STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	12/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 12/13/16 and completed on 12/14/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accommodate the needs of 3 of 9 sampled residents (Resident #1, #8, and #9). Failure to place a resident's call light within reach does not allow the resident to call for needed assistance and may result in an accident/injury. Findings include: - During the initial tour on the morning of 12/13/16 observations showed the following: * Resident #1 in bed with the call light laying on the floor under the bed, inaccessible to the resident. * Resident #8 in the bed with the call light laying on the floor, inaccessible to the resident. * Resident #9 in a low bed with the call light laying on the floor under the bed, inaccessible to the resident.	F 246	Call lights for Residents #1, 8, and 9 are being placed within reach of the resident. All residents have the potential to be affected. Audits on the accessibility of call lights for all residents in their rooms were completed on Dec. 22, 23, 24, 25,26,27, 28, 29, and Jan. 1 and 2. Staff education was given when any lights were found not within reach of the resident. All staff will receive training during department meetings on the importance of having call lights accessible and within the reach of the resident when in their rooms. Meetings will be held from Dec. 22, 2016 through Jan. 13, 2017. Audits on the accessibility of call lights will be completed by the DON or designee	1/18/17

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

Electronically Signed | 12/29/2016

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F 246	Continued From page 1 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included pelvic fracture, hip fracture, impaired vision, and above the knee bilateral amputations. The admission Minimum Data Set (MDS), dated 11/28/16, identified extensive assistance of two or more persons for bed mobility, transfers, and toilet use. The current care plan stated, " . . . Focus . . . The resident is at risk for falls R/T [related to] decreased mobility E/B [evidenced by] recent falls prior to admit . . . Interventions . . . Ensure/provide a safe environment: . . . call light within reach when in room . . ." On 12/13/16 at 10:50 a.m., observation showed Resident #1 in bed with the call light on the floor, inaccessible to the resident. On 12/13/16 at 12:30 p.m., observation showed two certified nursing assistants (CNA's) (#8 and #9) knocked and entered Resident #1's room. Resident #1 was in bed with call light laying on the floor, inaccessible to the resident. The CNA's (#8 and #9) completed personal cares, washed their hands and exited the room. The call light remained on the floor. The staff failed to place the call light within Resident #1's reach. During an interview on 12/13/16 at 3:30 p.m., an administrative staff (#6) confirmed the call light should be within reach of the resident when in their room.	F 246	weekly for 4 weeks, beginning on Jan. 16, 2017, then monthly for 3 months. The results will be reported to the QAPI committee for review and further recommendation.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F 253		1/18/17

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F 253	Continued From page 2 comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, review of Resident Council Meeting minutes, group interview, and staff interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior on 3 of 3 resident living areas (100, 200 and 300 wings). Failure to maintain a clean and sanitary environment does not provide a comfortable living environment for residents. Findings include: A group interview with a five residents occurred on 12/13/16 at 10:00 a.m. During the interview, two residents (Resident #6 and #12) stated it takes facility staff "weeks" to complete maintenance requests. During a confidential interview on the afternoon of 12/13/16, a staff member (A) stated it takes the maintenance department an extended time to address areas of concern brought to their attention by staff and residents. During a random observation on the afternoon of 12/13/16, an unidentified staff member saw a maintenance staff member and said "Good! You are here. I have a list for you." The maintenance staff member (#10) responded he had too much to do already and did not ask her what she needed. Review of the last four months of Resident Council Meeting minutes identified the following: *09/16/16 - "Repair slips written for leaky faucet"	F 253	The light in Resident #6's bathroom was replaced with a new fixture with LED lighting on Jan. 4/17. The bathroom sink in Room 115 was fixed on Dec. 16/16 The valve of the bedpan flushing system in room 204 will be replaced. The faucet on the sink in room 209 will be replaced with a new one. The light fixture in Room 307 was replaced with a new fixture with LED lighting on Dec. 16/16. The wall in the exam room where the back splash is missing will be sanded and painted to provide a cleanable surface. Caulking has been added between the wall and counter top. All residents have the potential to be affected. All sinks and bedpan flushing systems in resident rooms have the potential to leak. All of the resident bathrooms have the potential to have lights burnt out. The maintenance director will audit all resident rooms and bathrooms by Jan. 13, 2017, looking for leaking faucets, burned out lights and missing backsplash. Any items found to need repair will fixed. Faucets and light fixtures will be replaced as needed. The maintenance director will review the resident council minutes for the past six months to see if there are any maintenance issues that have not been resolved and will take care of them. The maintenance director will review resident	

