STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING _____ B. WING _____	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/30/12 and completed on 02/01/12, the sample included two residents for complete review, seven residents for focused review, and one closed record for review. The sample included two additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to follow accepted professional standards of practice during 1 of 4 observations of medication administration. Failure to administer medications as they are dispensed (and not "pre-dished") increases the risk of medications errors and has the potential to result in adverse drug events. Findings include: Review of the facility policy titled "Medication Administration" occurred on 02/01/12. This policy, revised in 2006, stated, ". . . 2. Safety . . . F. Do not Pre-Dish medications . . . 3. General Considerations . . . J. Medications should be prepared for the resident immediately before administration . . ." The Geriatric Medication Handbook, 7th ed.,	F 281	F 281 1&2: No residents were cited for this concern. All residents have the potential to be affected by this deficiency. 3. The DON met with the nurse involved & Reviewed the findings and our facilities Medication administration policy. Individual Meetings were held with every nursing staff member to ensure their knowledge and understanding of the survey, findings and PoC. There were no changes required in our policy. 4. A monitor was developed for Medication administration and will be completed for every nurse X 3 or until 100% compliance is achieved. This monitor will be added to the employees annual skill checklist, and all employees will have it reviewed during their annual evaluation. Ongoing monitoring will be completed once compliance is achieved at least every quarter for every shift . All monitoring will be done by the DON and/or designee. The monitoring has been added to the nursing QA calendar and will be reported on at least quarterly or as often as needed to verify compliance to the QA committee. 5. Feb. 29, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy Swenson — TITLE: RN-CEO — (X6) DATE: 2/23/2012

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.

I verify the above signature dated 2/23/12 is an original & not a copy. C Swenson

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

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

Cindy Swenson, RN-CEC — 2/23/12

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 281	Continued From page 1 American Society of Consultant Pharmacists, page 148 stated, "Medications should be prepared for the resident immediately before administration; medications should never be prepared in advance for multiple residents and left in unlabeled medicine cups for later use." Observation on 01/31/12 at 3:25 p.m. showed ten medications on a blue tray in the medication room and only two of the medications labeled with a resident's name. The unlabeled medications included 3 vials of DuoNeb (a mixture of albuterol sulfate and ipratropium bromide for inhalation), 1 vial of albuterol sulfate, 1 vial of ipratropium bromide, 2 medications cups containing Tylenol, and Neurontin (an anticonvulsant medication). The licensed nurse (#5) stated the medications belonged to all the residents who received medications at 4:00 p.m. and she prepares them for administration all at one time. When asked how she knows who the medications belong to she stated, "I just know." The nurse then labeled the medications cups with the resident's first name and labeled the vials with the first letter of the resident's first name. During an interview on 02/01/12 at 11:35 a.m., an administrative nurse (#2) stated facility staff should not pre-dish medications.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 2	F 309		

This REQUIREMENT is not met as evidenced by:
1. Based on observation, record review, and staff interview, the facility failed to offer interventions for relief of pain for 1 of 4 sampled residents (Resident #5) identified by the facility with pain. Failure of facility staff to inform the licensed staff of Resident #5's complaints of pain and failure to offer Resident #5 interventions for pain relief, resulted in the resident experiencing unrelieved pain and may have resulted in a limitation in the resident's range of motion.

Findings include:

Review of Resident #5's medical record occurred on January 30-February 01, 2012. The facility admitted the resident in September 2011. Current diagnoses included stroke with left hemiparesis and history of head injury. The resident's admission Minimum Data Set (MDS), dated 10/10/11, and significant change MDS, dated 12/11/11, identified the resident usually made himself understood and understood others, was severely cognitively impaired, demonstrated fluctuating inattention and disorganized thinking, and experienced mild pain.

