint scrapped off. *The hallway which extended off the resident commons area into the resident dining room contained scratches/scuff marks and the lower half of the wall next to the resident dining room showed a large area of paint scrapped off the wall. *Ceiling panels towards the end of hallway 100 and near the activity area contained discolored	F 584	1) All residents are affected by the deficient practice. Therefore, all noted gouged and chipped paint areas will be patched and painted and all stained ceiling tiles will be replaced. 2) All other residents, including new residents, could be affected by the deficient practice. Therefore, any concerns related to a safe, clean, comfortable and homelike environment will be addressed immediately. 3) The Director of Environmental Services or designee will ensure all noted high-traffic areas with gauges or chipped paint will be patched and repainted and a protective covering will be placed over the affected area so that the damage does not recur. The lower-traffic areas with gauges or chipped paint, such as resident rooms, will be patched and painted during a monthly preventative maintenance task in TELS. The Director of Environmental Services or designee will continue to do at least a monthly walk through in which any disrepair is documented and repaired in a timely manner. All staff will continue to report disrepair to the Director of Environmental Services or designee within the maintenance log, located near the charting station. In addition, staff will	

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F 584	Continued From page 5 stains, with one panel almost completely stained. During an interview on 02/11/20 at 1:45 p.m., an environmental services staff member (#9) reported the facility does not have a process for routine repair to damaged walls. The environmental services staff member (#9) stated, "We are aware of the condition of the walls in the resident common area and near the resident dining room but have not been able to complete the repair work." Review of the "Safety Committee Monthly Meeting Minutes" and "Open Issues Report" occurred on 02/11/20. The open issues report, dated 12/09/19, stated, ". . . Walls not in good repair (resident room) . . . Target Completion Date: 12/31/19 . . . Date Completed: [undated] . . ." The safety committee monthly meeting, dated 12/17/19, stated, ". . . Action Plan/Follow-up: Maintenance to fix walls of three resident rooms. . . . Maintenance to look at gouges in hallway, dining room and resident rooms . . . Some resident rooms with scratches fixed this Fall and will continue throughout the Winter. . . ." The facility staff failed to address the stained ceiling panels or the scuff marks, scratches/gouges, areas of paint scrapped off all the walls surrounding the resident commons area and failed to have a corrective action plan in place that was followed to the end and actually ended when the repairs were completed. During an interview on the afternoon of 02/11/20, an administrative staff member (#7) reported the facility experienced staff turnover this past	F 584	be educated on the importance of promptly reporting concerns related to a safe, clean, comfortable and homelike environment. 4) The Director of Environmental Services or designee will administer audits to ensure that no areas within the facility have gauged walls, chipping paint nor stained ceiling tiles. These audits will be performed monthly for two months then every other month for four months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F584. 5) The corrective action will be completed by March 17, 2020.	

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F 584	Continued From page 6 November 2019 in the maintenance department and agreed the condition of the walls in the resident commons area are in need of repair.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 12 sampled residents (Resident #12). Failure to accurately complete Section M (Skin Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and subsequently the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, pages M-2 through M-36 stated, ". . . M0100: Determination of Pressure Ulcer/Injury Risk . . . Steps for Assessment . . . Review the medical record, including skin care flow sheets, . . . Coding Instructions . . . Check A if resident has a Stage 1 or greater pressure ulcer/injury, . . . Check B if a formal assessment has been completed. . . . Check C if the resident's risk for pressure ulcer/injury development is based on clinical assessment. A	F 641	1) Resident #12's 11/27/19 MDS will be modified to reflect the following: a. Stage 1 pressure ulcer b. Affirmation of clinical assessment of risk factors c. Affirmation that resident was at risk for pressure ulcer d. Affirmation that resident was provided treatments for this pressure ulcer during the lookback period 2) All residents have the potential to be affected by this deficient practice. The staff members that complete MDS's will be mindful of accuracy and the deficient practices related to the specific inaccuracies noted. 3) Education will be provided to staff members who complete the MDS's in regards to accurate coding. 4) The Director of Nursing or designee will perform audits that check for accurate MDS coding. The audits will be performed in the following manner: weekly for one month, every two weeks for two months and monthly for three months. If errors are noted throughout the course of the audits, the Director of Nursing or	3/17/20

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F 641	Continued From page 7 clinical assessment could include a head to toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. . . . include the following. . . Co-morbid conditions. . . resident refusal of some aspects of care and treatment, cognitive impairment, urinary and fecal incontinence. . . . M1200: Skin and Ulcer/Injury Treatments. . . .1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. . . .Coding instructions, Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days. . . . M1200E Pressure Ulcer/Injury Care Pressure ulcer care includes any intervention for treating pressure ulcers. . . Examples may include the use of topical dressings. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included osteoarthritis, urinary incontinence. Review of physician's orders showed an order dated, 11/05/19, "Mepilex dressing to outer right hip wound. Change every 3 days and PRN [as needed]. Discontinue when area is resolved. . . . related to diagnosis of pressure ulcer of right hip, stage 1." Review of the November 2019 treatment administration record (TAR), showed the dressing changed every three days between 11/05/19 and 11/26/19 when the order was discontinued. The quarterly MDS, dated 11/27/19, showed staff failed to code section M0100 A., to indicate Resident #12 had a pressure ulcer during the 7-day look back period. Staff coded section M0100 B., "X", to indicate that a formal	F 641	designee will ensure the MDS maintains accuracy and a modification will be completed, if necessary. The results of the audits will be provided and reviewed at monthly QAPI meetings. 5) The corrective action will be completed by March 17, 2020.	