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F 253	Continued From page 3 (no room number identified) *10/28/16 - "[Resident #6] states light inside bathroom not working or else is just dim. [Room 115] sink needs looking at, [Resident no longer in facility] says her faucet is drippy as well." Observation of the environment occurred on the afternoon of 12/13/16 and the morning of 12/14/16 and identified the following: *Room 115 - bathroom sink pulling away from the wall *Room 204 - water dripping from a the bedpan flushing system affixed to the bathroom wall creating a large puddle of water on the bathroom floor *Room 209 - water running continuously in the resident's room sink (During the environmental tour on 12/14/16 at 9:30 a.m., a maintenance staff member (#10) stated the city's acidic water corroded the faucet handles affecting the ability to shut the water off easily.) *Room 307 - light burnt out in the bathroom *Exam room - Missing backsplash next to the sink During the environmental tour on the morning of 12/14/16, two administrative staff members (#10 and #11) confirmed the above items needed repair.	F 253	council minutes timely and will follow up on all maintenance issues per policy. The maintenance director will receive education from the administrator on Jan. 6, 2017 on the policy & procedure for "Building Operations Systems - Work Orders" and the importance of responding to resident requests timely. The maintenance director or designee will audit all of the faucets, bedpan flushing systems in resident rooms/bathrooms and audit lights in bathrooms weekly for 3 weeks, beginning Jan. 16/17 looking for any items that need repair. Repairs will be completed timely. Then the audits will be conducted monthly, for three months. The administrator or designee will audit the timeliness of the completion of work orders weekly, beginning Jan. 15/17 for 4 weeks, then monthly for 3 months to ensure that works orders are completed timely and the ""Building Operations Systems - Work Orders" procedure is being followed. The week of Jan. 16/17, the administrator will audit all the requests from resident council in the past 6 months to ensure all maintenance requests have been completed. For the next 3 months, the administrator will review resident council minutes and do follow-up audits on repair requests to ensure they are being completed timely. Results of the audits will be reviewed by the QAPI committee for further review and further recommendation.	

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE	F 278	Section K of the current MDS of Resident	1/18/17

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F 278	Continued From page 5 STANDARD SURVEY COMPLETED ON 12/09/15 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 accurate coding of Minimum Data Sets (MDSs) for 1 of 9 sampled residents (Resident #7) and 1 closed resident record (Resident #10). Failure to accurately complete Section K (Swallowing/Nutritional Status) and Section M (Skin Conditions) does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2016, page K-11, stated, ". . . Check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7-day look-back period. . . . K0510C, mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) . . ." Pages M-5 and M-6, stated, ". . . M0210: Unhealed Pressure Ulcer(s) . . . Code based on the presence of any pressure ulcer . . . in the past 7 days . . . Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300) . . . M0300: Current Number of Unhealed Pressure Ulcers at Each Stage . . ."	F 278	#7 has been modified and was sent to the state and CMS on Dec. 27, 2016. Section M on the closed record will not be modified. All residents that have a mechanically altered diet and all residents that have a pressure ulcer have the potential to be affected. Section K510C and Section M on the current MDS's of these residents will be reviewed to ensure the coding is accurate. If any errors are found, the MDS will be modified and sent to the state and CMS. The Care Plan team will receive education on coding section K510C on the MDS by the MDS coordinator on Dec. 29, 2016 and will receive education on coding section M on Jan 5, 2017. An audit will be conducted on all residents that have a pressure ulcer to ensure that an assessment is in place. Nurses will receive education on Jan. 5, 2017 on the procedure "Pressure Ulcer Practice Guidelines", which addresses the time frame for completing a wound assessment. Audits on section K510C and audits on section M for residents that trigger will be conducted weekly for 3 weeks, beginning Jan. 16, 2017, then monthly for 3 months by the DON or designee to ensure coding accuracy. Audits on wound assessments will conducted weekly for 3 weeks, then monthly for 3 months by the DON or	

