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 _____	11/10/2010

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 11/08/10 and completed on 11/10/10, the sample included 2 residents for complete review, 9 residents fro focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to post the most recent State health and life safety code survey reports for examination on 2 of 3 days of survey. Failure to post this information had the potential to limit residents' and families' access to this information. Findings include: Observation of the survey results posted by the facility on 11/09/10, at 9:40 a.m., showed the health survey report from 11/20/08 and the life safety code survey report from 07/27/09.	F 167	The facility remains in compliance with F-167 as evidenced by the following: The most current Life Safety and Medicare/Medicaid survey results were posted on 11-12-10. This was confirmed on 12-9-2010 when CQI monitoring was completed prior to date certain. Education on compliance with F-167 will be completed with managers and nursing associates at a staff meeting scheduled for 12-21-10. To be sure that the most current survey results remain posted CQI monitoring will be completed by the CQI Coordinator or her designee weekly X4 and then monthly X2 beginning the week of 12-13-10. The CQI Monitoring Worksheet titled F-167 Survey Monitoring Worksheet will be used to collect data. The results of this monitoring will be reviewed at least monthly as part of the facility CQI meetings and then at the Quarterly CQI meetings to be held in January and April with the Medical Director in attendance. The need for continued monitoring will be determined based on these results.	

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

[signature] | Administrator | 12-16-10

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 167	Continued From page 1 Review of the facility's records prior to the current survey showed the last State health survey as completed on 11/25/09 and the last State life safety code survey as completed on 09/13/10. During an interview, following the environmental tour on 11/09/10 at 3:00 p.m., an administrative staff member (#2) confirmed the facility had failed to post the proper survey reports.	F 167	Attachments: 1. CQI Monitoring worksheet dated 12-9-10	12/24/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide care in a manner that maintained or enhanced each resident's dignity and in full recognition of their individuality, for 2 of 3 meals observed when Resident #14 required assistance. Failure to provide assistance during meals did not maintain or enhance the residents' dignity, self worth or esteem. Findings include: Review of Resident #14's medical record occurred on 11/10/10. Current diagnoses included a radial fracture to the right arm. The resident's Significant Change Minimum Data Set (MDS), dated 09/21/10, identified the resident required set-up assistance with meals.	F 241	The facility remains in compliance with F-241 as evidenced by the following: A Therapy Screen was completed by the Speech Language Pathologist and the Occupational Therapist on 11-17-10 which addresses Resident # 14's seating, positioning, and adaptive devices necessary to enable her to dine in a dignified manner. A Seating and Positioning Plan of Care was completed by the COTA on 11-15-10 which identified the resident is seated adequately in the dining room. The dining care plan for Resident #14 was revised on 12-3-10 to guide associates on the resident's specific dining needs. CNA education was completed on 11-22-10 and included the importance of assisting a resident to dine with dignity and the importance of providing assistance to enhance their quality of life. Training will be completed with managers, therapists, and nursing associates on 12-21-10 with the importance of identifying and assisting with dining needs so that personal dignity is maintained Dining observations were completed on 11-29-10 of resident # 14 to insure that identified interventions are carried out in the dining room. All resident's have the potential to be affected by a deficient practice related to dining with dignity.	