Resident #5's Pain Evaluation, dated 09/28/11, stated ". . . Occassional [sic] shoulder pain treated [with] Tylenol. . . ." The Pain Evaluation identified the resident's pain frequency as "Occasionally" on a body diagram indicating the left shoulder and pain intensity as "3" with "10, Worst Possible Pain." The Pain Evaluation, dated

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F 309	Continued From page 3 12/30/11, also stated "Res. [Resident] using prn [as needed] Tylenol 650 mg [milligrams] for c/o's [complaints of] arm/leg pains. Baclofen [increased] to 10 mg TID [three times each day] to help [with] spasms. Prn Tylenol effective." Resident #5's current care plan, dated 10/02/11, stated "Problem . . . Res. needs assist. [assistance] [with] ADL's [activities of daily living] - due to past stroke & [and] some L) [left] side hemiparesis . . . Approaches . . . 6) Anticipate his needs. . . . 8) RA [Restorative Aide] program . . . [updated 01/03/12] O.K. to do hot pack b/4 [before] ROM [range of motion] . . . Problem . . . Potential for pain . . . Approaches, 1) Pain meds [medications] as needed. . . . 3) Assess for pain. . . ." Resident #5's physician orders included the following medications: *Baclofen 10 mg, TID (skeletal muscle relaxant) *Tylenol 325 mg, two tablets, every four hours, prn (non-narcotic pain reliever) Observations of facility staff assisting Resident #5 identified the following: *01/31/12, 9:30 a.m. - Two certified nursing assistants (CNAs) (#8) and (#9) assisted the resident to remove his clothing and positioned him in a chair for transport to the tub room for his bath. During removal of his shirt and positioning in the chair, the resident and the CNAs lifted his left arm. Resident #5 stated "Ow" regarding pain in the left arm during this process, acknowledged by the CNA (#8). *01/31/12, 10:00 a.m. - A CNA (#8) assisted Resident #5 to get dressed after his bath. While donning an undershirt and a sweater the resident	F 309		

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F 309	Continued From page 4 stated "Ow" regarding pain in his left shoulder. When questioned by the either CNA (#8), Resident #5 stated "Sore" and indicated his left shoulder. Observation following these episodes of care failed to show that CNA (#8) or (#9) questioned Resident #5 if he needed pain medication or informed the licensed nurse of Resident #5's pain complaints. *01/31/12, 1:10 p.m. - A CNA (#10) assisted Resident #5 with ROM to the left extremities. The resident reported pain with ROM to the shoulder and to the forearm, held his left arm with his right hand, and the CNA (#10) limited the ROM because of his pain. The CNA (#10) failed to offer Resident #5 hot packs, as identified in his care plan, and failed to inform the licensed nurse of his pain complaints. Review of Resident #5's prn medication administration record (MAR) showed the facility staff provided Resident #5 prn Tylenol on six occasions in January 2012, most recently on 01/25/12. The MAR and Nurse's Notes lacked any information regarding Resident #5's complaints of pain during the episodes of care previously identified. During interview, on 02/01/12 at 11:00 a.m., an administrative management staff member (#4) and a nursing management staff member (#2) agreed the CNAs should have informed the licensed nurse of Resident #5's pain complaints. Failure to inform the licensed nurse of Resident #5's pain complaints limited the facility staff's ability to assess and monitor the resident's pain and effectiveness of the pain management	F 309		