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F 278	Continued From page 6 - Review of Resident #7's medical record occurred on 12/14/16. Diagnoses included dementia and dysphagia. The resident's current care plan identified honey thick liquids and a pureed diet. A dietary note, dated 10/27/16, stated, ". . . Continues to receive a Regular Level 1 Diet with Honey thick liquids d/t [due to] dysphagia. . . ." Resident #7's current MDS, dated 10/31/16, failed to identify the resident's mechanically altered diet under Section K, Swallowing/Nutritional Status. During an interview on 12/14/16 at 3:03 p.m., a dietary supervisor (#1) identified she should have coded a mechanically altered diet for Resident #7. - Review of Resident #10's medical record occurred on 12/14/16. A "Wound RN [Registered Nurse] Assessment," signed on 04/14/16, identified a Stage 2 pressure ulcer to the resident's left gluteal fold. The wound assessment identified an effective date of 04/12/16. The admission MDS, dated 04/12/16, failed to identify the resident's Stage 2 pressure ulcer. During an interview on 12/14/16 at 4:00 p.m., a nurse (#4) stated she "is guessing" the direct care nurse completing the "Wound RN Assessment" discovered Resident #10's pressure ulcer on 04/12/16 but failed to complete the documentation until 04/14/16 so the nurse coding the MDS lacked knowledge the wound was present during the assessment reference	F 278	designee to ensure they are being completed, beginning January 16, 2017. Results of the audits will be reviewed by the QAPI committee for recommendations and/or follow-up.	

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F 278	Continued From page 7 period.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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 observation, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice for 2 of 6 residents (Resident #6 and #11) observed during medication pass. Failure to properly dispose of a transdermal patch (Resident #6) and appropriately prime an insulin pen (Resident #11) has the potential of abuse of medications and inaccurate doses of medication administered. Findings include: Manufacturer's instructions for NovoLog FlexPen stated, " . . . Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . Turn the dose selector to select 2 units, Hold your NovoLog FlexPen with the needling pointing upwards, press the push-button all the way . . . The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . . Selecting your dose. Check and	F 281	The NovoLog FlexPen will be primed before administering insulin to Resident #7. Resident #6's Fentanyl patch will be disposed of with two nurses present, according to the "Transdermal Patch Application" policy. All residents that receive insulin via a FlexPen and all residents that use Fentanyl patches have the potential to be affected. Training on the manufacturer's instructions for use of a NovoLog FlexPen; the procedure "Insulin Administration" which includes priming an insulin pen; and training on the procedure titled "Transdermal Patch Application" will be given to all licensed nurses on January 5, 2017. The DON or designee will observe the administration of insulin via a FlexPen and the disposal of a narcotic patch	1/18/17

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F 281	Continued From page 8 make sure that the dose selector is set at 0. Turn the dose selector to the number of units you need to inject. . . ." - Observation during medication pass on 12/13/16 at 10:30 a.m., showed a nurse (#7) administered 6 units of NovoLog insulin to Resident #11. The nurse failed to prime the insulin pen prior to the administration. Review of the policy titled "Transdermal Patch Application" occurred on 12/13/16. This policy, revised May 2016, stated, ". . . Procedure . . . 4. When removing a previously placed patch . . . Fold the patch in two with the medicated sides together. Place old patch in plastic bag for transport to medication room for disposal by two licensed professionals. It is not acceptable to put used patches in a sharps container . . . If it is not possible to immediately put the used patch into a DEA (Drug Enforcement Administration)-authorized collection receptacle, the FDA recommends flushing duragesic patches because they are especially harmful in small doses . . . It is Society policy that two nurses, or a nurse and pharmacist or a nurse and provider, always sign for destruction of narcotic patches . . ." - Observation on 12/13/16 at 1:45 p.m. identified a nurse (#5) changed Resident #6's Fentanyl (an opioid analgesic for severe pain) transdermal patch in the resident's room. After removing the previously placed patch, the nurse (#5) disposed of the patch by flushing it down the toilet in the resident's bathroom. No other staff were present at this time.	F 281	weekly for 4 weeks, beginning January 9, 2017, then monthly for 4 months. Results of the audits will be given to the QAPI committee for review and further recommendation.	

