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 _____	04/12/2018

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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 04/09/18 and concluded on 04/12/18.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604		5/17/18

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

Electronically Signed | 05/01/2018

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F 604	Continued From page 1 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess for the use of siderails, positioning bars, and bed and/or chair alarms for 6 of 12 sampled residents (Resident #1, #4, #13, #25, #27, and #34) observed with bed and chair alarms and/or a siderail/positioning bar. Failure to complete the necessary assessments, and document ongoing re-evaluation of the need for the need for the devices placed the residents at risk for injury and has the potential to act as a restraint by limiting their movement. Findings include: Review of facility policy titled "Restraints" occurred on 01/12/18. This policy, revised October 2017, stated, ". . . Residents are free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. When the use of restraints is indicated, the locations must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints . . . There must be documentation in the medical record . . . and ongoing re-evaluation of the need for the restraint . . . Prior to using a side rail, assess the rail for any safety issues . . .The registered nurse will complete the designated portions of the Physical Device and Restraint Assessment . . . Obtain the physician's order for the appropriate restraint . . . Obtain informed consent using the permission for use of physical restraints. . . ." - Review of Resident #1's medical record	F 604	1) Physical Device and Restraint Assessments will be performed on Residents #1, #4, #13, #25, #27, and #34 by May 17, 2018. A Physical Device and Restraint Review, a re-evaluation, will be done quarterly on each of these residents. 2) All residents have the potential to be affected by this deficient practice. Physical Device and Restraint Assessments will be performed on all other residents by May 17, 2018. A Physical Device and Restraint Review, a re-evaluation, will be done quarterly on each of those residents, as well. 3) Upon admission, a Physical Device and Restraint Assessments will be performed on a resident. A Physical Device and Restraint Review, a re-evaluation, will be done quarterly for all residents. In addition, any time there is an issue identified that is related to falls, restraints, assistance with mobilization, change in condition, etc., the Physical Device and Restraint Assessment will be performed. The interdisciplinary team will review this process and all assessments quarterly. 4) Audits will be performed on this process biweekly for the duration of one month, then weekly for the duration of one month, and monthly for the duration of four months. This audit will include a random selection of residents with either a bed rail, chair or bed alarm and will ensure there is an initial and subsequent review assessments documented for its	

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F 604	Continued From page 2 occurred on all days of survey. An annual Minimum Data Set (MDS), dated 3/19/18, identified the resident used bed rails and a bed alarm daily. A physician order, dated 11/11/17 stated, ". . . positioning bar for bed mobility. Review of the most current care plan stated, " . . . bed alarm to aid staff awareness of movement. . . ." The medical record lacked assessments for the bed rail and the bed alarm. Observations on 04/09/18 at 1:43 p.m., showed Resident #1 lying in her bed with a right side positioning bar and bed alarm in place on her bed. During an interview on 04/11/18 at 04:04 p.m., an administrative nurse (#1) identified the facility failed to complete assessments for Resident #1's bed rails and alarms. - Review of Resident #25's medical record occurred on all days of the survey. A quarterly MDS, dated 2/6/18, identified the resident used bed rails and a chair alarm daily. Review of the current care plan stated, " . . . chair alarm used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." The medical record lacked assessments for the bed rail and the bed alarm. Observations on 04/09/18 at 1:48 p.m., showed a 1/4 right side bed rail on Resident #25's bed. The back of the resident's wheelchair showed an alarm, with the string from the device attached to the resident's clothing. If the resident attempted to stand, the string would pull and an alarm would sound.	F 604	effectiveness and appropriateness. If any change has been occurred with the resident chosen, the audit will check that a Physical Device and Restraint Assessment was done once again. Progress will be measured and tracked by the QA Committee on a monthly basis. The Director of Nursing Services or designee will monitor this process and the corrective action involved, if any. 5) This deficiency will be corrected by May 17, 2018.	