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F 241	Continued From page 2 - Observation at meal times identified Resident #14 seated in her wheelchair at a dining room table, eating independently from a lipped plate. The following observations revealed staff did not provide the assistance necessary to enhance Resident #14 dining experience: *11/08/10, 5:30 p.m. - The resident attempted to eat lasagna that had not been cut up into bite size pieces. The resident was not able to cut the lasagna and attempted to put large pieces into her mouth which she dropped onto her clothing protector or the food hung from her mouth until it fell. Resident #14 would then scoop the food from her clothing protector and place it in her mouth. Facility staff members walked by her without providing assistance. *11/10/10. 8:00 a.m. - The resident picked up her ham after several attempts to cut it and ate it with her fingers. Facility staff members walked by her without providing assistance. During interview, on 11/10/10 at 9:20 a.m., an administrative staff member (#5) agreed Resident #14 should have received more assistance with her meal set up.	F 241	CQI monitoring will be completed by the CQI Coordinator or designee beginning the week of 12-13-10 using the attached CQI monitoring sheet-Resident Dining. Monitoring will be done weekly X4 and then monthly X2 of a minimum of 10% of all residents. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized at the Quarterly CQI meeting to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results, Attachments: 1. Therapy Screening completed 11-17-10 2. Dining Care Plan dated 12-3-10 3. Seating and Positioning Plan of Care and Progress Note completed 11-15-10 4. Agenda & Attendance for training held 11-22-10 5. CQI Monitoring worksheet-Resident Dining completed on 11-29-10	12/24/10
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246	The facility remains in compliance with F-246 as evidenced by the following. The policy and procedure "Seating and Positioning Needs Assessment" was reviewed along with the Plan of Care and Progress Note form. Emphasis is placed on adhering to this P & P and focusing on the timely completion of the Seating and Position assessment which includes specific interventions for dining and appropriate table height. The Seating and Positioning Plan of Care	

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F 246	Continued From page 3 Based on observation, record review, resident interview and staff interview, the facility failed to ensure reasonable accommodations of individual needs and preferences regarding wheelchair positioning and positioning at the dining room table fro 2 of 11 sampled residents (Resident #9 and #10) during 4 of 4 meal observations. Failure to accommodate individual needs regarding wheelchair and dining room positioning placed the residents at risk for reduced food and fluid intake and weight loss. Findings include: - Review of Resident #10's medical record occurred on November 9-10, 2010. Diagnoses included cerebral vascular accident with left-sided hemiparesis (stroke with left-sided paralysis), Bells Palsy, muscular spasticity, decreased appetite and weight loss. Resident #10's medical record indicated an electric wheelchair as her primary means of transportation. Observations on 11/09/10 at 8:19 a.m. and 5:38 p.m. and on 11/10/10 at 8:13 a.m. and 5:50 p.m., showed Resident #10 seated in her wheelchair, and positioned sideways with the dining table to her right. The resident extended her right arm to reach her utensil and carry the food across her lap to her mouth. The height of the table prevented the resident from sitting up to and facing the table with the arm rests beneath it. An interview with Resident #10 occurred on 11/10/10 at 8:55 a.m. The resident stated, "I have to sit sideways at the table because my wheelchair doesn't fit under it. It would be great if I could sit up to the table."	F 246	Assessments for residents #9 & #10 that included dining interventions were updated on 11-17-10. Training was held with the CNA staff on 11-22-10 that included the importance of adequate seating and position (including table height) at dining. Training will be held with nursing staff members on 12-21-10 that will include seating and position needs of residents in the dining room and the importance of adhering to the assessment schedule to insure that needs are identified and addressed in a timely manner. At both meetings an emphasis was placed on assisting all residents when need is identified. Because the concerns noted have the potential to affect residents of MCO Off Collins with seating and positioning needs a Seating and Positioning Plan of Care Assessment will be completed when a resident is admitted to the facility and then with each Quarterly MDS and PRN for residents in a wheelchair or with specific seating and positioning needs, especially those with specific dining needs. CQI monitoring will be completed by the CQI Coordinator or her designee beginning the week 12-13-10 for Resident #9 & #10 and the X1 month for those residents admitted to the facility and those with a Quarterly MDS completed to ensure completion of the Seating and Positioning Assessments. Monitoring will also be done to determine that	