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F 309	Continued From page 5 program. Failure to provide Resident #5 with pain relief and pain relieving options before his exercise, including medications and hot packs, may limit his ROM exercise and may result in increased limitations in mobility. 2. Based on record review, review of facility policy, and staff interview, the facility failed to provide the least aggressive/invasive intervention to promote regular bowel elimination for 1 of 1 sampled resident (Resident #9) who consistently received a suppository before other interventions. Failure to implement the bowel program according to the facility's protocol has the potential to result in unnecessary treatment and discomfort for the resident. Findings include: Review of the facility's policy, "Bowel Assistance," occurred on the morning of 02/01/12. This undated policy stated, ". . . Unless otherwise indicated, on the third day a prn [as needed] laxative should be considered as ordered by the physician. . . . Laxatives will be administered as appropriate to time of day per discretion of charge nurse. On day four of no bowel movement, a stronger laxative should be considered per physician or standing orders. . . ." - Review of Resident #9's medical record occurred on 02/01/12. The resident's diagnoses included dementia and Parkinson's disease. Medications administered to assist in stool elimination included Senokot twice a day, Miralax every day, Milk of Magnesia (MOM) as needed (prn), and Dulcolax suppository prn.	F 309	F 309: 1. Once notified of concern, facility staff offered pain intervention for Resident #5, with relief obtained. Resident #9 did not require any immediate action. 2. All residents experiencing pain, as well as any resident on a bowel management program has the potential to be affected by this concern. 3. Meeting was held with nursing staff 02/15/2012 to explain the deficiency and plan of correction. CNA skill evaluation checklist updated to include reporting of pain. Aides will document bowel results and to report any concerns re: pain/other to the charge nurse as it occurs. Staff nurse to inquire re: premedication before dressing for Resident #5 and inquire with all residents re: their pain and document results. Policy/procedures reviewed for both and remain as is. All MAR's reviewed with documentation to indicate "use first" for residents on a bowel program, and to document if not done to verify why not. Different clothing choices discussed with Resident #5 and refused at this time, but will reconsider. RA's reminded of pain interventions and noted on their documentation logs. Care plans and aide assignment sheets reviewed and revised to indicate reporting and recognizing signs of pain. 4. Monitor developed for Ambulation/ROM that includes pain monitors. Will be completed by DON/designee for resident noted during cares and ROM X 4, and then timelines reassessed to ensure compliance. Pain will also be monitored by staff nurses with documentation in the residents chart to indicate medicating and/or refusal of same.	

per phone call to Cathy Swenson, Admin. 3-8-12/1630

4 observations of cares with each CNA assigned to resident. need to meet 100% compliance 4 times in a row.

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F 309	Continued From page 6 Resident #9's current care plan related to constipation identified the interventions of medications and added fiber as ordered. Review of Resident #9's nurses' notes and prn medication administration records (MARs) from March 2011 to January 2012 identified the following days facility staff provided Resident #9 a suppository without prior interventions: *March 3, 7, 11 *April 16, 20 *May 7, 12, 21, 25 *June 5, 9, 10, 12, 15, 26 *July 23 *August 6, 20, 25 *September 3, 8 *October 22, 27 *November 11 *December 3, 22, 30 *January 7, 11 Review of Resident #9's nurses' notes, prn MARS, and the BM (bowel movement) list showed Resident #9 received MOM with results: *June 18 *August 14 During an interview on 02/01/12 at 9:20 a.m., two administrative nursing staff members (#2 and #3) confirmed on the third day facility staff should provide MOM to a resident without a bowel movement and on the fourth day facility staff should provide a suppository. The administrative nursing staff member #3 stated "always try MOM before suppository unless an order for something different."	F 309	Resident #5 Monitors will be done on MAR's daily X 5 days by DON/designee .DON or designee will check with resident #5 re: pain after dressing/ROM to determine if he demonstrated or voiced concerns re: pain and check of the MAR to see if interventions were implemented. Documentation of variances will be made in the daily communication book and on the resident's chart to be addressed immediately by staff nurses. Daily review of Resident involved in bowel compliance program shows compliance with same and offering least invasive method first. Monitor will continue by DON to ensure continued compliance as indicated by resident status until 100% compliance achieved. Continued monitoring will be done during provider visits, pharmacy chart reviews, and care plar meetings to ensure continue compliance. Monitoring has been added to the nursing QA calendar and will be reported to the Qa committee quarterly or as often as needed to verify continued compliance. 5. Feb. 29, 2012	per phone call to Cathy Swenson Admin. 3-8-12 1630