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F 604	Continued From page 3 - Review of Resident #34's medical record occurred on all days of the survey. Review of the current plan stated, " . . . bed and chair alarms used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." A physician's order, dated 03/27/18, stated " . . . order for bed and chair alarm. . . ." Observation on 04/09/18 at 2:07 p.m., showed Resident #34 laying in her bed. A 1/2 right side bed rail and an alarm were in place on her bed. The resident's wheelchair also showed an alarm in place. The medical record lacked assessments for the bed rail and alarm. - Review of Resident #4's medical record occurred on April 10-12, 2018. A Quarterly MDS, dated 03/23/18, identified both bed and chair alarms in use daily. A physician's order, dated 04/20/17, stated, ". . . alarms; bed and chair. . . safety/fall precautions." The resident's current care plan stated, "The resident has had an actual fall with no injury R/T slid off bed. . . . has bed alarm. . . ." Resident #4's record lacked assessments for the bed and chair alarms. Observations on all days of survey showed bed and chair alarms in use for Resident #4. - Review of Resident #13's medical record occurred on April 10-12, 2018. The resident's current care plan regarding falls stated, ". . . Personal alarms not used due to setting resident into a manic phase for her Schizophrenia. . . ." A Significant Change in Status MDS, dated 01/01/18 identified no alarms in use for Resident #13.	F 604		

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F 604	Continued From page 4 Observation on 04/09/18 at 3:49 p.m. showed Resident #13 seated in her wheel chair with a chair alarm in place. Further observations showed the alarm remained in place on all days of survey. - Review of the medical record for Resident #27 occurred on April 09-12, 2018. A quarterly MDS, dated 02/25/18, identified the resident used bed rails daily, a bed alarm daily, and a chair alarm less than daily. The medical record lack assessments for the bed rails and both alarms. Observations on the afternoon of 04/09/18 showed a bed alarm and bed rails in place, but failed to show a chair alarm in use for Resident #27. On 04/10/18, at 10:12 a.m., observation showed the chair alarm in place and functioning, as two CNAs (#2 and #3) assisted the resident to stand and the alarm sounded. During an interview on 04/11/18 at 04:04 p.m., an administrative nurse (#1) identified the facility failed to complete assessments for Resident #27's restraints.	F 604		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		5/17/18

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F 644	Continued From page 5 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 2 sampled residents (Resident #27) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC])	F 644	1) A Level II screening will be performed on Resident #27 by May 17, 2018. 2) All residents have the potential to be affected by this deficient practice. For other residents, all psychiatric appointments, all progress notes, and all orders will be reviewed from the last six months. This will ensure that all new diagnoses that may have been missed will be accounted for and treated accordingly with a new screening, if needed. 3) An in-service conducted by the Director of Nursing Services or designee will be provided to all licensed nurses by May 17, 2018. Within this in-service will be the importance of noting new diagnoses when observing orders. A list of diagnoses to look for will be posted at the charting station. In addition, upon admission, all diagnoses will be reviewed and checked for proper screenings. This task will be added to the facility's internal "admission checklist." The Director of Social Services or designee will look at all upcoming doctor's visits and check for progress notes with those visits that might	

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F 644	Continued From page 6 was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #27's medical record occurred on April 09-12, 2018. The record showed an initial PASARR completed August 2012, prior to the resident's admission to the facility and identified a diagnosis of dementia and no mental illness. A psychiatric progress note, dated 10/25/17, identified a new diagnosis of unspecified schizophrenia spectrum and other psychotic disorder. The record lacked evidence the facility completed a Level I screening/change in status assessment since this diagnosis. During interviews on the morning of 04/12/18, with administrative staff members (#5, #8 and #9) indicated the facility became aware of the new diagnosis during a medical record audit in March 2018 and added it to the resident's current diagnoses list. All the staff members agreed the facility failed to contact Ascend to update the Level I screen.	F 644	contain new or changed diagnoses. 4) Audits will be performed on this process biweekly for the duration of one month, then weekly for the duration of one month, and monthly for the duration of four months. This audit will choose a random resident and will ensure that, if they have a qualifying diagnosis, a proper screening was done. Progress will be measured and tracked by the QA Committee and Behavior Committee on a monthly basis. The Director of Social Services or designee will monitor this process and the corrective action involved, if any. 5) This deficiency will be corrected by May 17, 2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/17/18

