DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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RECEIVED
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Division of Health Facilities

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 ______	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 02/03/14 and completed on 02/05/14, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000	**GSS General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required y the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/21/13. Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess resident behaviors, develop and implement specific individualized interventions, monitor the effectiveness of interventions and revise them accordingly for 1 of 1 sampled resident (Resident #3) who displayed sexually aggressive behaviors. Failure to assess behaviors and monitor resident response has the potential to put residents' safety at risk. Findings include: Review of the facility policy titled "Behavior Management Committee" occurred on 02/05/14. This policy, dated September 2010, stated, " . . .	F 250	**F- 0250** ~~1. On February 11, 2014 the Behavior Management Committee met and specific behavior documentation options were added to the electronic medical record for Resident #3.~~ ~~2. A list of residents with behaviors has been identified through the CMS Census and Condition Report and the Behavior Management Committee.~~ 3. A mandatory All Staff personnel in-service was held on 2/25/14 to review policy and procedure "Behavior Management Committee" with an emphasis on individualized interventions. The Committee will meet monthly to analyze the root cause of a resident's behaviors as well as provide non-medical alternatives/interventions/education to staff and monitor the effectiveness of the interventions. Care plans will be updated as needed.	See page 2 See page 2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2-26-14

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

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F 250	Continued From page 1 A Behavior Management Committee is formed to analyze the root cause(s) of a resident's behavior as well as provide alternatives to staff for solutions. It is designed as an interdisciplinary vehicle using the talents of staff across all shifts and disciplines. The committee determines the frequency of the meetings. . . . focuses on the identified treatment and evaluation of behaviors . . . Information and plans generated from this meeting will be used to update care plans on these residents on a more frequent basis than the traditional quarterly care plan. . . . The social worker is considered to be the lead person in developing and promoting the concept of this committee and coordinating its actions. . . b. STANDARD MEETING AGENDA: . . . 3) . . . a) Review behavioral details; what when why. b) Review behavior interventions and their effectiveness. c) Develop additional or modified interventions. d) Review appropriateness of placement; room, unit, center. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included vascular dementia, anxiety and depression. The current Minimum Data Set (MDS), dated 01/01/14, identified the resident as cognitively intact. Resident #3's care plan, dated, 01/09/14, stated, " . . . The resident has a behavior symptom R/T [related to] vascular dementia E/B [evidence by] my [sic] try to follow resident [resident medical record number] to her room, coax her to a different room or try to hold her hand . . . Interventions: Intervene as necessary to protect the rights and safety of others. . . Divert attention. Remove from situation and take to alternative location. . .	F 250	4. An audit has been developed to monitor if interventions have been developed and documented properly for residents with behaviors identified through the Behavior Management Committee. The audit will be completed weekly times 4 weeks and monthly times 2 months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Social Worker or designee. F- 250 1. On February 11, 2014 the Behavior Management Committee met and looked at Resident #3's behaviors. Behaviors specific to Resident #3 were added to the electronic medical record. Facility is seeking different placement for Resident #3. 2. Residents with behaviors were identified through the CMS Census and Condition report and the Behavior Management Committee and behaviors specific to those residents have been added to each electronic medical record. per telephone conversation and Email with/from Adm & DON on 3/6/14 KB	03/12/14