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F 309	Continued From page 7 During an interview on 02/01/12 at 12:50 p.m., an administrative staff member (#4) confirmed facility staff failed to follow the bowel assistance policy.	F 309	F 312: 1. Upon notification of concern, call light was appropriately placed, dietary notified and implemented additional adaptive measures with offers of assistance and returns to the resident room after receiving a room tray was completed to ensure compliance. 2. All residents with limited functional ability and/or eating in their room have the potential to be affected by this concern. 3. Nursing staff informed of concern and interventions to correct same. Aide and/or dietary staff will open all containers when placed in a room. The care plan and aide assignment sheets were reviewed and updated. OT was asked to observe resident and provide additional interventions noting residents intake remained at 95-100%. An adaptive bowl and dycem mat was added to his tray to facilitate independence and eating. Call light was placed on his nonaffected side. The aide providing care to this resident was provided instruction on checking the room prior to leaving to ensure appropriate placement and accessibility of items. A note placed in the communication log as a reminder. 4. A QA monitor for hydration, nutrition, monitor for checking the residen'ts room , and an addition to the survey skill nurse monitor has been developed to check continued compliance. This monitor will be reviewed for 3 meals X 3 days and at least 2x/day for 5 days to ensure compliance, and then reevaluated with monitoring to be continued per a schedule that will ensure and verify continued compliance, depending	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #5) identified with upper extremity functional limitations received the necessary services to maintain nutrition and activities of daily living (ADLs). Failure to ensure Resident #5's access to his call light, fluids, and assistance with breakfast limited his ability to maintain his ADLs, nutritional and hydration status, and limited his ability to request assistance. Findings include: Review of Resident #5's medical record occurred on January 30-February 01, 2012. The facility admitted the resident in September 2011. The resident's current diagnoses included stroke with left hemiparesis, history of head injury, history of dehydration, and history of pressure sores. Resident #5's admission Minimum Data Set (MDS), dated 10/10/11, and significant change	F 312		

per phone call to Cathy/Adm. 3-8-12 1630 For Res. #5

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F 312	Continued From page 8 MDS, dated 12/11/11, identified the resident usually understood others and made himself understood, was severely cognitively impaired, required limited assistance of two or more persons for bed mobility, experienced functional limitation in range of motion of upper and lower extremities on one side, and demonstrated coughing and choking on liquids on 10/10/11. Resident #5's current care plan, dated 10/02/11, stated Problem . . . Res. [Resident] needs assist. [assistance] [with] ADLs - due to past stroke & [and] some L) [left] side hemiparesis . . . Approaches, 1) Assist [with] cares . . . 5) Call light in place. 6) Anticipate his needs. . . . Problem . . . Res. has some noted swallowing issues after CVA [cerebrovascular accident]. Goal . . . Res. will be monitored for s/s [signs/symptoms] of aspiration daily. Approaches . . . Con't [Continue] nectar thick [liquids], mech. [mechanical] soft diet. . . . 2) Meals in dining rm [room] when up. . . . 7) Likes to eat BR [breakfast] in room. . . ." Resident #5's Dietary Care Plan, initiated on 10/31/11 and revised on 01/10/12, stated "Problem . . . needs assistance with meals . . . Approach . . . supervise/assist with tray set-up/assist feed/feed. Adaptive equipment: scoop bowl & plate . . . Problem . . . maintain good hydration . . . Approach . . . Water at bedside. Thickened. . . ." Resident #5's medical record identified a swallow evaluation and treatment on admission and discontinued on 10/12/11. The medical record lacked indications of any episodes of difficulty swallowing. Observation of the resident during meals showed no difficulty swallowing.	F 312	on initial results. Monitors will be completed by the DON or designee and reported to Dietary and nursing, as well as the QA committee at least quarterly or as often as needed to verify compliance. Discussion will also occur during provider visits and care plan meetings to provide an ongoing evaluation. 5. February 29, 2012	