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F 641	Continued From page 8 assessment instrument/tool was completed. The medical record lacked evidence of this. Staff failed to provide documentation of this assessment when asked. Staff failed to code section M0100 C., to indicate a clinical assessment of risk factors for pressure ulcer/injury was completed on Resident #12. Staff coded section M0150, "0", or No, to indicate Resident #12 was not at risk for developing pressure ulcers/injuries. Staff failed to code section M0300 A., to indicate Resident #12 had a stage 1 pressure ulcer/injury, and coded section M1200 Z., "X", to indicate no ulcer/injury treatments were provided during the 7-day look back period. During an interview on 02/11/20 at 4:25 p.m., an administrative nurse (#3), agreed section M on the quarterly MDS was coded incorrectly for Resident #12.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		3/17/20

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F 657	Continued From page 9 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the care plan in response to changes in resident condition for 2 of 2 sampled residents (Resident #5 and #31) with weight loss. Failure to update the care plan as needed may result in delayed treatment interventions and inadequate/inconsistent care delivery. Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 02/11/20. This policy, revised December 2019, stated, ". . . The care plan is driven by identified resident issues/conditions and their unique characteristics. . . . Care plans are to be reviewed with each MDS [Minimum Data Set] completed. . . . In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes. . . ." - Review of Resident #5's medical record	F 657	1) Resident #5 and #31□s care plans have been updated to reflect weight loss and weight loss interventions have been updated as of February 10, 2020. 2) All residents with weight loss are at risk to be affected by this deficient practice. The Certified Dietary Manager or designee will monitor resident weights weekly. When a significant weight loss is identified, weight loss and weight loss interventions will be added to resident care plan. 3) At each resident care plan meeting, the Interdisciplinary Team or designee(s) will ensure that the resident care plan has weight loss and weight loss interventions on it if there has been a significant weight loss. Licensed nurses will be educated on the importance of monitoring weight loss alerts within the medical record. 4) The Certified Dietary Manager or designee will administer audits which verify that any resident with significant weight loss has weight loss and weight	

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F 657	Continued From page 10 occurred on all days of survey. The current MDS, dated 11/05/19, identified weight loss. A dietary note, dated 11/07/19, stated the following: ". . . Nutritional Status . . . Wt [weight]: 109 # [pounds] on 10/29/19, overall fairly stable x3 months. Regular diet, small portions, whole milk with meals. Intake averages 54% at meals. She was started on 4oz [ounce] supplement TID [three times daily] on 11/5/19 and so far is drinking it. . . . Will continue to monitor weight and meal intakes, and determine if supplement intervention is effective. Would recommend adding fortified to diet order for extra calories. . . ." - Review of Resident #31's medical record occurred on all days of survey. The current MDS, dated 01/08/20, identified weight loss. A dietary note, dated 01/03/20, stated, ". . . Triggered for significant weight loss of > [greater than] 5% in one month. Current weight is 151#, up 4# in the past week. Resident has been refusing some meals. Average intake is 56%. Staff has been offering Ensure Clear and mighty shakes when he refuses to eat, and he has been taking it. Will request order for supplements, either scheduled or as needed when resident refuses meals. Will have CDM [certified dietary manager] continue to monitor weekly weights. . . ." Resident #5 and #31's current care plans failed to identify weight loss, goals, and interventions to prevent further weight loss and ensure adequate nutrition until staff updated the care plans on 02/10/20. During an interview on the afternoon of 02/11/20, a dietary supervisor (#1) identified she should	F 657	loss interventions on the care plan. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F657. These audits will be administered weekly for two months, every two weeks for two months, and monthly for two months. 5) The corrective action will be completed by March 17, 2020.	

