STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCENTER ONE MANDAN CARE CENTER OFF COLLINS	201 14TH STREET NW MANDAN, ND 58554

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/24/11 and completed on 10/26/11, the sample included 3 residents for complete review, 9 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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, review of the Long-Term Care Facility Resident Assessment Instrument User's (RAI) Manual (Version 3.0), and staff interview, the facility failed to properly assess the use of and continued need for a lap seat belt, one-piece undergarment, and spandex shorts (Resident #1); and a wedge cushion (Resident #9) for 2 of 3 sampled residents observed with physical restraints. Failure to assess, monitor, and re-evaluate the necessity of these devices limited the residents' freedom of movement and access to their body and placed them at risk for decreased physical functioning, skin breakdown, and a loss of dignity. Findings include: The Long-Term Care Facility RAI Manual	F 221	**F-221: Right to be free from physical restraints** MCO Off Collins remains in compliance with F-221 as evidenced by the following: The P & P titled Restraint Program has been fully implemented. At the time of this survey the P & P was in its 30-day implementation period. Staff education was presented on 11-9-11 for nurses and therapists. This education covered identifying a restraint device, documenting its use and follow-up to include care plan development and MDS completion. A Restraint Assessment was completed on resident #1 to include the use of the lap seat belt, one piece undergarment, and spandex shorts. The care plan has been up dated to include these items.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Mann	Administrator	11/14/11

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 221	Continued From page 1 (Version 3.0), page P-1 defines a restraint as "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." The Centers for Medicare and Medicaid Services (CMS) defines "remove easily" as "the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff." Review of the facility policy titled "Restraint Program" occurred on 10/26/11. The policy, dated 03/05/00, stated, "PHILOSOPHY: . . . Before a positioning/protective device or a restraint is used, a Restraint Assessment will have been completed on the resident. Alternatives to restraints must be addressed and documented by the interdisciplinary team before considering the use of restraints. This may include evidence of consultation with appropriate health professionals, such as occupational or physical therapy. . . . PROCEDURE: 1. A Restraint Assessment will be completed on residents that exhibit medical symptoms that may warrant the potential use of restraints. 2. The care plan shall reflect the determination that was made, through the comprehensive assessment, that medical symptoms warrant use of restraints. A physician order should be obtained when restraint usage has been determined. 3. Alternative to restraints must be addressed and documented by involve [sic] disciplines before considering the use of restraints. This includes	F 221	A physicians order has been obtained and documentation of discussion with the personnel representative has taken place to explain the use of the devices. A Restraint Assessment and Seating and Positioning screen was completed for resident #9 to include use of the wedge device in the recliner. The care plan has been updated to include this item. CQI monitoring will be completed by the CQI Coordinator and/or her designee prior to 11-29-11 for resident's #1 & #9 to insure that all required elements related to the use of a restraint device are in place. Restraint use has the potential to affect any resident with a restraint device in use. Residents with a restraint and/or positioning device have been identified. CQI monitoring will begin the week of 11-21-11 to include those residents. Monitoring will be completed weekly X4 and then monthly X2.	

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F 221	Continued From page 2 evidence of consultation with appropriate health professionals, such as occupational or physical therapist. . . . 4. Restraints shall be released in accordance with the care plan . . . during normal waking hours . . . Restraint usage will be re-evaluated at least quarterly. 5. For those residents, whose care plan indicates the need for restraints, a systematic and gradual process toward reducing restraint usage will be utilized. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included mental retardation (MR) and history of a motor vehicle accident (MVA) with traumatic brain injury (TBI). The most recent MDS, dated 08/25/11, identified the resident rarely/never makes self understood or understands others; severely impaired daily decision making skills; short-term and long-term memory problems; total dependence on two or more staff for dressing, bed mobility, and transfers; and the use of a restraint while in bed (the "Posey" bed). The MDS failed to identify the use of a seat belt, one-piece undergarment, or spandex shorts. During an interview on the afternoon of 10/26/11, an administrative nurse (#2) stated staff initiated Resident #1's seat belt on 02/12/10, after discontinuing a pin-dot type seat belt. The nurse (#2) could not identify when staff initiated the one-piece undergarment. Resident #1's care plan indicated staff added the spandex shorts to her care plan on 04/15/11. On the afternoon of 10/26/11, the survey team requested an assessment of the one-piece	F 221	Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Agenda & Attendance sheet from 11-9-11 education 2. P & P titled Restraint Program 3. Restraint Assessments for resident's #1 & #9 4. Updated care plans for residents #1 & #9 5. CQI Worksheet titled Restraint Use Date Certain is 11-29-11	