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F 312	Continued From page 9 Observation of Resident #5 in his bed for the breakfast meals identified the following: *01/31/12, 7:52 a.m. - Head of the bed elevated at approximately 60 degrees, top half side rails left and right upright, call light attached to left side rail. A certified nursing assistant (CNA) (#6) placed the resident's breakfast tray, including a deep bowl (approximately three inch sides) of hot cereal, glasses of thickened milk, juice, and water, and a scoop bowl of yogurt, on his overbed table in front of him. Two unopened commercially packaged containers of thickened water, present before breakfast, remained on the overbed table. Resident #5 ate breakfast independently. 8:15 a.m. - Resident #5 continued eating breakfast. He positioned the cereal bowl on it's side, leaned against a water glass in an attempt to access the remaining three or four spoonfuls of cereal. He was unable to use his left hand to support the bowl. Each time he attempted to use his right hand to access a spoonful of cereal, the bowl would return to an upright position and he could not reach into the bowl. When asked if he used his call light to request staff assistance, Resident #5 stated "Try to get some more. They'll come back." The resident did not attempt to use the call light when requested to do so and would not have been able to access the call light on his left side with his right hand. The resident continued attempting to finish his cereal and did eat the last three or four spoonfuls by 8:28 a.m. (13 minutes later). Facility staff failed to monitor or offer to assist Resident #5 with his meal after the set up (36 minutes). The resident's call light was not accessible to request assistance. 9:00 a.m. - Resident #5 remained in bed, the head of the bed elevated at approximately 60	F 312		

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	355052	A. BUILDING _____ B. WING _____	02/01/2012

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F 312	Continued From page 10 degrees, top half side rails left and right upright, call light attached to left side rail. Two unopened commercially packaged containers of thickened water, present before breakfast, remained unopened and on the overbed table. *02/01/12, 7:45 a.m. - Head of the bed elevated at approximately 60 degrees, top half side rails left and right upright, call light attached to left side rail. An unidentified staff member placed the resident's breakfast tray, including a deep bowl (approximately three inch sides) of hot cereal, glasses of thickened milk, juice, and water, and a scoop bowl of yogurt, on his overbed table in front of him. Resident #5 ate breakfast independently. 8:05 a.m. - Resident #5 appeared to be sleeping, partially consumed his meal. 8:15 a.m. - Resident #5 awake and continued eating breakfast. He repeated the process identified on 01/31/12 at 8:15 a.m. until he had eaten the last three or four spoonfuls. 8:35 a.m. - Resident #5 consumed all of his cereal. Observation failed to identify any staff monitoring or assistance. During interview, on 02/01/12 at 11:00 a.m., an administrative management staff member (#4) and a nursing management staff member (#2) agreed staff should ensure the call light is accessible to Resident #5's right hand, he should be monitored for assistance at meals while in his room, and the commercially prepared thickened water should be opened for him.	F 312		
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		

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F 323	Continued From page 11 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 adequately assess and implement/modify interventions to prevent 1 of 2 sampled residents (Resident #4) who experienced falls related to self transferring from a wheelchair. Failure to assess, implement, and modify interventions related to this resident's falls resulted in avoidable falls and has the potential for injury. Findings include: Review of the facility policy titled "Fall Protocol" occurred on 02/01/12. This policy, revised 2008, stated, "Procedure: . . . 16. Reassess fall prevention strategies and implement as applicable. 17. Update the care plan as necessary. . . ." Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease, dementia, degenerative joint disease (DJD), and osteoarthritis. Review of Resident #4's quarterly Minimum Data Sets (MDS), dated 06/05/11 and 12/05/11, identified severe cognitive impairment and required extensive assistance with transfers and locomotion. The MDS, dated 06/05/11, identified two or more falls without injury and two or more	F 323	F 323: 1. The wheelchair pedals were removed from Resident # 4's wheelchair when notified of concern and family informed. 2. All residents in wheelchairs have the potential to be affected by this practice. 3. Facility staff were informed of the survey outcome and PoC. The resident's care plan and aide assignment sheets were reviewed and revised. Incident reports will include if wheelchair pedals were included in any incident that occurs in the facility to provide trending. 4. Monitoring has been developed to ensure wheelchair pedals are removed when resident(s) in wheelchairs are not being ambulated, as applicable. Monitors will be completed twice daily X 5, and then as often as necessary to ensure compliance. Monitors will occur on all shifts when resident is up in the wheelchair. Any resident who is identified with impulsive behavior and in a wheel chair will be monitored to ensure the pedals do not pose an accident hazard when not being transported. Monitors will occur for every shift resident(s) are up in their wheelchairs as often as needed until 100 % compliance is achieved. Monitors will be completed by the DON or designee. Positioning and wheel chair pedals will be evaluated by PT/OT to ensure proper resident positioning when pedals are removed. Monitors will be assessed as they occur to determine trending. Results of monitors will be reported at least quarterly or as often as needed to ensure compliance. Reports will be provided to the QA committee and medical staff. Care plans will be reviewed and evaluated during care	10 observations total until 100% compliance per phone call to Cathy, Adm. 3-8-12/1630