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F 656	Continued From page 7 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to implement perineal cares as specified in the care plan for 1 of 1 sampled resident (Resident #7) with physician's orders regarding perineal care. Failure to implement Resident #7's care plan as ordered by the physician may negatively impact the	F 656	1) Resident #7's cares will be done per the care plan. Reminders will be placed in the communication book, which is available to all nursing staff, at the charting station. All nursing staff will be encouraged and reminded to review the care plan before each shift. This particular	

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F 656	Continued From page 8 resident's quality of life. Finding include: Review of Resident #7's medical record occurred on April 09-12, 2018. An annual Minimum Data Set, dated 03/29/18, identified the resident required extensive assist of one person for toileting and extensive assist of two persons for transfers. The current care plan, stated, " . . . Toileting schedule: toilet before and after periods of rest, before and after meals and snacks and prn [as needed]. Check and change as needed. (DO NOT USE WIPES IN PERI AREA) Use warm water and mild soap, rinse well and pat dry. . . ." During observation on 04/10/18 at 11:10 a.m., two certified nurse aides (CNAs) (#2 and #3) assisted Resident #7 with toileting. One CNA (#2) cleansed Resident #7's peri area, soiled with stool, using premoistened wipes. The CNA (#2) failed to use warm water and mild soap, rinse Resident #7 well and then pat dry. During an interview on 04/12/18 at 11:05 a.m., an administrative nurse (#5) confirmed staff should follow Resident #7's physician order/care plan.	F 656	issue regarding Resident #7's peri cares will be placed in the daily assignment sheet from April 30 to May 17, 2018. 2) All residents have the potential to be affected by this deficient practice. Nursing staff will continuously be reminded of the importance of carrying out the care plan as it is written and checking the care plan before the start of their shift. This reminder will be placed in the communication book, which is available to all nursing staff, at the charting station. It will also be placed at the top of every daily assignment sheet. 3) A mandatory in-service training related to care plans and the importance of carrying out the care plan as it is written will be performed by the Director of Nursing Services or designee and will be attended by all nursing staff by May 17, 2018. Any changes to care plans will be communicated. 4) Audits will be performed on this process biweekly for the duration of one month, then weekly for the duration of one month, and monthly for the duration of four months. This audit will include a random sample of residents and will ensure that what is written in their care plans is indeed what is being performed. Progress will be measured and tracked by the QA Committee on a monthly basis. The Director of Nursing Services or designee will monitor this process and the corrective action involved, if any. 5) This deficiency will be corrected by May 17, 2018.	
F 657	Care Plan Timing and Revision	F 657		5/17/18

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F 657 SS=E	Continued From page 9 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). 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 observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 5 of 12 sampled residents (Resident #4, #13, #25, #27, and #34). Failure to revise the care plan limited staff's ability to communicate care needs and	F 657	1) Resident #4's care plan will be updated to reflect chair alarms in use. Resident #13's care plan will be updated to reflect chair alarms in use. Resident #27's care plan will be updated to reflect chair alarm use. Resident #25's care plan will be updated to reflect bed rail use.	