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F 657	Continued From page 11 have updated the care plans sooner.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to follow professional standards of medication administration for 1 of 12 sampled residents (Resident #31). Failure to follow physician's orders related to blood pressure monitoring may result in medication errors and adverse reactions. Findings include: Review of the facility policy titled "Medication - Documentation" occurred on 02/11/20. This policy, revised December 2019, stated, ". . . If applicable, appropriate precautionary measures will accompany administration of certain medications and will be documented according to physician orders . . ." Review of Resident #31's medical record occurred on all days of survey. Current physician's orders included Midodrine (used to treat hypotension) 2.5 milligrams (mg) twice a day and 5 mg once a day with the instructions "hold for systolic BP [blood pressure] > [greater than] 100 [millimeters of mercury, or mmHg] or diastolic BP >80 [mmHg]."	F 658	1) Resident #31's Midodrine was discontinued on February 20, 2020 and therefore this deficient practice will not recur. 2) All residents have the potential to be affected by this deficient practice. All medications with parameters will be scrutinously reviewed by the accepting nurse or designee. Any confusion will be clarified with the physician at the time of receiving the order. 3) Licensed nursing staff and medication aides will be educated on the importance of reviewing pharmacy orders with parameters and ensuring the orders are clear and clarified. 6) The Director of Nursing Services or designee will administer audits which ensure orders with parameters are being followed. These audits will be performed weekly for one month, every other week for two months and every month for three months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will	3/17/20

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F 658	Continued From page 12 Resident #31's medication administration records (MARs) for January and February 2020 identified nine occasions in January and 13 occasions in February that staff administered Midodrine when Resident #31's systolic blood pressure was over 100 mmHg. During an interview on the afternoon of 02/11/20, an administrative nurse (#3) confirmed staff gave the medication incorrectly.	F 658	discuss the progress of the Plan of Correction as relates to F658. 7) The corrective action will be completed by March 17, 2020.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 692	1) The following plan of care and nutritional interventions for Resident #31	3/17/20

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F 692	Continued From page 13 to ensure acceptable parameters of nutritional status for 1 of 2 sampled residents (Resident #31) with weight loss. Failure to adequately monitor and evaluate weights, assess the effectiveness of existing interventions and ensure consistent implementation, and re-evaluate the need for updated or additional interventions resulted in weight loss for Resident #31. Findings include: Review of the facility policy titled "Food First Philosophy" occurred on 02/11/20. This policy, revised September 2017, stated, ". . . Provide preferred foods and fortified food interventions before considering supplements. . . . Consider ways to increase calories and/or protein in food offered . . ." Review of the facility policy titled "Nutrition and Hydration" occurred on 02/11/20. This policy, revised June 2019, stated, ". . . Accurately and consistently assess a resident's nutritional status on admission and as needed. . . . Obtain food and beverage preferences from residents using Food and Nutrition Data Collection and include in resident's meal plan (e.g., tray/diet cards, reports/lists). . . . Develop care plan to address impaired nutrition and hydration that reflects resident's personal goals and preferences. . . ." Review of Resident #31's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The resident's quarterly Minimum Data Set (MDS), dated 01/08/20, identified weight loss. Current physician's orders identified "House Supplement Diabetic as needed for Weight Loss Offer for	F 692	will be modified immediately: a. The Food and Nutrition Data Collection will be updated to reflect resident #31□s current food preferences b. Any orders pertaining to Resident #31□s nutrition will be updated to reflect accurate information c. When resident #31 eats less than 25%, staff will administer a supplement and document intake. This has also been placed in the 24-hour nursing sheet as well as the communication book for all nursing staff to see d. Resident #31□s tray card will be updated to reflect current food preferences and the administration of supplements e. Any PRN or off-scheduled supplements will be documented in Resident #31□s medical record as needed 2) All other residents have the potential to be affected by the same deficient practice. The Food and Nutrition Data Collection will reflect resident preferences. After any significant weight loss, food preferences need to be re-evaluated. If weight varies by more than three percent, reweigh resident and document. Report weight to licensed nurse. All orders regarding resident nutrition will be followed appropriately. Tray cards will be reflective of current preferences and/or administration of supplements during meals. All scheduled, PRN and/or off-schedule supplements will be documented in the medical record accurately.	

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F 692	Continued From page 14 meal replacement [start date 01/07/20]" and "House Supplement Diabetic two times a day for (SPECIFY: Weight loss, poor appetite/intake, skin problems) Amount to serve: 120 mL [milliliters] or 4 oz [ounces] [start date 01/07/20]." Review of the resident's care plan on 02/09/20 failed to identify the weight loss and interventions. On 02/10/20, the updated care plan stated, ". . . The resident has unplanned/unexpected weight loss R/T [related to] chooses to receive tray service E/B [evidenced by] orders to offer a house supplement for meal replacement due to poor food intake. . . . Interventions . . . Resident has orders to offer a house supplement for meal replacement relating to decrease in appetite. . . ." The care plan lacked further interventions for weight loss. Review of Resident #31's Food and Nutrition Data Collection, dated 10/11/19 (admission assessment), lacked specific food preferences or dislikes; and identified apple juice, coffee, and water as beverage preferences. The quarterly Food and Nutrition Data Collection, dated 01/09/20, also failed to identify specific food preferences or dislikes, and identified the use of twice daily and as needed supplements. The staff failed to re-evaluate Resident #31's food preferences after the MDS identified weight loss. Resident #31's weights included the following: *10/08/19: 169.0 pounds (Lbs) *10/14/19: 162.0 Lbs (3% change from last weight) *10/28/19: 161.0 Lbs *11/04/19: 163.0 Lbs	F 692	3) All staff will be educated on the following: The Food and Nutrition Data Collection will reflect resident preferences. After any significant weight loss, food preferences need to be re-evaluated. If weight varies by more than three percent, reweigh resident and document. Report weight to licensed nurse. 4) The Certified Dietary Manager or designee will administer audits which ensure any resident with significant weight loss , is at risk for malnutrition, or is malnourished has the following within their medical record. The Food and Nutrition Data Collection will reflect resident preferences. After any significant weight loss, food preferences need to be re-evaluated. If weight varies by more than three percent, reweigh resident and document. Report weight to licensed nurse. If a weight loss of 3% or more is noted, audits should check that a re-weight was done. All orders regarding resident nutrition will be followed appropriately. Tray cards will be reflective of current preferences and/or administration of supplements during meals. All scheduled, PRN and/or off-schedule supplements will be documented in the medical record accurately. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F692. These	