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Resident #3's interdisciplinary progress notes (IDP) identified the resident exhibited the following behaviors:
* 07/30/13 at 7:30 p.m. " Res [resident] seen holding onto female res hand. Female res stated 'I'm going to hit you' When asked res [#3] why- stated "I want her to go over there' pointing to area near candy machine. . . ."
* 08/01/13 at 7:30 p.m. "Activity assistant reported to writer res. was asking female res (confused) to go to his room. . . ."
* 08/03/13 at 10:30 p.m. "At 1950 [7:50 p.m.] writer came down 100 wing to common area. Saw this res. sitting next to Female res. [room number] and he was sitting sideways in his chair facing her with his head down in front of her left chest. . . ."
* 09/18/13 at 8:05 p.m. "CNA [certified nurse assistant] heard [medical record number] say 'leave me alone' found res. [#3] and female res. by pop machine. When CNA asked female resident what happened she said he was kissing her. . . ."
* 09/20/13 at 10:00 p.m. "At 2110 [9:10 p.m.] CNA reports she noted resident [#3] coming out of TV lounge. Female res [medical record number] was in lounge area. Her robe was off laying across chair so had gown on only. Res. was asked if she took it off and said she did not know. When writer approached this res. [#3] he denied being in the lounge at all."
* 10/08/13 at 1:15 p.m. "Resident sitting at common area table-female resident [at] table- [Resident #3] leaned over to her and said 'Can I have a kiss?' . . . "
* 11/08/13 at 2:45 a.m. "Resident grabbed another female resident by the breasts . . . "
* 11/15/13 at 2:18 p.m. "resident tried to get

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female res to go to his room. the female resident said no. . . ."
* 01/24/14 at 7:23 p.m. "CNA reported resident had his hand under another resident's shirt and bra."
* 02/03/14 11:09 p.m. "Resident was very restless this pm. . . . He was seen holding hands with vulnerable resident and walking down the hall with her. . . ."

Observation on 02/03/14 at 4:35 p.m. showed Resident #3 sitting in the commons area holding hands with a female resident (not the resident identified in his care plan).

Review of Resident #3's medical record identified the last physician progress note was dated 08/27/13, and stated, ". . . Nursing staff expresses no new concerns or complaints. . . ."

Resident #3's IDP notes from the behavior committee identified a late entry on 08/29/13 - " Behavior Committee met to discuss . . . Behaviors tend to improve if he knows administration is watching him. He continues to seek out certain female resident [medical record number]."

During an interview on the afternoon of 02/04/14, an administrative social service staff member (#9) stated she is in charge of behavior meetings and they are usually conducted one time a month. On 02/05/14 at 9:45 a.m., this staff member (#9) stated the record lacked any additional behavior committee progress notes and stated, the last meeting may have been in October.

During an interview on the morning of 02/04/14, an administrative nursing staff member (#4)

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F 250	Continued From page 4 stated, she was not aware of Resident #3's last two behavior episodes and did question if this facility is appropriate for the resident. Failure to establish an individualized behavior management program with individualized interventions, to assess causative factors for the behavior, and monitor the on-going behavior for Resident #3 resulted in repeat incidents of sexually aggressive behavior. The facility failed to conduct behavior meetings and provide evidence they informed the physician of Resident #3's behaviors.	F 250		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	**F- 0278** F- 278 1. Residents #2, #4, #6, #7, #8, #9 will have bowel and bladder MDS coding corrected and submitted. Resident #3's MDS will be corrected and submitted for cognitive patterns. **2. All residents in the facility have the potential to be affected.** **3. A mandatory in-service for MDS coding personnel was held on 2/25/14 to review Policy and Procedure "Assessment" and "MDS 3.0/RAI" with an emphasis on accurate MDS coding for Bladder and Bowel and Cognitive patterns.**	per telephone conversation & Email on 3/6/14 c DON & Adm KB

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F 278	Continued From page 5 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 6 of 6 sampled residents (Resident #2, #4, #6, #7, #8, and #9) regarding a toileting program and 1 of 1 sampled resident (Resident #3) regarding delusional behaviors. Failure to accurately code the MDSs for these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, October 2011, page 2-1 stated, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 stated, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ."	F 278	4. An audit has been developed to monitor the accuracy of bowel and bladder and cognitive pattern coding with all quarterly MDS assessments. The audit will be completed weekly times 3 months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the DNS or designee.	03/12/14

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Page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of:
* an individualized care plan
* The Medicare Prospective Payment System
* Medicaid reimbursement programs
* quality monitoring activities . . .
* the data-driven survey and certification process . . .
* the quality measures used for public reporting . . ."

The Long-Term Care Facility RAI User's Manual, page E-1, stated, "Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary." Page E-2 stated, "Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis . . ."