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F 323	Continued From page 12 falls with injury in the past three months. The MDS, dated 12/05/11, identified two or more falls without injury in the past three months. Review of Resident #4's current care plan identified the following: "Problem/Need: Res. [resident] has hx [history] of falls - due to unsteadiness and her dementia . . . Approaches: 1) Remind to wait for assist, to ask for assist and to use FWW [front wheeled walker] - forgetful so doesn't do . . . 7) Answer alarms promptly to prevent all falls 8) [added to the care plan 04/12/11] Pedals on w/c [wheelchair] - use prn [as needed] * [Approach not dated] Tried & not appropriate [foot pedals] as when resident tries to get [up] - get tangled in them - and more of danger for falls . . ." Review of Resident #4's nurses's notes identified the following: * 07/25/11 at 12:40 a.m. - "Res was in day room next to the nurses station. Res had been looking for someone to 'take me home.' Res stood up from wheelchair by herself and proceeded to walk across the room. Res tripped over foot petals [sic] on wheelchair. Res fell on to her knees and then hit head on floor . . . Neuro [neurological] assessment initiated." * 08/13/11 at 10:00 a.m. - "Busy AM [morning] [with] standing up in w/c regularly . . ." * 08/15/11 at 7:00 p.m. - "Res sitting in wheelchair at table in Television Rm [room]. Res lifted petals [sic] of wheelchair up and placed feet on floor. Res then leaned forward and slid down onto floor . . ." * 08/16/11 at 9:00 a.m. - "Res. saw standing up	F 323	conferences or when changes occur . Aide assignment sheets will be revised as changes occur. DON or designee will be responsible for inclusion in care plan meetings and revision of aide assignment sheets and accuracy relating to each resident's status. Positioning and safety will be included, as applicable during provider visits, or as often as needed to assure compliance 5. February 29, 2012	

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F 323	Continued From page 13 from w/c et [and] alarm sounded, but staff unable to reach her b/4 [before] she fell onto her bottom [with] her feet caught in w/c pedal, 1/2 on floor 1/2 on pedals . . ." * 09/20/11 at 8:05 p.m. - "found on floor in front of w/chr [wheelchair]; w/chr alarm sounding; foot pedals in place . . ." * 10/01/11 at 9:50 a.m. - "Summoned to dayroom area - res sitting on floor in front of w/c [with] newspaper on floor trying to reach it . . . ? [question] also if tripped on foot pedals once standing up." * 10/01/11 at 3:00 p.m. - "Summoned to day room - res just had been served lunch - w/c pushed away from table & res found sitting on floor . . . again question the foot pedals - removed @ this x [time] . . . Foot pedals removed." Observations on all days of survey showed Resident #4's feet positioned on the foot pedals on her wheelchair. Even though Resident #4 experienced numerous falls related to tripping/tangling over her foot pedals, facility staff continued to utilize them. Facility staff failed to assess and monitor this resident's foot pedal use and individualize interventions specific for her needs.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to properly cool potentially hazardous foods and store food in a safe and sanitary manner in 1 of 1 kitchen. Failure to follow safe food sanitation practices has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared in these areas. Findings include: Review of the facility's policy, "General Food Preparation and Handling," occurred on the morning of 01/31/12. This undated policy stated, ". . . Leftovers must be . . . cooled to 70 [degrees] F [Fahrenheit] within 2 hours and then down to 41 [degrees] F within another 4 hours. . . ." - An initial dietary tour of the kitchen occurred on 01/30/12 at 11:55 a.m. with an administrative dietary staff member (#1). Observation at 12:10 p.m., showed a foil-covered pan containing two beef roasts on a work table. The administrative dietary staff member (#1) stated a dietary staff member had just removed the pan from the oven. The staff member measured the temperature of the roasts at 165 degrees F and placed the pan in a reach-in cooler. At 1:45 p.m., (an estimated one and a half hour after placement of the roasts in the reach-in cooler), this surveyor returned to the kitchen. Observation showed one whole, five pound roast	F 371	F 371: 1. No residents were found to be affected by this concern. 2. All residents have the potential to be affected by this concern. 3. Dietary consultant was informed of survey findings. Dietary staff were informed of survey findings and interventions implemented. Dietary policies were reviewed and updated re: cooking meats. A new policy was created re: cooling. All areas were cleaned and policy/procedure and cleaning schedule reviewed and staff informed of expectations/requirements re: same for the department. 4. QA will be done weekly X 1 month, then 2 times/month for 3 months, and then monthly with reports to the QA committee on a quarterly basis, or as often as needed to ensure compliance with cleaning and cooling. Random monitoring and verification of compliance will be done by Administration and/or designee to verify compliance throughout the next 3 months at least monthly or as often as needed to verify continued compliance. 5. February 29, 2012 done per Dietary Manager or designee done per Administrator Dietary mtg. held 2-15-12 per phone call to Cathy Swenson, Adm. 3-8-12/1630	