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F 246	Continued From page 4 An interview with an administrative staff member (#6) occurred the morning of 11/10/10. This staff member agreed the wheelchair and dining position did not accommodate the resident's individual needs and placing Resident #10 at a higher dining table would be beneficial for the resident. - Review of Resident #9's medical record occurred on November 9-10, 2010. Diagnoses included macular degeneration, osteoarthritis, hearing loss, and history of trans-ischemic accident (TIA). The resident's MDS, dated 09/09/10, identified her as independent in eating with assist for set up. Observation on 11/09/10 at 8:20 a.m. and 5:40 p.m. and on 11/10/10 at 8:20 a.m. and 5:40 p.m., showed Resident #9 seated in her wheelchair at the dining table eating. Resident #9 ate while leaning over her food, scooping it into her mouth. The arm rests of the wheelchair were at the level of the dining room table, came in contact with the table top, and prevented the resident from moving closer to her food. An interview with an administrative staff member (#6) occurred on 11/10/10 at 10:20 a.m.. This staff member agreed the height of the table should be adjusted to accommodate the resident's individual needs for dining and placing Resident #9 at a higher table would be beneficial for the resident.	F 246	recommendations made by the OTR/L and/or PT are included on the residents individualized care plan and implemented accordingly. Then 10% of all residents admitted or having a quarterly MDS completed will be monitored X2 months to determine that compliance is maintained. Results of the CQI Monitoring will be reviewed at least monthly as a part of the facility CQI meetings and then summarized at the Quarterly CQI meeting to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Seating and Positioning Needs Assessment P & P 2. Seating and Positioning Assessments for Resident #9 #10 completed 11-17-10 3. CNA Meeting agenda & attendance for 11-22-10 4. CQI monitoring of Residents #9 & #10 completed the week 12-13-10	12/24/10
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	The facility remains in compliance with F-323 as evidenced by the following: Resident #7 discharged home from the facility.	

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F 323	Continued From page 5 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff used the appropriate assistive device for 1 of 2 sampled residents (Resident #7) observed transferred with a stand lift. Failure to use the appropriate device could result in injury to the resident and/or staff member during the transfer. Findings include: The facility policy "Use of Standing and Total Lifts - General Guidelines" occurred on 11/10/10. The policy, dated 06/01/09, stated, "Policy: 1. Nursing associates identify the need for use of a standing lift or a total lift device. This is specified on the resident's individualized care plan and conveyed to the staff caring for the resident. . . ." Resident #7's medical record, reviewed November 08-10, 2010, identified diagnoses including polymyalgia rheumatica, peripheral neuropathy, and chronic obstructive pulmonary disease. An initial Minimum Data Set (MDS), dated 08/10/10, identified the resident with short and long term memory problems and moderate impairment with decision making. The MDS further identified the resident required extensive assistance of two or more persons for transfers. Resident #7's Activities of Daily Living care plan identified an approach, dated 09/29/10, "E-Z	F 323	Education will be completed with department managers and team leaders on 12-22-10 to include the importance of Care Cards posted in resident rooms being consistent with the master care plan as a means of preventing accidents. The process was established that care plan changes related to transfer assistance are to be made on both documents at the same time. These changes will be made by an associate designated by the DON. Education was provided to CNA associates on 11-22-10 and included the importance of reporting any discrepancies/resident changes/need for changes to be made so that the Care Cards posted in the room and the master care plan remains consistent. Because inconsistent care plans have the potential to affect any resident requiring assistance with transfers CQI monitoring was completed on 11-30-10 of all residents to insure that both the master care plan and the care cards posted in the room are consistent. To maintain a consistent care planning process related to transfers CQI monitoring will be completed by the CQI Coordinator or her designee beginning the week of 12-13-10 on 10% of all MCO Off	