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F 692	Continued From page 15 *11/11/19: 165.0 Lbs *11/18/19: 162.0 Lbs *11/25/19: 160.0 Lbs *12/02/19: 160.0 Lbs *12/09/19: 157.0 Lbs *12/18/19: 157.0 Lbs *12/23/19: 147.0 Lbs (the record lacked evidence of staff notification of the 10 lb weight loss or a reweigh of Resident #31) *12/30/19: 151.0 Lbs *01/13/20: 152.0 Lbs *01/20/20: 148.0 Lbs *02/03/20: 149.0 Lbs (11.8% weight loss in four months) Observations during the survey showed the following: *02/09/20 at 11:51 a.m.: Staff served Resident #31 turkey, stuffing, green beans, 8 oz apple juice, and 8 oz water. At the conclusion of the meal, Resident #31 ate approximately 25% of his meal. Staff failed to offer a supplement to enhance his intake. *02/09/20 at 5:44 p.m.: Observation showed an unidentified certified nursing assistant (CNA) assisted Resident #31 to eat in his room. The CNA left the room and stated Resident #31 "ate a couple bites and then pushed it away, ate about half his soup, a couple bites of macaroni salad, a couple bites of sandwich." The staff failed to offer a supplement to enhance Resident #31's intake. *02/10/20 at 8:26 a.m.: A CNA delivered a room tray to Resident #31. Observation showed cold cereal, one piece of toast, and peanut butter. At the conclusion of the meal, the resident ate 100%. *02/11/20 at 8:13 a.m.: Resident #31 eating breakfast consisting of cold cereal and toast in	F 692	audits will be done by selecting one resident every week for three months and every two weeks for three months. 5) The corrective action will be completed by March 17, 2020.	

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F 692	Continued From page 16	F 692		

the dining room. The menu also identified eggs and bacon served for breakfast that morning. A dietary staff member (#14) stated Resident #31 receives the same breakfast every morning - cold cereal, one piece of toast, and cream for his cereal. She stated the resident does not want anything else.

Review of the Resident #31's dietary tray card identified the resident likes scrambled eggs, meat, 2 pieces of toast, and corn flakes. The tray card did not identify the use of additional supplements or the addition of cream to his cereal.

Review of Resident #31's medication administration record (MAR) identified, "House Supplement Diabetic two times a day . . . 120 mL or 4 oz" and "House Supplement Diabetic as needed [prn] for Weight Loss Offer for meal replacement." The MAR for 02/10/20 showed an amount of 240 mL given at 9:00 a.m. and 4:00 p.m. A staff member (#2) identified she gave the resident one carton of house supplement (chocolate shake), and he gets one carton twice per day. Observation of the supplement identified the total volume as 120 mL. Failure to record actual supplement intakes may result in an inaccurate depiction of Resident #31's intakes and nutritional status. The medical record lacked evidence of prn supplements offered to enhance Resident #31's meal intakes.

During an interview on the afternoon of 02/11/20, a dietary supervisor (#1) stated the facility does not have a specific diabetic supplement, and Resident #31 receives the house supplement. The staff member stated they do not have a

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F 692	Continued From page 17 re-weigh policy, but Resident #31 "should have been reweighed" after his 10 pound weight loss, and she should have made a care plan sooner.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview the facility failed to provide respiratory care consistent with standards of practice and physician's orders for 1 of 1 sampled residents receiving continuous oxygen (Resident #235). Failure to appropriately administer oxygen as ordered may complicate a resident's respiratory status. Findings Include: Review of the facility policy titled "Procedure Oxygen Administration with Nasal Cannula, Face Mask or Face Tent. . . ." occurred 02/11/20. This policy dated, October 2017, stated, "Verify physician order. . . . Turn gauge to start flow rate at prescribed liters per minute [per physician's orders] . . . . Place cannula. . . ." - Observations of Resident #235 showed the following:	F 695	1) Resident #235 is deceased so the deficient practice will not recur. 2) All residents have the potential to be affected by the deficient practice. All physician orders as relates to oxygen will be followed appropriately at all times. 3) All nursing staff to be educated on following physician orders as relates to oxygen administration. 4) The Director of Nursing Services or designee will administer audits which will ensure that physician orders pertaining to oxygen are followed. These audits will be performed weekly for one month, every other week for two months and every month for three months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the	3/17/20