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F 281	Continued From page 9 During an interview on 12/13/16 at 2:05 p.m., an administrative nurse (#6) stated staff should dispose of narcotics by flushing them down the toilet with another staff member present as a witness.	F 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to maintain an environment free of hazardous	F 323	The can of End bac II spray, the fabric softener, the bottle of Virex, the bottle of Dreft detergent and the Epsom salt have	1/18/17

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F 323	Continued From page 10 chemicals on 2 of 2 days of survey (December 13-14, 2016). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility policy titled "Procurement and Storage of Equipment Products and Supplies" occurred on 12/14/16. This policy, dated March 2016, stated, ". . . Storage . . . 5. Ensure that all products (chemicals and disinfectants) are labeled and stored in a manner that eliminates risk of improper use, contamination, inhalation, skin contact or personal injury. 6. Housekeeping equipment, products and supplies should not be stored in resident rooms or units. Store these items in a locked cabinet and/or storage rooms as appropriate . . ." Observation of the environment occurred on the afternoon of 12/13/16 and the morning of 12/14/16 and showed the following unlocked chemicals: *Storage room located by the nurse's station - one can of End Bac II spray disinfectant, the label stated "HAZARD TO HUMANS AND DOMESTIC ANIMALS" *Exam room located by the nurse's station - in an unlocked cabinet under the sink - a bottle of fabric softener; a bottle of Virex cleaner, the label stated "HAZARD TO HUMANS AND DOMESTIC ANIMALS," a bottle of Dreft laundry detergent, the label stated "HARMFUL IF SWALLOWED," and a carton of Epsom salt, the label stated "KEEP OUT OF REACH OF CHILDREN"	F 323	all been moved to a locked cupboard. All residents have the potential to be affected. All storage rooms and the exam room were searched for chemicals and items that can be harmful on Dec. 15, 23 29, 2016 and Jan. 2, 2017. Any potentially harmful items found were removed and put in a locked room or cabinet and staff on duty were educated on the importance of keeping chemicals in a locked area. All staff will receive education during department meetings on the procedure listed in the "Housekeeping and Laundry Department Safety Rules" for storage of chemicals. These meetings will be held Dec.22, 2016 through Jan. 11, 2017. An audit on the proper storage of chemicals will be completed by the DON or designee weekly for 4 weeks, beginning on Jan. 16, 2017, then monthly for 3 months with the results reported to the QAPI committee for review and further recommendation.	

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F 323	Continued From page 11 During an interview on the morning of 12/14/16, a supervisory staff member (#10) stated staff should store all chemicals in locked areas.	F 323		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide adaptive equipment to maintain eating ability for 2 of 4 sampled residents (Resident #2 and #7) who used adaptive eating equipment. Failure to consistently provide nosey glasses (a plastic cup with a cutout that helps maintain proper head and neck positioning when swallowing) for residents with dysphagia may result in improper swallowing and decreased fluid intake. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current Minimum Data Set (MDS), dated 11/09/16, identified short and long term memory problems, severely impaired daily decision-making skills, and extensive assistance from one person for eating. Resident #2's current care plan stated, ". . . The resident has nutritional problem R/T [related to] Alzheimer's, Dysphagia . . . Adaptive	F 369	Nosey glasses are being placed in the rooms of Residents #2 and #7 and are being used to provide liquids to the residents. Audits were completed on Dec. 20, 27, 2016 and Jan. 2, 2017 and the nosey glasses were in the rooms. All residents that have a recommendation from the Interdisciplinary Care Team and Dietary Manager for a nosey cup have the potential to be affected. The Interdisciplinary Care Team will identify these residents and will make nosey cups available in their rooms and on the med cart for use when giving liquids. A list of residents that need nosey cups will be made available to all staff. The nursing and activity departments will receive education on the procedure "Assistive Devices" on Jan. 4 and 5, 2017. The dietary department will receive the education on Jan. 11, 2017.	1/18/17