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F 323	Continued From page 6 stand (a stand lift) for all transfers [with] assist of 2." Observation of care on 11/08/10 at 12:50 p.m. identified two Certified Nursing Assistants (CNAs) (#7 and #8 - both contract staff) transferred Resident #7 from her wheelchair to the bathroom, then to the bed using a stand lift. On 11/08/10 at 3:50 p.m., observation identified a CNA (#9 - contract staff) answered Resident #7's call light. The resident requested to get out of bed and stated to the CNA that she could pivot transfer with assistance of one and a walker. The CNA obtained the walker and prepared to transfer the resident. At that point, the surveyor stopped the observation and asked the CNA to check on the type of transfer, since earlier two CNAs had transferred the resident with a stand lift. The CNA (#9) went to the resident's door and found a yellow laminated card. The card stated Resident #7 could pivot transfer with assist of two staff. The CNA then stepped out into the hall to obtain assistance. A CNA (#10 - not contract staff) took a sheet from her pocket titled, "PM [evening] Aides Routine," which identified Resident #7 as "EZ stand for all transfers." The two CNAs (#9 and #10) then assisted Resident #7 out of bed using the stand lift. During the transfer, Resident #7 had difficulty sitting upright at the edge of the bed. An interview with an administrative nurse (#12) took place on 11/10/10 at 10:40 a.m. When asked about the yellow laminated cards in the resident's rooms, the nurse stated the facility implemented the cards for use by contract staff. She stated staff placed the cards in resident's rooms late in September 2010 and update them	F 323	Collins residents weekly X4 and then monthly X2 using the CQI worksheet titled Care Cards CQI Worksheet. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meetings and then summarized at the Quarterly CQI meetings to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. CNA education agenda and attendance sheet dated 11-22-10 2. Care Card CQI Worksheet completed 11-30-10	12/24/10

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F 323	Continued From page 7 as changes occur, or about twice a week. The nurse (#12) stated she delegated the task of updating the yellow cards to another staff member and Resident #7's card must have been overlooked. Failure to ensure staff responsible for providing direct resident care had accurate information regarding mode of transfer for Resident #7 placed the resident and staff at risk for an injury during a transfer.	F 323		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, resident interview, and staff interview, the facility failed to provide dental services in a timely manner for 1 of 1 sampled resident (Resident #4) experiencing dental/mouth pain. Failure to provide dental services in a timely manner resulted in the resident experiencing	F 411	It is the intent of this facility to remain in compliance with F-411 as evidenced by the following: Resident #4 was seen by a dentist on 11-11-10 and his complaints of jaw pain have been resolved. He requires no further appointments. The process of scheduling appointments has been reviewed by the management team. Education will be provided to the nursing associates and Ward Clerks on 12-21-10 to emphasize the importance of observing orders accurately and scheduling clinic appointments (especially dental appointments) as soon as orders are observed. Because all residents have the potential to be affected by the process of scheduling appointment CQI monitoring will be completed by	

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F 411	Continued From page 8 continued mouth pain. Findings include: - The Centers for Medicare and Medicaid Services (CMS) guideline states, the facility is directly responsible for the dental care needs of its residents. The facility is responsible for selecting a dentist who provides dental services in accordance with professional standards of quality and timeliness. The intent of this regulation is to ensure the facility be responsible for assisting the resident in obtaining needed dental services. Resident #4's medical record, reviewed on all days of survey, identified the facility admitted the resident on 09/28/10. The record identified the resident was hospitalized from October 20-25, 2010. The facility identified Resident #4 as interviewable. Resident #4's Medication Administration Record (MAR) showed he received the following as needed oral medications for complaints of mouth pain: * 11/05/10 at 9:00 a.m. Percocet 5/325 two tablets * 11/06/10 at 9:15 a.m. Percocet 5/325 two tablets * 11/06/10 at 9:30 p.m. Tylenol 650 mg * 11/07/10 at 8:00 a.m. Tylenol 650 mg * 11/07/10 at 5:05 p.m. Percocet 5/325 two tablets * 11/07/10 at 9:25 a.m. Percocet 5/325 two tablets * 11/08/10 at 7:00 a.m. Percocet 5/325 two tablets * 11/08/10 at 12:35 p.m. Percocet 5/325 two	F 411	the CQI Coordinator or her designee weekly X4 and monthly X2 beginning the week of 12-13-10 of all dental appointments ordered to insure that appointments are made by the end of the next working day following the date ordered. Results of the CQI monitoring will be reviewed at the least monthly as part of the facility CQI meetings and then summarized at the Quarterly CQI meeting to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Progress note for Resident #4- Dental Visit 2. CQI Monitoring Worksheet- Dental Services completed the week of 12-13-10	12/24/10