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F 695	Continued From page 18 *02/09/20 at 4:34 p.m.: The resident sitting in the wheelchair (w/c) with oxygen on via nasal cannula (NC) on a portable tank set at 3 liters per minute (L/min). *02/10/20 at 8:16 a.m.: The resident sitting in the w/c in the dining room with oxygen on via NC on a portable tank set at 1L/min. *02/10/20 at 9:01 a.m.: Two certified nursing assistants (CNAs) (#4 and #5) transferred the resident with a mechanical stand lift to a recliner in the commons area. The CNAs applied oxygen via NC on a portable tank set at 1L/min. *02/10/20 at 3:06 p.m.: The resident resting in bed with oxygen on via NC per concentrator set at 3L/min. *02/11/20 at 8:44 a.m.: The resident propelling himself in his w/c wearing oxygen via NC on a portable tank set at 1L/min. Review of Resident #235's medical record occurred on all days of survey. Diagnoses included Chronic Obstructive Pulmonary Disease, (a lung disease that blocks airflow to the lungs). Physician's orders included, "O2 [oxygen] 2L/min continuous." The care plan stated, "O2 @ [at] 2L/min continuous." During an interview on 02/11/20 at 8:47 a.m., when asked how staff knew what liter flow Resident #235's oxygen should be set at, a CNA (#5), stated, "It's care planned." During an interview on 02/11/20 at 4:25 p.m., an administrative nurse (#3) confirmed she expected staff to follow physicians orders for oxygen liter flow. The staff failed to provide oxygen therapy at the	F 695	progress of the Plan of Correction as relates to F695. 5) The corrective action will be completed by March 17, 2020.	

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F 695	Continued From page 19 prescribed liter flow.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 1 of 1 sampled resident (Resident #135) receiving hemodialysis outside the facility. Failure to have a written agreement with a dialysis facility and a coordinated care plan for dialysis care and services limited both nursing home and dialysis staff's ability to collaborate and communicate care needs to ensure continuity of care. Findings include: Review of the facility policy titled " Dialysis Services" occurred on 02/10/20. This policy, dated September 2016, stated, ". . . Locations caring for residents receiving dialysis services must have an agreement in place with the provider of the service. . . Care plan dialysis care specific to the resident: for example unique nutrition needs or fluid restriction. . . . " Review of Resident #135's medical record occurred on all days of the survey. The record showed admit diagnoses included ESRD (end	F 698	1) Resident #135 has since discharged and therefore the deficient practice will not recur. 2) All residents on dialysis have the potential to be affected by the deficient practice. All dialysis centers utilized by the facility will have a written agreement in place before a resident is sent for services. In addition, all dialysis residents will include on the care plan the name of the dialysis facility, the dietary dialysis guidelines, specific dialysis pre and post treatment, and documentation of the resident□s condition, access site care, nutritional care to include monitoring, documenting, and deciding how and when to address weight changes and nutritional issues. 3) All nurse management and administration personnel will be educated on the importance of having a written dialysis agreement in place before sending a resident for services as well as ensuring the care plan is updated with all pertinent dialysis documentation. This care plan documentation will be managed	3/17/20

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F 698	Continued From page 20 stage renal disease) on HD (hemodialysis - treatment that replaces the work of your own kidneys to clear wastes and extra fluid from your blood). Review of the progress notes showed the following: * 01/30/20 at 8:10 a.m. - ". . . Dressed in winter coat and hat for trip to [name of town] for dialysis. . . ." * 01/30/20 at 5:25 p.m. - ". . . Returned from Dialysis and appears very tired. While transferring to bed using full lift and assist of two began gagging. When settled on bed had large foody emesis. . ." * 02/01/20 at 3:36 p.m. - "Resident left at 0830 this AM for scheduled dialysis at [name of dialysis facility (incorrect facility documented)] [name of town]. . . Resident returned at 2:45 p.m. Tired but tol [tolerated] trip fairly well. Calm and pleasant. Assisted to bed to rest. . . ." Review of the current care plan showed, ". . . The resident needs dialysis on Tuesday-Thursday-Saturday E/B [evidenced by] end stage renal disease. . . Interventions: Monitor/document/report to health care provider PRN [as needed] for s/s [signs/symptoms] of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. . . . Monitor/document/report to health care provider PRN and s/s of infection to access site: Redness, swelling, warmth or drainage on subclavian dual lumen port. . . . Dialysis meal: send a packed lunch to dialysis with resident on Tuesday-Thursday-Friday. (encourage following Dietary dialysis guidelines) . . ."	F 698	through a dialysis UDA. 4) The Administrator or designee will administer audits which ensure that dialysis contracts are in place before our facility is utilizing their services. In addition, these audits will monitor the care plan has the name of the dialysis facility, the dietary dialysis guidelines, specific dialysis pre and post treatment, and documentation of the resident□s condition, access site care, nutritional care to include monitoring, documenting, and deciding how and when to address weight changes and nutritional issues. We will audit any resident new to dialysis services. These audits will be performed monthly for six months. The effectiveness of the audits will be discussed during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F698. 5) The corrective action will be completed by March 17, 2020.	

