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 _____	12/19/2018

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 The standard Medicare/Medicaid recertification survey started on 12/16/18 and concluded 12/19/18.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional	F 561	1) Corrective actions for concerns	1/16/19

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

Electronically Signed | 01/14/2019

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F 561	Continued From page 1 reference, resident and family interview, and staff interview, the facility failed to honor resident choices for 1 of 3 sampled residents (Resident #29) who require total assistance with wheelchair mobility. Failure to honor Resident #29's choices related to evening preferences and educate staff does not respect their autonomy or right to determine what is important in their lives. Findings include: The Residents' Rights ND handbook, dated 11/22/16, stated, ". . . you can choose to set your own schedule . . . make your own choices . . . your daily schedule (for example sleeping times) . . ." Review of Resident's #29 medical record occurred on all days of survey. The care plan identified "reduced mobility requiring standing lift for transfers . . . to keep call light in reach . . . allow choices and pursue own routine . . . and prefers to go to bed approximately 7-7:30 p.m. . . ." Review of Resident #29's progress notes/care plan review note, identified the following: * 11/27/18: ". . . care plan meeting held . . . resident and family voiced a couple of complaints/concerns in regard to nursing services . . . wait for an extended period of time . . . re-assured that [they]could look into wait times and try to resolve her concerns . . ." * 11/28/18: ". . . resident moves about the facility in a wheelchair propelled by others . . . resident and her family attended care conference and did express a couple of concerns for the nursing department; DON and staff will look into these	F 561	regarding Resident #29 include reiteration to p.m. nursing staff to take her to her room after supper (informed oncoming p.m. CNA□s by word-of-mouth 12/19, 20 and 21, and a Point Click Care communication memo was posted on 12/19/18); resident feedback regarding when she is getting back to her room and her degree of satisfaction; and department management staff staying on random p.m.□s to oversee dispersion of residents from dining area. 2) All residents could be affected by the same deficient practice. Department management staff, as they continue to observe, will identify any resident who might be affected and will discuss it at the weekday morning IDT meetings. 3) To ensure the deficient practice does not recur, a new policy is in place called Promoting/Maintaining Resident Self-Determination, which includes: " All staff members will promote and facilitate resident self-determination by honoring the residents□ choices regarding their schedules, in accordance with physician orders and residents□ abilities. " Care Plans will include residents□ choices; this will be discussed in care plan meetings and documented. This policy will be introduced and discussed at the nurses□ meeting 1/16/19. 4) With respect to this deficient practice, resident #29 will be monitored with a QA	

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F 561	Continued From page 2 concerns and provide a resolution in a timely manner. During an interview on 12/16/18 at 4:22 p.m., Resident #29 and a family member (A) identified a concern related to her request to return to her room after the evening meal. They stated that after the evening meal, the resident asks for assist with toileting cares and to stay in her room until she calls staff for a preferred bedtime around 8:00 p.m. They stated the resident is taken to the commons area where no call light is available, instructing the resident she has to wait until approximately 9 p.m. for her snack and medications before going to bed. During an interview on 12/18/18 at 9:09 a.m., Resident #29 stated on 12/17/18, she requested to go to her room after the evening meal and recieve her snack and medications around 8:00 p.m. Facility staff told her she needed to stay in the commons area until she received her snack and evening medications. Resident #29 stated staff finally brought her to her room about 9:00 p.m.	F 561	report, to assure that her wishes have been granted, weekly for four weeks; monthly for six months, and at care conference meetings thereafter. This will be accomplished by direct resident interview, and direct interviews or phone calls to daughter. Monitoring of all residents that have the potential to be affected by this deficient practice will be conducted with care conferences, and by grievances filed. An in-service for all staff will be conducted on 1/16/19 regarding Residents Rights and Self Determination, with an attendance roster. 5) Corrective action will be completed on 1/16/19, with the in-service educating staff. QA has started and will be ongoing as outlined in (4) above. Staff is educated on a yearly basis regarding Residents Rights.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) 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; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must--	F 577		1/17/19