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F 411	Continued From page 9 tablets * 11/09/10 at 8:15 a.m. Percocet 5/325 two tablets The MAR further identified the resident obtained relief from the medications. Resident #4's care plan showed an undated hand written entry which stated, "Problem: Resident does have an occasional c/o [complaint of] jaw/mouth pain . . . Approach(s): Medicate before planned activity. Follow up after providing pain medication and chart pain rating and outcome of medication. Monitor sleep and eating patterns. Teach, encourage, and assist resident to rate pain. Notify MD [medical doctor] of uncontrolled pain. Get medications scheduled if pattern develops. Make res. [resident] aware first." The record did not indicate the physician was notified of the resident's ongoing pain. On 11/08/10 at 9:15 a.m., during the initial tour of the facility, Resident #4 stated, "I wish someone would help me with my mouth pain. They just keep putting me off and giving me pain pills. No one will make me a dental appointment." An interview with Resident #4 occurred on 11/09/10 at 9:50 a.m. The resident stated, "I can't eat, my mouth hurts so bad. I keep asking when I'm going to see the dentist, but they just say they'll check into it. Nothing happens." On 11/09/10 at 8:10 a.m., Resident #4 called a surveyor to his breakfast table and stated, "I guess I'm going to have to call my family. No one will make an appointment with the dentist for me. I can't eat because of the pain." An interview with a nursing staff member (#13)	F 411		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 411	Continued From page 10 occurred on 11/10/10 at 9:46 a.m. The staff member stated Resident #4 had a dental appointment scheduled the week of his hospitalization and the appointment was cancelled. Upon his return to the facility, the appointment was not rescheduled.	F 411		
F 441 SS=E	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	It is the intent of this facility to remain in compliance with F-441 as evidenced by the following: Bathing: The facility P & P titled "Cleaning and Disinfecting Whirlpool Bath Tub System" has been revised to include a step directing staff to check the chemical used for total contact time necessary for disinfection. It was noted that the CNA had followed the P & P in place at the time of survey but the chemical used had been changed to one that required a longer contact time. Staff education was provided on 11-22-10 at which time this P & P was reviewed with the staff present and also with the bath aides primarily responsible for resident bathing. An observation was completed on 12-13-10 to insure that the correct chemical contact time was allowed for prior to the bathing of a resident. Because all residents have the potential to be affected by improper disinfecting of the whirlpool bath tub system CQI monitoring will be completed by the CQI	

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	355106	A. BUILDING _____ B. WING _____	11/10/2010

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F 441	Continued From page 11 (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 manufacturer's recommendations, and staff interview, the facility failed to follow accepted infection control practices for food handling and tub cleaning during 2 of 3 days of survey (November 09-10, 2010). Failure to follow proper infection control procedures has the potential to adversely affect the health of all residents. Findings include: - Observation on 11/09/10 revealed the following: * 8:08 a.m., a CNA (Certified Nursing Assistant) (#3) handling Resident #15's toast with her ungloved hand while applying jelly. * 8:28 a.m., a CNA (#3) handling Resident #16's toast with her ungloved hand while applying jelly. - Observation on 11/10/10 revealed the following: * 8:14 a.m., a CNA (#4) applying jelly with a knife while handling an unidentified resident's toast with ungloved hands. * 8:22 a.m., a CNA (#4) handling Resident #9's English muffin with her ungloved hands while spreading cream cheese. * 8:25 a.m., a CNA (#4) handling Resident #4's toast with ungloved hands while applying jelly. An interview with an administrative dietary staff member (#5) occurred on 11/10/10 at 1:30 p.m.	F 441	Coordinator and or her designee beginning the week of 12-13-10 using the attached CQI monitoring worksheet- F-441 Infection Control weekly X4 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 at the Quarterly CQI meeting to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Cleaning and Disinfecting Whirlpool bath tub System P & P 2. CNA agenda & attendance for training held 11-22-10 3. CQI observations completed 12-13-10 Dining: Staff education was provided at the CNA meeting held on 11-22-10 at which time hand hygiene practices in the dining room was reviewed. It will be addressed with managers and nursing associates at a staff meeting to be held on 12-21-10 at which time dining etiquette will also be covered.	