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F 221	Continued From page 3 undergarment and spandex shorts; however, facility staff provided no additional information. Resident #1's medical record contained a form titled "Seating and Positioning Plan of Care and Progress Note." This note identified a positioning aide for "Trunk Positioning" and stated, "Seat belt for positioning." Therapy staff reviewed and signed the form on 03/04/11, 06/07/11, and 08/23/11. A "Restraint-Positioning Note," dated 07/12/11, stated, "Restraint Committee met to discuss continued need for Posey bed restraint. . . . Seat belt for pelvis/trunk position will remain in place. [Resident name] has ability [and] at times open her belt however makes no attempt to get up out of her chair. . . . Restraint team will meet quarterly [and] PRN [as needed] to determine continuation of restraint [and] lap seat belt. . . ." A restraint committee meeting held on 10/05/11 indicated the committee discussed the use of the Posey bed; however, they failed to discuss the use of the seat belt, one-piece undergarment, and spandex shorts. Resident #1's current physician's orders failed to include an order for the use of the lap seat belt, one-piece undergarment, or spandex shorts. Observations of Resident #1 occurred throughout the survey and identified a seatbelt loosely buckled around the resident's waist when she was in her wheelchair. There was approximately a four-inch gap between the belt and the resident's abdomen. On 10/26/11 at 8:56 a.m., an administrative nurse (#1) confirmed the seat belt was loose and did not support Resident #1's trunk/pelvis.	F 221		

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F 221	Continued From page 4 On 10/25/11 at 8:49 a.m., the surveyor asked Resident #1 to release her seatbelt. The resident made no attempt to release it. A certified nursing assistant (CNA) (#5) stated Resident #1 does not purposefully remove her belt, and if the resident does open the belt, it is because she "plays around with it." A second CNA (#15) also confirmed Resident #1 can not open the seatbelt on command. On 10/26/11 at 12:20 p.m., an administrative nurse (#11) asked Resident #1 to remove her seatbelt. The resident was unable to do so. A CNA (#15) also asked the resident to remove her seatbelt, and the resident was again unable to do so. During an interview on 10/26/11 at 9:40 a.m., a physical therapy staff member (#3) stated the seat belt is used as a positioning device. She stated it does not matter if the belt is not tight because it is not used for trunk support, it is used to prevent Resident #1 from leaning forward and playing with her feet and shoes. On the afternoon of 10/26/11, an administrative nurse (#11) stated the seat belt "reminds" Resident #1 to sit back if she reaches out to grab items off tables or reaches down to play with her shoes/feet. On 10/25/11 at 8:49 a.m., observation showed two certified nursing assistants (CNAs) (#5 and #15) checked and changed Resident #1's brief as she lay in bed. Observation identified a one-piece undergarment (with "snaps" that fasten between the legs) and spandex-type shorts worn by the resident under her clothes. Observation also showed the resident's groin area was reddened. "It's pretty red," stated a CNA (#15) as she	F 221		

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applied moisture barrier cream to the resident's groin area. The other CNA (#5) stated, "I would think she'd get sore. Having all that stuff between her legs [indicating the resident's brief, onesie, and spandex shorts]."

In an interview during the above observation of care, the CNA (#5) stated Resident #1 wears the onesie and shorts under her clothes "otherwise she'll dig and pick [at her brief]," and the resident "has put pieces [of the brief] in her mouth." The other CNA (#15) further stated the resident "wears spandex shorts and a onesie [the one-piece undergarment] because she'll rip up her brief. She wears them all the time. If there are no onesies clean, she just wears the shorts."

A Social Services Progress Note, dated 04/12/11, stated the following: ". . . Had a telephone conversation [with] [Resident's brother] re: [regarding] purchase of some bike shorts to prevent [Resident name] from digging into attends [incontinence brief] at night as onesies [one-piece undergarment] weren't working completely. . . ."