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F 657	Continued From page 10 ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Care Plan and Care Conferences" occurred on 4/12/18. This policy, revised February 2018, stated, ". . . to provide an on going method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest level of functioning . . . designated employee will . . . implement a system for developing and updating care plans . . . interventions are what employees do to help residents reach their goals . . . care plans must be revised as the resident's needs/status changes. . . ." - Review of Resident #25's medical record occurred on April 10-12, 2018. A Quarterly Minimum Data Set (MDS), dated 02/06/18, identified the resident used a bed rail and a chair alarm daily. The current care plan stated, " . . . chair alarm used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." The resident's care plan failed to identify the use of the side rail. Observation on 04/09/18 at 1:48 p.m., showed a bed rail in place on Resident #25's bed. During an interview on 04/12/18 at 10:45 a.m., two administrative nurses (#1 and #7) identified staff failed to update the resident's care plan to include the use of the bed rail. - Review of Resident #34's medical record occurred on all days of the survey. The record	F 657	Resident #34's care plan will be updated to reflect her non-weight bearing status. All these changes will be performed by May 17, 2018. 2) All residents have the potential to be affected by this deficient practice. The care plans are reviewed quarterly and will have timely updates. Care plans will be reviewed in regard to side rails, mobility, and bed and chair alarms. 3) A mandatory in-service training related to care plans and the importance of revising the care plan will be performed by the Director of Nursing Services or designee and will be attended by all licensed nursing staff by May 17, 2018. Any changes to care plans will be communicated. Nurse Managers will be the only ones able to change care plans and charge nurses and/or other nursing staff will have the responsibility to recommend changes. A care plan book will be established and maintained in the charting station for any and all nursing staff to review. This will provide consistent conversation surrounding care plans and their changes. 4) Audits will be performed on this process biweekly for the duration of one month, then weekly for the duration of one month, and monthly for the duration of four months. This audit will include a random sample of residents and will ensure any changes to the care we are providing is reflected in the care plan. Progress will be measured and tracked by the QA Committee on a monthly basis. The Director of Nursing Services or	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 indicated Resident #34's left arm disabled due to a birth defect and missing left hand. The current care plan identified the resident was non-weight bearing on her left leg due to a fractured patella (knee cap). The care plan stated, ". . . Educate resident on safe use of walker with using both arms instead of guiding it with only her dominant hand. W/C [wheelchair] adjusted to disabled left arm for safety et [and] comfort. . . ." During an interview on 4/12/18 at 10:45 a.m., two administrative nurses (#1 and #7) identified staff failed to update Resident #34's care plan regarding use of the walker. - Review of Resident #4's medical record occurred on April 10-12, 2018. A Quarterly MDS, dated 03/23/18, identified bed and chair alarms used daily. The resident's current care plan identified the bed alarm, but failed to identify use of the chair alarm. Observations on all days of survey showed bed and chair alarms in use. - Review of Resident #13's medical record occurred on April 10-12, 2018. A Significant Change in Status MDS, dated 01/09/18 identified no alarms in use for Resident #13. The resident's current care plan regarding falls stated, ". . . Personal alarms not used due to setting resident into a manic phase for her Schizophrenia. . . ." Observations on all days of survey identified a chair alarm in place on Resident #13's wheel chair. - Review of the medical record for Resident #27 occurred on April 09-12, 2018. A quarterly MDS, dated 02/25/18, identified the resident used bed rails daily, a bed alarm daily, and a chair alarm	F 657	designee will monitor this process and the corrective action involved, if any. 5) This deficiency will be corrected by May 17, 2018.	

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	355104	A. BUILDING _____ B. WING _____	04/12/2018

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F 657	Continued From page 12 less than daily. The care plan failed to identify Resident #27 used a chair alarm. An observation on 04/10/18, at 10:12 a.m., showed the chair alarm in place and functioning, as two CNAs (#2 and #3) assisted the resident to stand and the alarm sounded. During an interview on the morning of 04/12/18, an administrative nurse (#1) identified staff were trying to be "helpful" and applied the chair alarm to Resident #27. She stated Resident #27 had used them in the past but is no longer using the chair alarm.	F 657		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		5/17/18

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F 880	Continued From page 13 §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: (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	F 880		

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F 880	Continued From page 14 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, and staff interview, the facility failed to ensure staff followed infection control practices during observations on 3 of 4 days of survey (April 9-11, 2018). Failure to follow infection control practices may result in the spread of infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 04/11/18. This policy, revised January 2018, stated, " . . . Regular handwashing with soap and warm not hot water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others . . . The goal is to prevent the spread of infection between residents . . . Proper handwashing and appropriate use of gloves protects residents against foodborne illness . . . gloves require handwashing when donned and doffed. . . ." Review of the facility policy titled " Procedure for cleaning portable equipment: blood pressure cuffs, thermometers, lefts, etc." occurred on 4/11/18. This undated policy stated, " . . . To disinfect equipment that is taken into individual rooms and prevent possible cross contamination from resident to resident . . . use a germicidal	F 880	1) Mandatory education on the importance of hand washing/proper ware washing will be provided at for all Nursing and Food and Nutrition staff by May 17, 2018. 2) This deficiency has the potential to affect all residents. The facility will continue to maintain all basic infection control standards. 3) Mandatory education on the importance of hand washing/proper ware washing will be provided at for all Nursing and Food and Nutrition staff by May 17, 2018. This education will include the use of a clean apron when putting away clean dishes, cleaning the lifts in between cares, as well as the importance of hand washing after the use of gloves. 4) Audits will be performed on this process biweekly for the duration of one month, then weekly for the duration of one month, and monthly for the duration of four months. This audit will include a random observation of residents and that the infection control practices, specific to hand washing, lift cleaning between cares and ware washing, were appropriate. Progress will be measured and tracked by the QA Committee on a monthly basis. The Director of Nursing Services or	