- Review of Resident #6's medical record occurred on February 03-05, 2014. A quarterly MDS, dated 11/27/13, identified the resident as occasionally incontinent of bladder and on a urinary toileting program.

Resident #6's Bladder Assessment, dated 12/02/13, indicated this resident was not recommended for a toileting program. The assessment identified the proposed schedule for a toilet program as "Resident toilets self frequently throughout the day."

Resident #6's current care plan identified the problem of "Alteration in Elimination R/T [related to] urinary incontinence M/B [manifested by] DX [diagnosis] of overactive bladder" and the plan of "Toilet per schedule: Upon rising, before and after

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meals, HS [hour of sleep] and PRN [as needed] . . ."

During an interview on 02/04/14 at 1:45 p.m., a Certified Nursing Assistant (CNA #2) stated the resident usually takes herself to the bathroom during the day. The staff member confirmed facility staff cues the resident according to the above schedule.

- Review of Resident #9's medical record occurred on February 03-05, 2014. A quarterly MDS, dated 0/10/14, identified the resident as frequently incontinent of urine, on a urinary toileting program, and on a bowel toileting program.

Resident #9's Bladder Assessment, dated 02/05/14, identified the proposed schedule for toileting program as "Cont [continue] on scheduled toileting before et [and] [after] periods of rest, meals, and snacks."

Resident #9's current care plan identified the problem of "The resident has ADL [activities of daily living] self care performance deficit R/T Dementia E/B [evidenced by] need for assistance" and the plan of ". . . Toileting schedule: upon rising, immediately after breakfast, before and after meals and rest periods and prn . . ."

Resident #9's toileting record identified 29 episodes of incontinence and 10 episodes of continence for the week of January 28-February 5, 2014.

During an interview on 02/04/14 at 3:30 p.m., a CNA (#3) stated facility staff toilet Resident #9

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F 278	Continued From page 8 "every one and one half to two hours." The staff member stated Resident #9 requested to be toileted. - Review of Resident #2's medical record occurred on all days of survey. The annual MDS, dated 11/14/13, identified the resident as frequently incontinent of bladder, occasionally incontinent of bowel, and on a urinary and bowel toileting program. The Care Area Assessment (CAA), dated 11/14/13, stated, "Has been incontinent of urine for years and does not show improvement despite toileting schedule. Incontinent 17 times verses 10 continent voiding during assessment week." Resident #2's bladder assessment, dated 11/15/13, recommended a scheduled toileting program and stated, "Proposed Schedule: Before et [and] [after] periods of rest/sleep, before et [after] meals and snacks and PRN [as needed]." The bowel assessment, dated 11/15/13, failed to identify a scheduled plan. Review of Resident #2's voiding record identified 25 episodes of incontinence and eight episodes of continence from 01/28/14 to 02/04/14 (seven days). During an interview on 02/05/14 at 8:55 a.m., an administrative nursing staff member (#4) confirmed toileting schedules "must be more specific to qualify as a toileting program." During an interview on 02/04/14 at 1:20 p.m., the CNA (#5) stated staff try to take Resident #2 to the bathroom when she gets up in the morning, after each meal, and at bedtime.	F 278		

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F 278	Continued From page 9 - Review of Resident #7's medical record occurred on February 04-05, 2014. The quarterly MDS, dated 12/03/13, identified the resident as frequently incontinent of bladder, occasionally incontinent of bowel, and on a bowel and bladder toileting program. Resident #7's bladder assessment, dated 11/19/13, recommended a scheduled toileting program and stated, "Proposed Schedule: Before et [after] periods of rest/sleep, before et [after] meals and snacks and PRN [as needed]." The bowel assessment, dated 11/19/13, failed to identify a scheduled plan. Review of Resident #7's voiding record identified 18 episodes of incontinence and 13 times of continence from 01/28/14 to 02/04/14 (seven days). - Review of Resident #8's medical record occurred on February 04-05, 2014. A quarterly MDS, dated 01/01/14, identified the resident as frequently incontinent of urine, occasionally incontinent of bowel and on a urinary and bowel training program. Resident #8's care plan stated, "The resident has an ADL self care performance deficit R/T [related to] CAD [coronary artery disease] with history of Cardiac Arrest . . . Interventions . . . Toilet Use: Resident is totally dependent on staff for toilet use. Toileting schedule: toilet before and after periods of rest, before and after meals and snacks and prn. Check and change as needed. . . ." Review of Resident # 8's voiding record identified 26 episodes of incontinence and eight episodes	F 278		