Resident #1's care plan stated, ". . . Problem [start date of 03/10/11] . . . ADLS [activities of daily living] . . . [Resident name] was admitted to the nursing [sic] after being hospitalized from a MVA with head injury . . . She has severe MR and speak [sic] a few words and is unable to make her needs known. . . . Most of her actions are like an infant . . . When in bed she will shread [sic] and chew on pieces of her attends placing her at risk for choking. Onsies [sic] are needed to be worn at all times to help keep her from reaching her attends. [on 04/15/11, staff added a

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hand-written note to indicate Resident #1 needed "spandex shorts" in addition to the onesie.] . . . Approach . . . DRESSING/UNDRESSING . . . [intervention added 04/15/11] spandex shorts with onsie [sic] under shorts. . . ." Review of nurses' notes since the initiation of the spandex shorts identified no further incidents of Resident #1 digging/picking at her brief.

During an interview on 10/26/11 at 3:21 p.m., an administrative nurse (#2) agreed the one-piece undergarment and spandex shorts restricted Resident #1's access to her body.

- During the initial tour of the facility, on 10/24/11 at approximately 8:30 a.m., observation identified a wedge cushion in a recliner in Resident #9's room. A wedge cushion is a foam filled cushion thicker at one end. When positioned with the thick end to the front of a chair, it can act as a restraint, making it more difficult to exit the chair. Observation showed the cushion positioned with the thick end to the front of the recliner.

Observation in the dining room, on 10/25/11 at 5:30 p.m., identified Resident #9 seated in a standard wheel chair with flat gel cushion in place.

Review of Resident #9's medical record occurred on October 25-26, 2011. Resident #9's record lacked an assessment, physician's order, and/or care plan for the wedge cushion. A quarterly MDS, dated 09/09/11, identified Resident #9 had moderately impaired cognitive status and required extensive assistance of 2 or more persons for transfers. The MDS failed to identify the wedge cushion as a restraint. Resident #9's

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ADL care plan (kept in the residents' rooms and referred to by staff when providing cares), dated 08/26/09, stated ". . . Due to her generalized weakness, she continues to need assistance from the staff to complete daily ADL tasks . . . Transfers - ext [extensive] assist of 1 staff with EZ stand [a sit to stand lift]. Ambulation - Resident does not ambulate in room or hallways. . . ." The ADL care plan failed to identify use of the wedge cushion.

A "Seating and Positioning Plan of Care and Progress Note," dated 11/26/10, and updated on 03/29/11, 06/22/11, and 09/23/11, identified Resident #9 used a standard wheel chair with a pressure relief cushion. The progress note failed to identify use of the wedge cushion.

An interview with a physical therapy (PT) staff member (#3) occurred on 10/26/11 at 10:46 a.m. The therapy staff member (#3) stated staff used the wedge cushion in Resident #9's recliner to assist with transfers because it is "firm." When asked when staff implemented the cushion, the staff member (#3) stated Resident #9 has used the wedge cushion for "quite a while."

Observation on 10/26/11 at 1:06 p.m. showed a CNA (#5) transferred Resident #9 from her standard wheel chair to the bathroom using an EZ stand lift. The CNA used a seat sling as well as the trunk sling during the transfer. (The seat sling fits under the resident's buttocks and provides additional support for the resident during the transfer.) After the resident used the bathroom, the CNA (#5) transferred Resident #9 from the bathroom to her recliner using the EZ stand lift and both slings. Observation showed the

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F 221	Continued From page 8 wedge cushion remained in Resident #9's recliner. On 10/26/11 at 2:40 p.m. observation showed a CNA (#6) transferred Resident #9 from the recliner to her standard wheel chair using the EZ stand lift and both the trunk and seat sling. During the transfer, Resident #9 did not attempt to stand, but "sat" in the seat sling. A telephone interview occurred with an occupational therapy staff member (#4) on 10/26/11 at 2:10 p.m. The staff member stated Resident #9 used a wedge cushion because she had a "tendency to slid out of the reclining wheel chair." She stated the wedge keeps Resident #9 in a more "upright position" and "takes the weight bearing off the sacrum" when the resident is in the reclining wheel chair. This interview conflicts with the medical record and observations during the survey which identified Resident #9 used a standard wheel chair for mobility and an easy chair type recliner in her room. An interview occurred with an administrative nurse (#2) on 10/26/11 at 2:40 p.m. The nurse stated her expectation is that the staff member implementing a device should document the device in the medical record. On 10/26/11 at approximately 5:15 p.m., the facility provided a "Seating and Positioning Plan of Care and Progress Note" for Resident #9, dated 10/26/11. The progress note evaluated how Resident #9 transferred with a FWW and identified the resident transferred with maximum assistance of one staff member with the wedge cushion in place. Observation and review of	F 221		