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F 880	Continued From page 15 wipe to wipe down the item that was used. . . allow the item to air dry . . . remove the portable equipment item from the resident's room . . . wash your hands . . . follow these steps each time the item is used in a resident room. . . ." HAND HYGIENE/EQUIPMENT CLEANING - Observation on 04/09/18 at 3:03 p.m., showed two Certified Nursing Assistants (CNAs) (#7 and #10) donned gloves and performed a brief check and change for Resident #3. Both CNAs removed their gloves, and without performing hand hygiene, transferred the resident from his bed to his wheelchair with a full body mechanical lift. Resident #3 asked the CNAs for a "piece of chocolate." The CNA (#7) reached into the resident's bag of candy, selected a snack size candy bar, unwrapped it, and gave it to the resident, then performed hand hygiene and left the room. The other CNA (#10) removed the lift from the room, parked it in the hall, and walked away. The CNA (#10) failed to clean the lift after removing it from Resident #3's room. - Observation on 04/09/18 at 3:23 p.m., showed two CNAs (#3 and #7) donned gloves and transferred Resident #1 from her bed to the bathroom, assisted her with toileting, and performed perineal cares. Without performing hand hygiene, the CNAs (#3 and #7) transferred Resident #1 to her chair. The CNA (#3) then handed her a glass of water, brushed her hair, and placed the foot pad on the chair. The CNAs (#3 and #7) then washed their hands and left the room. - Observation on 04/09/18 at 4:30 p.m., showed	F 880	designee will monitor this process and the corrective action involved, if any. 5) This deficiency will be corrected by May 17, 2018.	

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F 880	Continued From page 16	F 880		

two (CNAs) (#6 and #7) assisted Resident #33 with perineal cares following a bowel movement. The CNA (#7) removed her soiled gloves, and without performing hand hygiene, positioned Resident #33 in his wheelchair, attached the foot pedals, placed the resident's feet on the pedals, removed a soaker pad from bed, placed the resident's hat and glasses, and removed the lift from the room.

- Observation on 04/10/18 at 10:12 a.m., showed two CNAs (#2 and #3) assisted Resident #27 with perineal cares following a bowel movement. After positioning Resident #27 in her wheelchair, and without performing hand hygiene, the CNA (#2) handed Resident #27 a glass of water.

- Observation on 04/10/18 at 11:10 a.m., showed two CNAs (#2 and #3) assisted Resident #7 to the bathroom and back to her wheelchair with a mechanical lift. Following the transfer, the CNAs (#2 and #3) took the lift to another resident's room without cleaning it.

During an interview on 04/11/18 at 4:30 p.m., an administrative nurse (#7) stated she expected staff to perform hand hygiene after performing perineal cares and expected staff to clean lifts after each use.

WARE WASHING

Review of the facility policy titled "Ware Washing" occurred on 04/11/18. This policy, dated December 2017, stated, ". . . Employees wash hands between dirty/clean sides of dish machine. . . ."

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F 880	Continued From page 17 During the dietary tour on 04/11/18 at 12:35 p.m., observation showed an unidentified dietary staff member wore an apron and gloves while handling dirty dishes. The staff member rinsed left over food from the dishes on the dishwasher rack. Water splashed off the dirty dishes onto the staff member's apron. The staff member prepared three racks of dishes for washing in this manner, then changed glove, and without performing hand hygiene or removing her apron, went into the kitchen and returned with a plate storage rack. The dietary aide moved clean plates into the plate rack while wearing the wet/soiled apron. When interviewed during the dietary tour, an administrative dietary staff member (#4) confirmed staff should wash their hands between the clean and soiled dish washing tasks and should remove their soiled aprons before handling clean dishes.	F 880		