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F 371	Continued From page 15 in the walk-in cooler in a covered, plastic container. The administrative dietary staff member (#1) measured the temperature of the roast at 102 degrees F. Observation showed the second whole roast in the walk-in freezer in a covered plastic container. The administrative dietary staff member (#1) measured the temperature of the roast at 107 degrees F. When interviewed at 2:00 p.m. on 01/30/12, the administrative dietary staff member (#1) stated the roasts should be cooled in "four hours to less than 70 degrees and in two more hours from 70 degrees to 40 degrees." This statement contradicted the facility policy which stated, ". . . cooled to 70 degrees F within 2 hours and then down to 41 degrees within another 4 hours . . ." The staff member stated dietary staff do not measure the temperatures of cooling roasts rather "just once they are cooked." The administrative dietary staff member (#1) agreed the roasts would not cool to the required temperature of 70 degrees F within the required two hours without an adjustment in the cooling method. The administrative dietary staff member (#1) made adjustments to the cooling process so the roasts cooled to the proper temperature in the required amount of time. When interviewed on the afternoon of 01/30/12, an administrative dietary staff member (#1) confirmed dietary staff should conduct monitoring during the cooling of foods to ensure time and temperature parameters are met for food safety. - Review of the facility's policy, "Cleaning of Refrigerator," occurred on the morning of	F 371		