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F 221	Continued From page 9 Resident #9's care plan identified staff are to transfer Resident #9 to and from her recliner with the E-Z stand lift, using both the trunk and seat sling, not with a FWW. The assessment failed to evaluate transfers using the E-Z stand lift.	F 221		
F 278 SS=D	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 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	F 278	**F-278: Assessment Accuracy** The facility remains in compliance with F-278 as evidenced by the following: Please refer to the actions taken as part of the POC for F-332 which will better assess and identify those residents with a restraint device properly in place. Staff education was presented on 11-9-11 for all nurses and therapists. This education covered identifying a restraint device, documenting its use and follow-up to include care plan development and MDS completion. A modification will be completed prior to 11-30-11 on the most recent MDS for residents #1 & #9 so that the restraint device is captured on the MDS. The resident's care plans have been updated to include use of the devices in place.	

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F 278	Continued From page 10 by: Based on observation, record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 2 of 2 sampled residents (Resident #1 and #9) utilizing a restraint. Failure to accurately assess residents and code the MDS accordingly does not allow residents the opportunity to receive care consistent with their individual needs, problems, and strengths. Findings include: The Long-Term Care Facility RAI Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and 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, such as the quality indicator/quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development . . ." The Long-Term Care Facility RAI Manual (Version 3.0), page P-1 defines a restraint as, "Any manual method or physical or mechanical	F 278	Residents with a restraint and/or positioning device will be identified prior to 11-21-11. If necessary, an MDS modification will be complete for these residents. Restraint use and incorrect MDS coding has the potential to affect all residents with a restraint in place. CQI Monitoring will be completed by the CQI Coordinator and/or her designee weekly X4 and then monthly X2 beginning the week of 11-21-11 of MDS' completed that week to ensure that restraint use is coded correctly when indicated. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Agenda & Attendance sheet from 11-9-11 education 2. CQI Monitoring worksheet titled CQI-MDS Accuracy 3. Modification Transmittal Notices for resident #1 & #9 Date Certain: 11-29-11	

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device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body."

- Observations of Resident #1 occurred throughout the survey and identified a seatbelt used by the resident in her wheelchair. Observation during personal cares also identified a one-piece undergarment (with "snaps" that fasten under the crotch) and spandex-type shorts worn by the resident under her clothes.

On 10/25/11 at 8:49 a.m., the surveyor asked Resident #1 to release her seatbelt. The resident made no attempt to release it. On 10/26/11 at 12:20 p.m., an administrative nurse (#11) asked Resident #1 to remove her seatbelt. The resident was unable to do so.

Review of Resident #1's medical record occurred on all days of survey. The most recent MDS, dated 08/25/11, identified the use of a restraint while in bed (the "Posey" bed). The MDS failed to identify the use of the seat belt, one-piece undergarment, or spandex shorts under section P- Physical Restraints.

During an interview on 10/26/11 at 9:40 a.m., a physical therapy staff member (#3) stated the seat belt is used as a positioning device to prevent Resident #1 from leaning forward and playing with her feet and shoes. On the afternoon of 10/26/11, an administrative nurse (#11) also stated the seat belt "reminds" Resident #1 to sit back if she reaches out to grab items off tables or reaches down to play with her shoes/feet.

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MEDCENTER ONE MANDAN CARE CENTER OFF COLLINS	201 14TH STREET NW MANDAN, ND 58554

(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 278	Continued From page 12 During an interview on 10/26/11 at 3:21 p.m., an administrative nurse (#2) agreed the one-piece undergarment and spandex shorts restricted Resident #1's access to her body. Refer to F221. - During the initial tour of the facility, on 10/24/11 at approximately 8:30 a.m., observation identified a wedge cushion in a recliner in Resident #9's room. When interviewed, on 10/26/11 at 10:46 a.m., a physical therapy staff member (#3) stated Resident #9 has had the wedge cushion in her chair "for quite a while." Review of Resident #9's medical record occurred on October 25-26, 2011. Review of the record failed to identify use of the wedge cushion. A quarterly MDS, dated 09/09/11 also failed to identify the use of the wedge cushion under section P - Physical Restraints. Refer to F221.	F 278		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.	F 283	**F-283: Discharge Summary** It is the intent of this facility to remain in compliance with F-283 as evidenced by the following: The P & P titled Discharge Planning has been reviewed and remains in place as is. A Discharge Summary is completed for all residents planning to be discharged that details the planning accomplished for the resident. A Physician Discharge Summary form has been added that is to be signed by the physician and placed on the resident's chart within 30 days of discharge or death.	