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F 369	Continued From page 12 equipment needed: Nosey glasses . . . All fluids no less than NECTAR thick. . . ." A dietary note, dated 01/27/16, stated, ". . . [Resident #2] is experiencing swallowing difficulties at times with food/fluids coming back out of her mouth. Toddler spoons are used to provide small bites along with nosey glasses for safer intake of fluids. . ." Observation of Resident #2's personal cares occurred on 12/13/16 at 10:18 a.m. and 4:13 p.m. Observation showed a small, plastic container of honey thick water at the resident's bedside, but no nosey glasses available. The certified nursing assistants (CNAs) gave Resident #2 several sips of the thickened water from the container, and at times the water dribbled out the sides of the resident's mouth. During one observation, a CNA (#2) stated, "It seems like she does better with those toothettes [a type of oral swab]." Observation of meals on the morning and evening of 12/13/16 identified Resident #2 received fluids in Nosey glasses. - Review of Resident #7's medical record occurred on 12/14/16. Diagnoses included unspecified dysphagia. The current MDS, dated 10/31/16, identified intact cognition and supervision with set-up help for eating. Resident #7's current care plan stated, ". . . Dysphagia E/B [evidenced by] need for L1 [level one] pureed diet with honey consistency fluids. . . . Monitor closely, report s/s [signs and symptoms] of swallowing difficulties, coughing or signs of aspiration, notify CN [charge nurse]. Nosey glasses & reminders to keep chin down as able	F 369	The Dietary Manager or designee will conduct weekly audits for 4 weeks, beginning on Jan. 16, 2017, then monthly audits for 3 months to ensure that all residents with a recommendation for a nosey cup have them available. The results will be reviewed by the QAPI committee for further recommendation.	

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F 369	Continued From page 13 while drinking. . . ." A dietary note, dated 08/05/16, stated, ". . . Nosey glasses provided to aid with fluid intake. . . ." Observation of Resident #7's personal cares occurred on 12/14/16 at 1:18 p.m. Observation showed a small, plastic container of honey thick water at the bedside, but no nosey glass available. The CNA (#3) used a spoon to give Resident #7 water from the container. During an interview on 12/14/16 at 3:03 p.m., a dietary supervisor (#1) identified Residents #2 and #7 use nosey glasses for fluids due to dysphagia.	F 369		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431		1/18/17

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F 431	Continued From page 14 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: SECURING MEDICATIONS 1. Based on observation and review of facility policy, the facility failed to store all medications in a secure manner on 2 of 2 days of survey (December 13-14, 2016). Failure to store all	F 431	The licensed nurses have been instructed to be sure that the medication and treatment carts are locked prior to walking away. Unopened Lantus SoloStar insulin pens for resident #11 are being kept in the medication refrigerator.	

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F 431	Continued From page 15 medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Acquisition, Receiving, Dispensing and Storage of Medications" occurred on 12/14/16. This policy, revised September 2016, stated, ". . . 4. Medications will be stored in a locked medication cart, drawer or cupboard . . ." - Observation during a medication pass on 12/13/16 at 11:00 a.m., showed a nurse (#5) administer eye drops to Resident (#6). The nurse obtained the eye drops from the medication cart and failed to lock it prior to walking away and into another room. During an interview on 12/13/16 at 3:30 p.m., an administrative staff (#6) confirmed the medication cart should be locked before walking away especially if it will be out of sight. - Observation on 12/13/16 at 4:50 p.m. identified an unlocked treatment cart stored in the exam room with the door propped open. The treatment cart contained numerous medications, including: silver sulfur cream, nystatin powder, clotrimazole cream, santyl ointment, antifungal cream, triamcinolone cream, lidocaine solution, estrace vaginal cream, and albuterol and budesonide nebulizer treatments. Residents and staff walked by and gathered near the room containing the unlocked treatment cart. - Observation on 12/14/16 at 9:00 a.m. showed the exam room door closed but unlocked. The	F 431	After opening, they are stored at room temperature. All residents have the potential to be affected. The licensed nurses will received education on the procedure entitled "Acquisition, Receiving, Dispensing & Storage of Medications" which includes the importance of locking the medication and treatment carts. Licensed nurses will also receive education on the manufacturer's guidelines for storage of a Lantus SoloStar insulin pen on Jan. 5, 2017. The DON or designee will conduct weekly audits for 4 weeks, beginning on Jan. 9, 2017, then monthly for 3 months to ensure the medication and treatment carts are being locked when the nurse is not beside the cart. Audits on the location of insulin pens will be conducted weekly for 3 weeks, then monthly for 3 months. The results of the audits will be reviewed by the QAPI committee for further recommendation.	