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F 441	Continued From page 12 This staff member stated she would expect all staff assisting residents with dining to use utensils or clean gloved hands while handling residents' food and to not handle food with bare hands. - Observation of the bathing room and interviews with two certified nursing assistants/bath aides (CNAs #15 and #16), occurred on 11/10/10 at 10:35 a.m. and 1:55 p.m. The interview identified both CNAs clean the whirlpool tub with a pre measured cleaning solution following each resident's bath and at the end of the day allowing the product to remain on the interior surface of the tub and chair for "about five minutes". The CNA (#15) stated she "adds more solution if the resident is known to have an infection." Review of the manufacturer's recommendations for the "Mikro-Quat" disinfectant cleaner, used in cleaning the whirlpool tub, occurred on 11/10/10 at 10:35 a.m., and identified "Contact time 10 minutes." During an interview, on 11/10/10 at 2:00 p.m. an administrative staff member (#2) stated the facility changed disinfectant products one month ago and failed to educate staff on the new product or update the policy for disinfecting the whirlpool tub. Failure to follow the chemical manufacturer's recommendations regarding solution concentrations and contact time for disinfecting surfaces placed residents at risk for developing infections from contaminated bathing equipment.	F 441	CQI monitoring of dining hand hygiene was completed for the resident # 4, #9, & #16 to insure that staff did not touch the resident's food while preparing it to be eaten. Proper hand hygiene when preparing a residents food has the potential to affect all MCO Care Center resident, especially those requiring assistance in the dining room. The CQI Coordinator and/or her designee will begin monitoring the week of 12-13-10 10% of facility residents receiving assistance with meal set-up weekly X4 and then monthly X2 to insure compliance is maintained. The CQI worksheet Resident Dining F-441 will be used to gather data. The results of this monitoring will be reviewed at least monthly as part of the facility CQI meetings and then at the Quarterly CQI meetings in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. CNA Agenda & attendance for training held 11-22-10 2. CQI observations for Resident's #4, #9, & #16	12/24/10
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	F 454	It is the intent of this facility to remain in compliance with F-454 as evidenced by the following:	

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F 454	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 1 of 1 oxygen storage area. This failure could result in an oxygen tank falling and becoming a projectile, placing residents, staff, and visitors in the area at risk of injury. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 state "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." - During review of oxygen storage, on 11/09/10 at	F 454	A facility P & P titled Oxygen Storage and Use Guidelines was established. Education on the proper storage of Oxygen was provided to the CNA staff on 11-22-10. Education will be provided to managers and nursing staff on 12-21-10 with an emphasis placed on adhering to the policy so as to maintain safety. CQI Monitoring was completed the week of 12-9-10 by the CQI coordinator using the CQI worksheet titled F-454 Oxygen Storage to insure that oxygen was stored correctly. Monitoring will continue weekly X4 and then monthly X2 to insure that safe oxygen storage is achieved and maintained. Results of the CQI monitoring will be reviewed at least monthly as part of the facility CQI meeting and then summarized at the Quarterly CQI meeting to be held in January and April with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. Attachments: 1. Oxygen Storage and Use Guidelines P & P	

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F 454	Continued From page 14 9:45 a.m., observation of the oxygen storage area located in a nursing office, showed an empty oxygen tank standing unsecured in the storage area. The tank stood away from the wall and the available storage rack. The storage area contained two partitioned storage racks one for empty oxygen tanks and one for full oxygen tanks. The rack for empty tanks had openings for the unsecured oxygen tank. When interviewed, during the above review of the oxygen storage area, a maintenance staff member (#1) confirmed staff failed to store the oxygen properly. This staff member (#1) moved the unsecured oxygen tank into the partitioned storage rack provided for empty oxygen tanks. During an interview on 11/09/10, at 10:15 a.m., with an administrative staff member (#2) and the maintenance staff member (#1), the administrative staff member (#2) identified the facility did not have a policy on oxygen storage. These staff members (#1 and #2) identified staff are educated to secure the oxygen tanks in the storage area.	F 454	2. CNA education agenda and attendance sheet dated 11-21-10 3. CQI monitoring completed 12-9-10	12/24/10