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F 283	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, this facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 closed record (Resident #13) reviewed. Findings include: - Review of the facility procedure on "Subject: Discharge Planning" occurred on 10/26/11. This procedure, dated 11/04/09, included #9, which addressed the areas to be included in discharge summaries. This procedure did not address the need to provide a recapitulation of the resident's stay. The procedure did, however, indicate, ". . . 14. Following discharge the physician signs the face sheet and lists the final disposition, condition on discharge, final diagnosis and/or cause of death." The policy did not include a timeline of when this documentation should be completed. Review of Resident #13's medical record occurred on 10/26/11. The facility admitted Resident #13 on 05/17/11. The admission Minimum Data Set, with an assessment reference date of 05/23/11, indicated there is an active discharge plan in place. On 07/15/11, the facility discharged the resident. Resident #13's record did not contain a recapitulation of her stay. The record also lacked the required documentation by the physician, as per the above facility policy. During interview at 2:30 p.m. on 10/26/11, two administrative staff members (#1 and #2) confirmed Resident #13's record did not contain	F 283	All discharged or deceased residents will have the Physician Discharge Summary completed beginning 11-10-11. Staff education is planned for 11-29-11 that will detail the requirements of the Discharge Planning P & P. Emphasis will be placed on completing the required Discharge Summary (recapitulation) paperwork within 30-days of discharge. A Physician Discharge Summary was completed by the MD and has been placed on resident #13's chart. Discharge planning is a valuable resource that affects all living center residents. CQI monitoring will be completed beginning 11-21-11 by the CQI Coordinator and/or her designee X3 months on all residents discharged during this time period to be certain the necessary summaries are completed and placed on the chart within 30 days of discharge. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. P & P Titled Discharge Planning-includes Discharge Summary (recapitulation) form 2. Physician Discharge Summary form to be completed within 30 days of discharge 3. Physician Discharge Summary dated 11-10-11 4. CQI monitoring worksheet titled Discharge Planning Date certain is 11-29-11	

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F 283	Continued From page 14 the required information.	F 283		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation on 1 of 3 days of medication pass (10/25/11). Failure to ensure medications are administered according to physician's orders (calcium-vitamin D) resulted in administration of the wrong medication and crushing long-acting/enteric-coated medications (aspirin, oxybutynin, Toprol), which may alter their absorption rate and place residents at risk for adverse drug effects. Four errors occurred during staff administration of 43 medications, which resulted in a nine percent error rate. Findings include: The Nursing 2011 Drug Handbook, 31st edition, Lippincott, Williams & Wilkins, page 983, stated, ". . . oxybutynin chloride [an incontinence drug] . . . ADMINISTRATION . . . Don't crush extended-release tablets. . . ." Saxton and Clark, "Geriatric Medication Handbook," Seventh Edition, American Society of Consultant Pharmacists, page 57 and 63, stated, "Medications Not To Be Crushed . . . aspirin EC	F 332	**F-332: Medication Errors** The facility remains in compliance with F-332 as evidenced by the following: The P & P titled Medications-Crushed was reviewed and remains in place without changes The medication order for resident #14 has been clarified with her attending physician to insure that the amount ordered of Vitamin D and C is the amount administered. The medication orders for resident #15 have been reviewed by the MD and orders obtained to change enteric coated or sustained release medications to ones that can be crushed or delivered in a liquid form. Staff education was presented on 11-9-11 for all nursing and CMA associates. The Meds-Crushed P & P was reviewed along with the med pass process, insuring that the meds ordered and meds administered match. Emphasis was also placed on educating these associates on the correct process related to crushed medications and monitoring. The medication administration process for residents receiving crushed medications has the potential to affect all residents in the facility. Because of this, prior to 11-21-11 the Consulting Pharmacist will review the medication lists of those residents who require their meds be crushed to ensure that meds are identified that can't be. Change orders will be obtained as necessary.	