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F 371	Continued From page 16 01/31/12. This undated policy stated, ". . . Remove the shelves . . . Run through dishwasher and air dry. . . ." During the initial tour of the kitchen, observation of a reach-in cooler, used to store beverages, showed a black residue on the surface a thermometer and the underside of two wire shelves. When interviewed on 01/30/12 at 2:00 p.m., a dietary staff member (#1) agreed the black residue appeared to be "mold." Review of the January 2012 cleaning schedule for the "A.M." staff member, completed the afternoon of 01/30/12, showed the reach-in refrigerator assigned to be cleaned weekly. A staff member had completed this cleaning two of four weeks. The administrative dietary staff member (#1) stated the staff member may not be removing the shelves and running them through the dishwasher. The administrative staff member (#1) confirmed this procedure should be completed by the a.m. staff member per policy and cleaning schedule.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 17 (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, review of professional reference, and staff interview, the facility failed to encourage/assist 1 of 1 sampled resident (Resident #1) with hand hygiene after the resident performed perineal cares following a bowel movement. The facility failed to sanitized the glucometer (a device used to test blood sugar) during 1 of 2 observations of blood sugar tests. Failure to follow infection control procedures related to hand hygiene	F 441	F 441: 1. The accuchek was cleaned after being informed of the identified concern. Handwashing was offered to the resident when staff were notified of concern, which was refused by the resident. 2. All residents using reusable equipment have the potential to be affected by this practice. All residents who are toileted have the potential to be affected by this practice. 3. Facility staff followed the facility policy and glucometer machine's manual from the manufacturer for cleaning the machine after use. A change in the policy per the direction of the surveyor was done, and an EPA disinfectant will now be utilized for same. The facility policy was revised, and facility staff were informed of the change and interventions implemented. The aide involved in the resident toileting was informed of the concern and actions that should have been taken. A review of the facilities IC policies re: cleaning and handwashing was done with all nursing staff. 4. A QA monitor for disinfecting the accuchek machine will be done on all nursing staff as part of their skills evaluation. The nurse involved will be monitored on random medication passes X 3 in one week, and X 2 in the following week. Monitoring will be done randomly on all other nursing staff to ensure continued compliance. Skills and monitoring will be included in their employee evaluations. Ic monitors will continue as per calendar schedule and reported to the QA committee and medical staff on at least a quarterly visit or as often as needed to ensure compliance.	sep error each nurse was initially informed of deficiency and change in procedure individually and monitored x 3 to verify compliance, then done x2 in the next week until 100% compliance. per phone call to Cathy, Adm 3-8-12 1630

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F 441	Continued From page 18 following toileting and disinfecting the glucometer between residents has the potential for the spread of infection to other residents. Findings include: Kozier and Erb's "Fundamentals of Nursing," 9th edition, Pearson Education, Inc., Upper Saddle River, New Jersey, 2012, page 685, stated, "Hand Hygiene is important in every setting . . . Any client may harbor microorganisms that are currently harmless to the client yet potentially harmful to another person . . . It is important that . . . the clients' hands be cleansed . . . after using the bedpan or toilet, and after the hands have come in contact with any body substances . . ." Review of the facility policy titled "CARING FOR THE ACCU-CHEK ADVANTAGE MONITOR [glucometer]" occurred on 02/01/12. This undated policy stated, ". . . Clean the monitor as needed using one of the following: a. 70% alcohol b. a solution of mild dishwashing liquid and water c. 10% household bleach solution (1 part bleach in 9 parts water) mad [sic] fresh daily . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding disinfecting of glucometers which states glucose monitoring devices may transmit pathogens if devices contaminated with blood or body fluids are shared without cleaning and disinfecting between uses for different residents. Glucometers are considered semi-critical items. For such items, it is recommended to use either an Environmental Protection Agency (EPA) registered detergent/germicide with a	F 441	The DON or designee is responsible for monitoring and reporting, along with any identification of trends – including but not limited to diabetic patients with glucose monitoring, and UTI infections in independent residents, 5. February 29, 2012	

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F 441	Continued From page 19 tuberculocidal or HBV (hepatitis B virus)/HIV (human immunodeficiency virus) label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water). - Observation on 01/31/12 at 12:35 p.m. showed the certified nursing assistant (CNA) (#6) assisted Resident #1 into the bathroom. After using the toilet, the resident obtained a small amount of toilet paper and wiped her perineal area. Observation showed stool on the toilet paper and the CNA (#6) entered the bathroom and assisted Resident #1 with perineal cares. After completion, the CNA assisted the resident to the recliner in her room. The CNA failed to encourage/assist the resident with hand hygiene. - Observation on 01/30/12 at 5:00 p.m. showed a licensed nurse (#7) obtained the glucometer from a drawer in the medication cart and entered a resident's room. The nurse placed the glucometer on a resident's bedside stand, checked her blood sugar, exited the room, and returned the glucometer to the drawer. The nurse (#7) failed to sanitize the glucometer after she checked the resident's blood sugar and returned it to the drawer. During an interview on 02/01/12 at 11:35 a.m., an administrative nurse (#2) stated she expected facility staff to encourage residents to wash/sanitize their hands after using the bathroom and to sanitize the glucometer after checking a blood sugar.	F 441		