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F 278	Continued From page 10 of continence from 01/28/14 to 02/04/14 (seven days). During an interview on 02/04/14 at 3:55 p.m., the CNA (#8) stated staff toilet Resident #8 whenever she is up and walking, on rounds, before snacks and meals. During an interview on the morning of 02/05/14, an administrative staff member (#4) confirmed Resident #8's toileting schedule did not qualify as a toileting plan. - Review of Resident #4's medical record occurred on all days of survey. The annual MDS, dated 01/16/14, identified the resident as frequently incontinent of bowel and on a toileting program. Resident #4's bowel assessment dated 02/05/14, failed to identify a consistent bowel pattern. Resident #4's care plan stated, "The resident has bowel incontinence R/T dementia. . . . Interventions: Observe pattern of incontinence. Toilet resident upon rising, before and after meals and rest periods, at HS [hour of sleep] and prn. . . ." Review of Resident #2, #4, #6, #7, #8, and #9's medical record lacked evidence staff developed an individualized, resident-specific plan based on the resident's bladder and/or bowel patterns. - Review of Resident #3's record occurred on all days of survey. Diagnoses included vascular dementia, anxiety, agitation, and history of hallucinations and paranoia. The current MDS, dated, 01/01/14, identified Resident #3 exhibited delusions during the seven day assessment	F 278		

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F 278	Continued From page 11 period. Review of the medical record failed to identify any delusional behaviors exhibited by Resident #3 during the MDS assessment period. During an interview on the morning of 02/05/14, an administrative social service staff (#9) confirmed Resident #3's medical record lacked documentation of any delusional behaviors observed during the seven day assessment.	F 278		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store foods in a safe and sanitary manner for 1 of 1 kitchen. This practice placed food at risk for contamination which may result in food borne illness when consumed by residents. Findings include: Review of the facility's policy "Leftovers" occurred on the morning of 02/04/14. This policy, dated	F 371	**F- 0371** **1. After the dietary tour conducted on 2/4/14, the open, two pound package of sliced deli turkey and one case containing three and a half flats of eggs were discarded.** **2. All residents in the facility have the potential to be affected.** **3. A mandatory dietary personnel in-service was held on 2/25/14 to review Policy and Procedure "Leftovers" with an emphasis on items that do not have a planned use within 72 hours and proper food storage practices.**	

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	355104	A. BUILDING ______ B. WING ______	02/05/2014

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F 371	Continued From page 12 March 2009, stated ". . . 3. Refrigerated leftovers will be utilized within 72 hours. . . . Items which do not have a "planned use" within 72 hours should be dated/labeled and placed in the freezer within 24 hours. . . ." - An initial dietary tour occurred on 02/03/14 at 12:00 p.m. Observation of the walk-in cooler showed the following: *One open, two pound, package of sliced deli turkey, labeled with the date 01/25/14 (9 days prior). *One case containing three and a half flats (approximately 100 eggs) labeled by the manufacturer with a "sell by" date of 12/14/13 (7 weeks prior). - A dietary tour conducted on 02/04/14 at 7:45 a.m. showed the above items remained in the walk-in cooler. When interviewed during the dietary tour, an administrative dietary staff member (#1) confirmed dietary staff should use or freeze the deli meat within three days and the eggs within two weeks.	F 371	4. An audit has been developed to ensure that all steps are followed according to policy and procedure for food storage and leftovers. The audit will be completed once per week for one month, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendation. The audit will be completed by the Dietary Manager or designee.	3/12/14
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386	F- 0386 1. Residents #2, #3, #4, #5 and #8 past progress notes have been received and filed as appropriate. 2. All resident in the facility have the potential to be affected.	