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F 332	Continued From page 15 [enteric-coated] . . . Toprol XL [extended release] [a blood pressure medication] . . ." Observation of medication pass occurred on 10/25/11 at 8:20 a.m. A licensed nurse (#14) administered a calcium tablet with vitamin D to Resident #14. The drug label indicated a concentration of 500 milligrams (mg) calcium and 400 international units (IU) vitamin D. Resident #14's physician's orders identified an order for a calcium-vitamin D tablet with a concentration of 600 mg calcium and 400 IU vitamin D, not 500 mg calcium as administered by staff. Observation of medication pass occurred on 10/25/11 at 8:31 a.m. A licensed nurse (#14) administered medications to Resident #15 including enteric-coated aspirin, extended release oxybutynin chloride, and extended release Toprol. The nurse crushed the medications and mixed them with pudding. Resident #15's medication administration record (MAR), as well as the physician's orders, stated, "Administration Note: MEDS [medications] GIVEN WHOLE." The nurse stated the staff need to crush Resident #15's medications or "she spits them out." During an interview on the morning of 10/26/11, a licensed pharmacist (#13) confirmed staff should not crush extended release and enteric-coated medications.	F 332	Med administration errors have the potential of affecting all residents. CQI monitoring will be completed by the CQI Coordinator and/or her designee beginning the week of 11-21-11 and include those residents identified as receiving crushed medications along with those resident who receive a Vitamin D & C combination. This monitoring will include resident #14 and #15. Monitoring will be completed weekly X4 of 10% of the identified residents and then monthly X2. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized by the CQI Coordinator at the Quarterly CQI meetings with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Agenda & Attendance sheet from the 11-9-11 education 2. P & P titled Meds-Crushed 3. Copy of MD order clarifying the dose of Vitamin D and C for resident #14 4. Copy of MD medication order changes for resident #15 5. CQI monitoring worksheet for med pass observations Date Certain: 11-29-11	
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	F 441		

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F 441	Continued From page 16 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 6	F 441	**F-441 Infection Control – Hand Hygiene** The facility remains in compliance with F-441 as evidenced by the following: The Hand Hygiene P & P was reviewed and remains in place as written. Education and QI monitoring will focus on adherence to this procedure. Education will be provided at the mandatory All Staff meeting scheduled for 11-29-11. This education will include Hand Hygiene, specifically the proper use of gloves and performing hand hygiene in between removing and then donning clean gloves. The MCO Net Learning Course titled "Hand Hygiene" will also be assigned to all Off Collins associates with a completion date no later than 11-21-11. This course includes a post test as a means of measuring associate knowledge. Improperly performed hand hygiene has the potential to affect all residents. Beginning 11-21-11 CQI monitoring of 10-15 direct care associates will be done weekly X4 by the CQI Coordinator and/or her designee. Monitoring of 10-15 associates will continue monthly X 2 to insure that the desired practice is maintained.	

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F 441	Continued From page 17 sampled residents (Resident #1, #2, and #6) observed receiving personal cares. Failure to perform hand hygiene following assistance with personal cares may result in the spread of infection to other residents, visitors, and staff. Findings include: Review of the facility policy "Hand Hygiene" occurred on 10/26/11. This policy, revised 11/04/09, stated, ". . . Recommendations for Hand Hygiene include but are not limited to: . . . 7. Before and after assisting a resident with personal care . . . 16. After handling soiled or used linens . . . 19. After removing gloves . . ." - Observation on 10/24/11 at 1:11 p.m. showed two CNAs (#16 and #17) entered Resident #6's room to check and change her brief as she lay in bed. The resident was incontinent of urine and a moderate amount of watery stool. The CNA (#16) performed perineal care, changed her gloves, placed a clean brief on the resident, removed the sheets (soiled with stool), removed her gloves, and left the room to obtain new sheets. The CNA (#16) failed to perform hand hygiene before leaving the room. The CNA (#16) re-entered the room, put on gloves, placed new sheets under Resident #6, checked the resident's brief again, and performed perineal cares as the resident was incontinent of a small amount of watery stool. The CNA (#16) then changed her gloves, applied a moisture barrier ointment, changed her gloves, assisted the other CNA (#17) to lift Resident #6 up in bed using a draw sheet, repositioned the resident using pillows, and covered her with a sheet. The CNA (#16) failed to perform hand hygiene after completing perineal cares and	F 441	Cares provided to residents #1, #2, & #6 will be monitored the week of 11-21-11 to insure that hand hygiene is completed after removing gloves and before putting on a new pair, especially when providing perineal & nursing care. Results of the CQI monitoring will be reviewed as part of the facility CQI meeting and then summarized by the CQI Coordinator at the Quarterly CQI Meetings with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Hand Hygiene P & P 2. CQI Worksheet-Hand Hygiene 3. MCO Net Learning Course Outline-Hand Hygiene Date Certain is 11-29-11	