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F 698	Continued From page 21 The facility failed to include in the current care plan the name of the dialysis facility, the dietary dialysis guidelines, specific dialysis pre and post treatment monitoring and documentation of the resident's condition, access site care, nutritional care to include monitoring, documenting, and deciding how and when to address weight changes and nutrition issues. During an interview on 02/10/20 at 3:00 p.m., an administrative staff member (#3) acknowledged the progress note on 02/01/20 identified an incorrect dialysis facility and agreed the care plan failed to identify the name of the facility Resident #135 received dialysis treatments and failed to include specific pre and post dialysis care monitoring/interventions. During an interview on 02/10/20 at 3:45 p.m., an administrative staff member (#7) provided a written agreement between the long-term care facility and the dialysis facility. The agreement identified 02/10/20 as the effective date and date signed by both parties. The administrative staff person (#7) confirmed the facility failed to obtain a signed written agreement with the dialysis facility prior to services provided to Resident #135.	F 698		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		3/17/20

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F 755	Continued From page 22 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to establish a system to account for all controlled medications awaiting destruction in 1 of 1 cabinet containing narcotics for disposal. Failure to assure all controlled medications are accounted for until destruction has the potential for medication loss and/or diversion. Findings include:	F 755	1) No specific residents have been identified to be affected. 2) All residents have the potential to be affected by this deficient practice as this is a potential misappropriation of resident property. 3) All discontinued controlled medications will be counted each shift by two licensed nurses until disposal is completed. All licensed nurses and	

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F 755	Continued From page 23 Review of the facility policy titled "Medications - Controlled" occurred on 02/11/20. This policy dated December 2019, stated, ". . . Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming and off-going nurse/medication aide will work together to reconcile all controlled medications, including all discontinued controlled medications and document the same. . . . Controlled medications that have been discontinued should be placed in a locked box in the medication room as soon as they have been discontinued, or as indicated by state regulation. Controlled medications should continue to be counted by two nurses until disposal is completed." Observation of the medication room occurred on 02/10/20 at 10:17 a.m. with a medication aide II (MAII) (#2) and showed a locked box which contained an envelope with three Tramadol (narcotic) 50 mg pills designated for disposal along with an "Individual Resident's Narcotic Record" form dated 01/26/20 as the last counted date. An interview during the observation of the medication room, the MAII (#2) stated, "the narcotic record form is placed in the lock box along with the discontinued controlled medications and the medications are destroyed monthly by the director of nursing and the pharmacist." The MAII confirmed the controlled medications are not reconciled at the beginning/end of each shift and the charge nurse and MAII have keys to the medication room and locked box.	F 755	medication aides will be educated on the importance of counting discontinued controlled medications each shift with two nurses. 6) The Director of Nursing Services or designee will administer audits which ensure all discontinued controlled medications are counted every shift by two licensed nurses. These audits will be performed weekly for one month, every other week for two months and every month for three months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F755. 7) The corrective action will be completed by March 17, 2020.	

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F 755	Continued From page 24 During an interview on the morning of 02/11/20, an administrative nurse (#3) confirmed the discontinued controlled medications stored in the medication room lock box do not get counted by the nursing staff every shift until disposal is completed and agreed the facility does not have a good system for accountability of controlled medications waiting for disposal.	F 755		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F 790		3/17/20

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F 790	Continued From page 25 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, family interview, and staff interview the facility failed to assist in obtaining dental care to meet the needs of 3 of 12 sampled residents (Resident #10, #20 and #22). Failure to complete or accurately assess the resident oral/dental status, assist with oral care, and assist with making routine dental appointments may result in delayed dental care and/or dental complications. Findings include: Review of the facility policy titled "Dental/Oral Health Services and Assessments" occurred on 02/11/20. This policy, dated October 2017, stated, ". . . Residents are assisted, when necessary, in making routine and annual appointments. . . basic dental/oral health assessments may be performed by registered nurses . . . These assessments will be conducted before initial, quarterly and annual MDS [minimum data set] or with any oral changes. . . . The purpose of these assessments is for early	F 790	1) Resident #10, 20, and 22 will all have an oral assessment done immediately. Any dental referrals needed will be made immediately. Any refusals will be documented immediately. Any pertinent information needed on their care plans will be added as relates to dental cares. 2) All residents have the potential to be affected by this deficient practice. All resident or family concerns of dental issues will be addressed in a timely manner. Oral assessments will be completed on all residents in a timely manner. 3) All nursing staff will be educated on the importance of oral cares and documenting it properly. 4) The Director of Nursing Services or designee will administer audits which ensure oral assessments, oral hygiene documentation, and assistance with making routine and as-needed dental appointments are being carried out. Documentation if a resident or family	