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F 386	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician progress notes were written and/or dictated at the time of each visit and signed within a timeframe not to exceed thirty days for 5 of 9 sampled residents (Resident #2, #3, #4, #5, and #8). Failure to ensure the medical records are complete limited the facility's ability to ensure the provision of appropriate care and services. Findings include: - Review of Resident #5's medical record occurred on all days of survey. The facility admitted Resident #5 on 10/01/13. The record lacked physician progress notes for the first 90 days of the resident's stay. - Review of Resident #2's medical record occurred on all days of survey. The record identified the last physician progress note as 08/27/13. - Review of Resident #3's medical record occurred on all days of survey. The record identified the last physician progress note as 08/27/13. - Review of Resident #4's medical record occurred on all days of survey. The record identified the last physician progress note as 08/27/13. - Review of Resident #8's medical record occurred on February 04-05, 2014. The record identified the last physician progress note as 08/27/13.	F 386	3. Physician was contacted and education regarding 30 day receipt of progress notes was reviewed. A system will be developed to monitor receipt of progress notes within 30 days of each Physician visit. 4. An audit has been developed to monitor the receipt of progress notes from physicians. The audit will be completed weekly times 2 months and monthly times 3 months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the HIM or her designee.	3/12/14

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F 386	Continued From page 14 During an interview on 02/05/14, an administrative nurse (#4) stated the physician visits the residents on a routine basis, but failed to dictate the visits.	F 386		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F- 0441** **1. On 2/5/14 an education on proper hand washing with an emphasis on contact isolation affecting Resident #7 was provided to staff.** **2. All residents in the facility have the potential to be affected.** **3. A mandatory all staff meeting was held 2/25/14 to review Policy and Procedure for "Clostridium Difficile" (C-Diff) and "Hand washing" emphasizing contact isolations signage and specific problems and interventions for residents identified as having an MDRO (Multiple Drug Resistant Organism).**	

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F 441	Continued From page 15 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices related to hand hygiene for 1 of 1 sampled resident (Resident #7) observed in contact isolation. Failure to follow infection control practices has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "CLOSTRIDIUM DIFFICILE (C-DIFF)" occurred on 02/05/14. This policy, dated August 2011, stated, "If Clostridium difficile infection is in the healthcare setting, follow the guidelines listed below . . . 3. Use contact precautions for residents with known or suspected C-diff . . . 7. Perform hand hygiene after removing gloves. Alcohol does not kill Clostridium difficile spores; therefore, the use of soap and water is more effective than alcohol-based hand rubs . . ." Review of Resident #7's medical record occurred on all days or survey. Diagnoses included C. Diff. The quarterly Minimum Data Set (MDS), dated 12/03/13, identified the resident had a Mulit-Drug Resistant Organism (MDRO) and required extensive assistance for transfers, toilet use, and personal hygiene.	F 441	4. An audit has been developed to monitor that proper hand washing procedures are followed on each shift. Contact isolation procedures are followed with residents that have a known MDRO. The audits will be completed weekly on each shift times four weeks, then monthly times two months. The results of the audits will be reported to the QA/CQI committee for future recommendations. The audit will be completed by the Infection Control Nurse or her designee.	3/12/14

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F 441	Continued From page 16 Observation on 02/05/14 at 9:40 a.m. showed a certified nursing assistant (CNA) (#5) and a licensed nurse (#6) donned gowns and gloves and utilized a full body lift to transfer Resident #7 from a wheelchair to bed. Once in bed, the CNA checked the resident's brief (dry), provided perineal cares, and applied a clean brief. The CNA (#5) removed her gown and gloves, used the bed control to lower the bed, handed the resident her call light, attached an alarm tab the resident, and left the room. The CNA (#5) failed to wash her hands after removing her gloves and before leaving the room. During an interview on 02/05/14 at 1:15 p.m., an administrative nurse (#7) stated the facility staff are instructed to wash their hands anytime they have provided perineal cares and especially after cares with a resident in contact isolation.	F 441		