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F 577	Continued From page 3 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the results of the most recent Federal and/or State surveys and have available or post notice of the availability of survey results from the preceding three years for residents, family members, and/or legal representatives for 2 of 4 days (December 16-17, 2018) of survey. Failure to post the most recent Health and Life Safety Code surveys and make available survey results of the prior three years is an infringement of the residents' rights. Findings include: Observations on December 16-17, 2018 showed Federal/State survey results posted in a binder by the facility entrance in an easily accessible area. The binder included the Health surveys dated 11/9/16 and 12/30/15. The binder failed to contain the most recent Health survey completed	F 577	1) Corrective measures have been completed. A three ring binder, called the Blue Book, containing the last 3 years of survey results is located in a wall pocket in the alcove near the front entrance of the facility. This ensures that the survey results are readily accessible to residents/the public. The wall pocket clearly states that the survey results can be found in this binder. 2) It has been identified that all residents have the potential to be affected by this deficient practice. 3) To correct this deficient practice, the following new policy has been put into place: 1. The Blue Book has been placed in a wall pocket in the alcove near the front entrance with a sign clearly stating that the survey results can be found in this	

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F 577	Continued From page 4 on 01/18/18 and the Life Safety Code survey completed on 11/06/18. The binder also failed to contain the Life Safety Code surveys from 2016 and 2017 or post a notice of their availability. During an interview on 12/17/18 at 3:55 p.m., two administrative nurses (#1 and #4) stated they were not aware the survey binder was missing the required Health and Life Safety Code survey results. During an interview on 12/17/18 at 4:01 p.m., a social services staff member (#5) stated the social services department placed the survey results in the binder and the recent Health survey should be there. The staff member stated someone probably removed the survey report and didn't return it to the binder. The staff member (#5) agreed the facility also needed to place Life Safety Code surveys in the binder.	F 577	binder 2. Social Service staff will present the Blue Book at monthly Resident Council meetings 3. The Blue Book and its contents will be reviewed with the Resident Council 4. A notification has been placed in each admission packet stating where the survey results are located. 5. Mandatory Staff in-service will be held to discuss deficiency F-577 4) Social Service staff will visually monitor that the Blue Book is accessible to residents /the public by ensuring that it is in the wall pocket in the alcove near the front entrance on a weekly basis for 1 month. Thereafter, a log will be kept and the Blue Book will be checked monthly at the Resident Council meetings. The contents of the Blue Book will be reviewed at the Resident Council meetings and a notation will be made in the Resident Council meeting minutes. 5) The deficient practice has already been corrected. The Blue Book contains 3 years of surveys. Monitoring of the Blue Book and its contents will begin on 1-14-19 times 4 then monthly thereafter. Presenting of the Blue Book to the Resident Council will begin on 1-17-19 and then monthly thereafter. Mandatory staff in-service will be held on 1-16-2019	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/16/19

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F 657	Continued From page 5 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan for 3 of 12 sampled residents (Resident #6, #11 and #35). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident.	F 657	1) The Care Plans have been reviewed and modified for Residents #6, 11 and 35 to reflect their current health status, problems and interventions. Verification of documentation in their medical records has been done to ensure the correct development and current reflection of their health status within their person-centered care plans.	

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F 657	Continued From page 6 Findings include: Review of facility policy titled "General and Administrative Comprehensive Care Plan" occurred on 12/19/18. This policy, revised July 2018, stated, ". . . Person-centered care means to look to the resident as the focus of control and support the resident in making his/her own choices and having control over his/her daily life. . . . The comprehensive care plan will describe. . . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. . . ." - Review of Resident #6's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 12/13/18, identified resident had one fall since admission, severely impaired cognition, and receives an antidepressant medication. Fall Risk Evaluation completed 12/10/18 by the facility identified resident had 1-2 falls in past 3 months, is disorientated, ambulatory, incontinent, and has a balance problem with walking. Resident #6's current care plan failed to address residents potential risk for falls. Resident #6's medical record included the following physician order:, "Ensure wander guard is on every day and evening shift. . . " Current diagnosis included Alzheimer's disease. The current care plan stated, "Resident #6 will wander. . . not knowing where she is. . . intervene as necessary. . ." Resident #6's progress notes included the	F 657	2) All residents in the facility have the potential to be affected by inaccurate and outdated information within the Care Plan. Department managers are reviewing care plans and updating them to identify any further concerns; this will be completed by 1/16/19. 3) The DON or designee, along with the Resident Care Coordinator, will review and update all resident Care Plans and documentation, with support from other Department Managers (MDS Coordinator, Activities, Social Services and Dietary). This information will be gathered from recent documentation, orders, and health status of all residents. This information will help develop a comprehensive Care Plan that will promote attainment or maintenance of residents□ highest practicable physical, mental and psychosocial wellbeing. Professional nursing staff and Department Managers will be educated on updating and revising Care Plans at the staff meeting scheduled for 1/16/19. A committee consisting of DON□s, MDS Coordinator, Activities, Dietary and SSD personnel will meet, discuss, review and update Care Plans on an ongoing basis. This will ensure prompt changes/updating of all resident Care Plans. Each supervisor will be in charge of updating his or her area of concern. The MDS Coordinator will be able to update all areas of concern in the event that a manager is not available, or in his/her absence. Nursing and staff	