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F 441	Continued From page 18 before performing other tasks. Observation on 10/24/11 at 4:05 p.m. showed a CNA (#18) entered Resident #6's room to check and change her brief as she lay in bed. The CNA performed perineal care for Resident #6, who was incontinent of a moderate amount of watery stool. Upon completing perineal care, the CNA put on new gloves, applied a moisture barrier cream, placed a new brief on Resident #6 and removed her gloves. The CNA then placed pillows under the resident's arms and knees, covered her with a sheet, adjusted her bed using the bed control, and gave the resident her call light. The CNA failed to perform hand hygiene after completing perineal cares and before performing other tasks. Observation on 10/26/11 at 1:15 p.m. showed a licensed nurse (#21) entered Resident #6's room to change a dressing to her coccyx. The nurse applied gloves and removed the soiled dressing. The nurse changed her gloves and cleaned the wound site with saline and gauze pads. The nurse then performed perineal care for Resident #6 who was incontinent of a small amount of watery stool. The nurse changed her gloves, applied ointment with a cotton swab to the open wound area, and covered the wound with an adhesive dressing. The nurse again changed her gloves, applied moisture barrier cream to the perineal area, removed her gloves, placed a new brief on the resident, repositioned the resident using pillows, and covered her with a blanket. The nurse failed to perform hand hygiene after completing perineal cares and when moving from a contaminated site to a clean site during the dressing change.	F 441		

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F 441	Continued From page 19 - Observation on 10/25/11 at 1:17 p.m. showed two CNAs (#17 and #20) assisted Resident #2 with perineal care as she lay in bed. Resident #2 voided in a bedpan, and the CNA (#17) performed perineal care. The CNA (#17) changed her gloves, placed a new brief on the resident, removed her gloves, and placed the resident's cleansing wipes and foam soap back in her cupboard. The CNA (#17) then assisted the other CNA (#20) to reposition Resident #2 in bed, placed a pillow under the resident's knees, and covered her with a blanket. The CNA (#17) failed to perform hand hygiene after completing perineal care and before performing other tasks. - Observation on 10/26/11 at 9:06 a.m. showed two certified nursing assistants (CNAs) (#15 and #19) checked and changed Resident #1's brief as she lay in bed. One CNA (#15) performed perineal cares, changed her gloves, applied Calmoseptine cream to Resident #1's groin area, changed gloves, assisted the other CNA (#19) to place pants on the resident, and repositioned her in bed. The CNA (#15) then covered Resident #1 with a blanket, adjusted her bed using the bed control, and zipped the resident's Posey bed. The CNA failed to perform hand hygiene after completing perineal care and before performing other tasks. During an interview on 10/26/11 at 3:21 p.m., an administrative nurse (#2) stated she expected staff to perform hand hygiene after removing their gloves and moving from a clean to dirty area (such as with a dressing change).	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

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F 465	Continued From page 20 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safety equipment to prevent backflow of contaminated water into the potable (drinking) water system of the facility in 1 of 1 soiled laundry room. The lack of safety devices has the potential to affect the water supply for the entire facility. Findings include: A tour of the environment occurred on 10/26/11 at 9:30 a.m. with two environmental staff members (#9 and #10) and two administrative staff members (#7 and #8). Observation in the soiled laundry room identified a sink for rinsing soiled linen with a hose attached to the faucet. Observation showed the hose extended into the sink. Observation showed the faucet lacked a back flow device. An environmental staff member (#9) confirmed the faucet had no backflow device.	F 465	**F-465 Environment** It is the intent of this facility to remain in compliance with F-465 as evidenced by the following: A backflow device was installed in the soiled laundry sink on 10-27-11. The lack of a backflow device has the potential to affect all residents in the facility. To prevent this from occurring all sinks in the facility with a hose attached have been checked to confirm that backflow devices are in place. Attachments: 1. Verification Checklist Date Certain: 11-11-11	