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F 431	Continued From page 16 treatment cart stored inside the room remained unlocked. STORAGE OF INSULIN PENS 2. Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to correctly store 1 of 1 supplemental resident's (Resident #11) in-use insulin pen. Failure to properly store opened in-use insulin pens has the potential to affect the potency and efficacy of the medication. Findings include: The manufacturer's guidance for Lantus SoloStar insulin pen stated, ". . . Once SoloStar is opened (in-use), SoloStar should NOT be refrigerated but should be kept at room temperature (below 86 [degrees] F [Fahrenheit] . . .) away from direct heat and light . . ." Observation of the medication refrigerator in the medication room occurred on 12/14/16 at 8:42 a.m. with a staff nurse (#7) and identified one in-use Lantus SoloStar insulin pen stored in the refrigerator. The nurse stated she was not aware of the manufacturer's guidelines regarding storage of in-use insulin pens.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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:	F 441		1/18/17

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F 441	Continued From page 17 (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 (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 18 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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, record review, and staff interview, the facility failed to follow infection control practices for 2 of 7 sampled residents (Resident #1 and #8) observed during cares. Failure to follow infection control practices related to hand hygiene and perineal cares has the potential to spread infection within the facility. Findings include: Review of facility policy titled "Hand Hygiene and Handwashing" occurred on 12/14/16. This policy, revised March 2016, stated, " . . . Background: Regular handwashing is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others. . . . Wash hands . . . if	F 441	CNA's will receive training on the proper procedure for perineal care on Resident #1 and resident # 8. All residents have the potential to be affected by the same deficient practice. All CNA's will receive re-training on the policy "Perineal Care" and the procedure for glove use and handwashing, "Hand Hygiene and Handwashing" by the DON at their regular meeting on January 4, 2017. Follow up audits will be performed weekly for 4 weeks, beginning on Jan. 9, 2017, by the DON or designee, then monthly for 3 months.	

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F 441	Continued From page 19 hands are visibly soiled (dirty) . . . visibly contaminated with . . . body fluids . . . after removing gloves . . ." Review of facility policy titled "Perineal Care" occurred on 12/14/16. This policy, revised May 2016, stated, " . . . Purpose: . . . To prevent infection and odors in the perineal area . . . to promote good perineal hygiene . . . For females: . . . using gentle downward strokes from the front to the back of the perineum. . . . After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included incontinence. An admission Minimum Data Set (MDS), dated 11/28/16, identified extensive assistance of one to two persons for bed mobility, toileting cares, dressing, and personal hygiene. Observation on 12/13/16 at 3:20 p.m., showed two certified nursing assistants (CNAs) (#12 and #13) provided Resident #1 with perineal cares after urine and stool incontinence. Both CNAs (#12 and #13) washed their hands and donned gloves. The CNA (#12) performed perineal cares wiping from the back to the front with visible stool on the disposable wipe. Then the CNA (#12) folded the wipe in half, wiped the front to the back, removed her gloves, put her hands up to her face, and adjusted her glasses and hair two times. After sanitizing her hands, the CNA (#12) applied clean gloves, rolled Resident #1 over onto her right side, wiped the rectal area from front to back folding the wipe, with a large	F 441	Audit results will be given to the QAPI committee for review and further recommendations.	

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F 441	Continued From page 20	F 441		

amount of visible stool on the disposable cleansing wipes, adjusted Resident #1's brief, clothing, and placed lift sheet underneath her. The CNA failed to cleanse from front to back and complete hand hygiene prior to performing other tasks.

- Review of Resident #8's medical record occurred on 12/14/16. Diagnoses included dementia and Parkinson's disease. The resident's current care plan identified, " . . . Focus The resident has an ADL [activities of daily living] self care performance deficit . . . need for assist . . . Interventions . . . TOILET USE: Resident requires extensive assist of 2 staff assist. . . ."

Observation on 12/14/16 at 2:40 p.m., showed two CNAs (#14 and #15) assisted Resident #8 to the toilet utilizing a stand lift. The CNAs (#14 and #15) applied gloves and removed her brief wet with urine. After the resident voided both both CNAs (#14 and #15) applied gloves and assisted Resident #8 to a standing position using a stand lift. Both CNAs (#14 and #15) wiped Resident #8's perineal area, pulled up the clean brief, adjusted clothing, and removed their gloves. One CNA (#15) lowered Resident #8 onto her recliner using a mechanical stand lift and the other CNA (#14) adjusted her clothing, removed the transfer belt, gave her a drink of water, placed the call light, and covered her up with a blanket. Both CNAs (#14 and #15) failed to perform hand hygiene following perineal care and prior to completing other tasks.

During an interview on 12/14/16 at 3:30 p.m. an administrative staff (#6) confirmed staff should complete hand hygiene as soon as they remove

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F 441	Continued From page 21 their gloves and before completing other cares.	F 441		