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F 790	Continued From page 26 identification and evaluation of any dental/oral health problems in order for treatment by a dentist or other professional to begin as early as necessary. . . ." Review of the facility procedure titled "Oral/Dental Assessment" occurred on 02/11/20. This procedure, dated September 2018, stated, ". . . Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions missed. Referral for dental evaluation should be considered for these residents . . ." - Observation on 02/10/20 at 09:08 a.m., showed Resident #10 seated in the commons area of the facility seated in a wheelchair. Resident #10 indicated tooth pain. - Observation on 02/10/20 at 3:14 p.m., showed Resident #10 seated in a recliner in his/her room yelling out and complained of pain to the left lower gum. Review of Resident #10's medical record occurred all the days of survey. Diagnoses included dementia, and age related physical debility. The quarterly MDS, dated 11/19/19, identified moderately impaired cognition and personal hygiene (including oral care) with extensive assist of one staff. Review of the certified nursing assistant task documentation, for the previous 14 days, showed one instance of resident refusal of oral cares with no other documentation of oral care. Resident #10's care plan, revised 08/29/19, stated "ORAL CARE: Resident has full upper	F 790	refuses dental cares will also be audited. These audits will be performed weekly for two months, every other week for two months and every month for two months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F790. 5) The corrective action will be completed by March 17, 2020.	

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plate and partial lower plate. Encourage resident to brush his teeth, denture, partial and rinse his mouth. May report discomfort with teeth but has refused dental exams. Report any c/o [complaints] of mouth discomfort."

The medical record lacked documentation of routine oral care, documentation of routine oral/dental assessments for the past 12 months, and documentation of resident refusal of dental exams. The facility failed to provide this documentation when asked.

During an interview on 02/11/20 at 4:30 p.m., an administrative nurse (#3) agreed staff failed to document oral cares, dental assessments, and resident refusals of exams as expected.

- Observation on 02/09/20 at 2:14 p.m., showed Resident #20 lying in bed in his/her room, verbal responses were nonsensical. Resident #20 was observed to have missing teeth, broken teeth and a white plaque-like substance along the lower gumline.

Review of Resident #20's medical record occurred all the days of survey. Diagnoses included dementia. The most recent quarterly MDS, dated 12/20/19, identified severe cognitive impairment and extensive assistance of one staff with personal hygiene. The current care plan stated, ". . . The resident has oral/dental health problems R/T [related to] missing natural teeth . . . Provide oral care daily. May need extensive assistance of one with oral cares. . . ."

Review of progress notes showed the following: *01/31/20 at 5:38 a.m. - "One of resident's upper

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front teeth is broken off to the gum. Does not appear to be bothering her."
*02/3/20 at 1:58 p.m. - ". . . Message left on [name of family member] cell phone regarding missing front tooth. Asked he call to discuss if he wants his mum [sic] to be followed up by a dentist."

During an interview on 02/11/20 at 12:00 p.m., when asked about dental follow up regarding Resident #20's broken tooth, the administrative nurse (#3) stated they were waiting for family to call back and placed another call to family on 02/11/20. When asked about the frequency of oral/dental assessments, the administrative nurse (#3) reported the assessments should be completed quarterly and provided a copy of a completed oral/dental assessment. The assessment form showed a completion date of 02/11/20 and indicated, "date of last dental exam: Unknown" . The administrative nurse (#3) failed to provide any further oral/dental assessments for the past 12 months or identify a last dental exam date for Resident #20.

During a phone interview on 02/11/20 at 12:20 p.m., Resident #20's family member (A) reported he notified the facility the afternoon/evening of 02/03/20, the same day he received the message regarding the broken tooth.

The facility failed to document family member (A) response to the facility notification of change in oral health and/or a directive given regarding dental follow up.

- Observation on 02/09/20 at 2:38 p.m., showed Resident #22 seated in the recliner chair in

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F 790	Continued From page 29 his/her room, verbal responses were nonsensical. Resident #22 was observed to have broken/missing teeth. Review of Resident #22's medical record occurred all the days of survey. Diagnoses included dementia. The most recent quarterly MDS, dated 12/22/19, identified severe cognitive impairment and extensive assistance of one staff with personal hygiene. The current care plan stated, ". . . ORAL CARE: Resident has her own teeth, Needs assistance with brushing or swabbing mouth and gums. Last dentist appointment 4-01-19. . . ." During an interview on the afternoon of 02/11/20, when asked where to find daily documentation of oral care and the completed oral/dental assessments from the past 12 months for Resident #22, the administrative nurse (#3) provided one oral/dental assessment form which showed a completion date of 02/11/20, and reported she was unable to find any recent documentation (within the past 30 days) of daily oral care provided by staff for Resident #22. The administrative nurse (#3) stated she would expect certified nurse assistants to complete oral care at least daily and document care provided and/or document if the resident refused. The facility failed to complete and document quarterly, annual, or with any oral changes routine oral/dental assessments as stated in their policy.	F 790		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/17/20

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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F 880	Continued From page 31 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview the facility failed to ensure staff followed infection control practices for 1 of 1 sampled resident (Resident #12) with dressing change observed, 1 of 3 meals observed (supper on 02/09/20), 2 of 2 supplemental resident's (Resident #1 and #25) wheelchairs, and 2 recliners in the common area with uncleanable surfaces. Failure to ensure staff complete proper	F 880	1) No specific residents can be affected anymore during the hand hygiene instances, however Resident #1□s Broda chair will be repaired utilizing materials which can be cleaned. Resident #25□s wheelchair will be replaced with a wheelchair with all cleanable surfaces. The recliner chairs in the commons area will be replaced with new recliners with all-cleanable surfaces. The nurse whom	

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F 880	Continued From page 32 hand hygiene and ensure chairs have an intact surface for proper disinfecting may result in the spread of infection to residents, staff, and visitors. Findings include: Review of the facility policy titled "Wound Dressing Change" occurred on 02/11/20. This policy dated, October 2017, stated, ". . . Put on gloves. . . . Remove soiled dressing and discard in plastic bag . . . . Remove gloves and discard in same plastic bag. Perform hand hygiene. Create field with equipment/dressing wrappers. . . . Open all supplies and pour solutions if ordered. Put on gloves. . . ." "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, authors Audrey Berman, Shirlee Snyder, and Geralyn Frandsen, page 619 ". . . Standard Precautions: . . . Designed to reduce risk of transmission of microorganisms from recognized and unrecognized sources. . . . Perform proper hand hygiene immediately after removing gloves. . . ." page 617 ". . . Disinfecting: . . .When disinfecting articles . . . consider the following . . . The type and number of infectious organisms. Some microorganisms are readily destroyed whereas others require longer contact with the disinfectant. . . .The surface areas to be treated. The disinfecting agent must come into contact with all surfaces and areas. . . ." HAND HYGIENE - Observation on 02/10/20 at 10:51 a.m. showed a staff nurse (#6) entered Resident #12's room to	F 880	addressed Resident #12's dressing change during the survey will be educated on proper infection control practices as relates to wound dressings. 2) All residents have the potential to be affected by this deficient practice. Staff will exerciser proper hand hygiene in general, hand hygiene as relates to wound dressing changes and all equipment will be cleanable. 3) All staff will be educated on the importance of hand hygiene always and specific to these cases. Staff will also be educated on the importance of identifying when equipment is torn or unclean-able in any way and to report those concerns immediately. 4) The Director of Nursing Services or designee will administer audits which ensure proper hand hygiene practices in general and as relates to wound dressing changes as well as all equipment to remain cleanable. These audits will be performed weekly for two months, every other week for two months and every month for two months. These audits will be monitored for effectiveness during QAPI committee, wherein negative audit outcomes will be discussed and addressed. At each monthly QAPI committee meeting, we will discuss the progress of the Plan of Correction as relates to F880. 5) The corrective action will be completed by March 17, 2020.	

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change a pressure ulcer dressing. The staff nurse (#6) performed hand hygiene, donned gloves, and removed the soiled dressing from Resident #12's right hip. The staff nurse (#6) changed gloves without performing hand hygiene, cleansed the wound with normal saline, measured the wound, and removed soiled gloves. Without performing hand hygiene, the staff nurse (#6) opened the packing material to be placed into the wound, donned clean gloves, and packed the wound. The staff nurse (#6) removed gloves, covered the wound with a dressing, closed Resident #12's brief, pulled up Resident #12's pants, cleaned up the supplies, and performed hand hygiene.

In an interview on 02/11/19 at 4:25 p.m., an administrative nurse (#3) confirmed she expected staff to perform hand hygiene after removing gloves.

- Observation during meal service on 02/09/20 at 5:40 p.m., showed a resident at table #4 spilled a beverage, the liquid spilled on the table and onto the floor. The dietary staff member (#15) used a cloth to clean the liquid off the floor, then disposed of the soiled cloth into a laundry basket, removed his/her gloves, donned a clean pair of gloves and continued to serve residents coffee and plates of food. The dietary staff member (#15) failed to complete hand hygiene between glove changes.

DISINFECTING

Observation on all days of survey showed the following:
* Two recliner chairs located in the common area

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F 880	Continued From page 34 contained cracked/peeling vinyl/leather at the headrest, hand, and foot areas, as well as small holes on the backrest. * Resident #1's Broda chair had yellow duct tape wrapped around the left armrest. * Resident #25's wheelchair had cracked/tore/peeling vinyl on the outer side of the backrest. The surface area of the recliners and resident chairs is not cleanable. During an interview on the afternoon of 02/11/20, an administrative staff member (#7) agreed it would be difficult to ensure proper disinfection of chairs when the material is not intact.	F 880		