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F 657	Continued From page 7 following: * 11/17/2018 at 4:40 a.m.: ". . . She (Resident #6) has made several attempts to leave the facility however when alarm sounds she turns around. . . ." * 11/25/2018 at 2:03 a.m. "my car must be broke so I am looking for a ride. . ." Observation of Resident #6 on 12/16/18 at 3:26 p.m., showed a wander guard bracelet to residents right wrist. Resident #6's care plan failed to include wander guard. Resident #6's medical record identified the following progress notes: * 10/12/2018 at 6:20 p.m., "Social Service Note: Residents daughter [Resident #6's daughters name], visited this afternoon and found a letter in residents room that she [resident] had written to [residents daughters name] her daughter stating that 'I am going to kill myself ' along with the statement that she is worthless and 'no good to nobody'. . . . Department managers have been notified and will put resident on 15 minute checks throughout the weekend. Resident will see physician on Monday rounds. . . . Staff will observe resident for any suicidal statements or actions throughout the weekend. Suicidal Policy will be followed if any further incidents." * 11/1/2018 at 4:48 p.m., "Behavior Note: Resident is wandering the halls. . . When approached she states that she's 'just going to shoot her self ' and 'she has the gun to do it'. . . ." Resident #6's care plan failed to include suicide ideation.	F 657	education will include a review of the facility□s Comprehensive Care Plan policy, to help ensure realistic, achievable goals and interventions for all residents and their areas of concern. 4) The interdisciplinary team (IDT) will meet five of seven days to review documentation and reports. From this point, the IDT will discuss residents regarding their dietary needs, behavioral health and activities status and any concerns that need to be addressed. This meeting will help ensure that concerns are identified, and help ensure current and accurate representation of needs in resident care plans. Monitoring of random resident care plans, along with any residents that are identified during our IDT meetings, will be completed daily five of seven days for two weeks, three of seven days for two weeks, followed by one of seven days for one month. Random monitoring will then be completed as directed by the DON/designee, to ensure compliance remains as part of the QA Process, over the remainder of the year. The Care Plan IDT will meet to review, evaluate and make changes to the resident care plan as applicable. A monthly monitor report will be made and reported as part of the QA process. 5) Corrective action was completed on 1/14/19, for Residents #6, 11 and 35. Furthermore, all care plans will be reviewed and updated. This will be	

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F 657	Continued From page 8 During an interview on 12/18/18 at 4:30 p.m., an administrative nurse (#1) stated he would expect staff to add suicidal ideation to Resident #6's care plan. - Review of Resident #11's medical record occurred on all days of the survey. The current care plan stated, "Focus: Resident #11 has Diabetes Mellitus. . . CHO [Carbohydrate consistent diet]. . . . Dietary consult for nutritional regimen. . . Fasting serum blood sugars. . . " During an interview on 12/17/18 at 8:04 a.m., Resident #11 stated he does not eat any of the meat at the facility due to the smell of it and he dislikes several foods that the facility continues to serve him. Resident #11's care plan failed to individualize residents dietary preferences, likes/dislikes and to put interventions in place. During an interview on 12/18/18 at 4:40 p.m., an administrative nurse (#1) stated he would expect staff to individualize residents care plan with the residents dietary likes/dislikes and interventions. - Review of Resident #35's medical record occurred on December 17-19, 2018. A physician's order for trazodone (an antidepressant), dated 11/21/18, stated, "Give 50 mg [milligrams] by mouth as needed for difficulty sleeping take at bedtime. May repeat x [times] 1 before 3 a.m." Staff failed to develop a care plan for Resident #35's problem related to insomnia and	F 657	completed by 1/16/19 by all department managers.	

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F 657	Continued From page 9 interventions to enhance sleep, including the use of trazodone and alternatives to medication.	F 657		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure the residents' environment remained free of accident hazards in 6 of 6 resident rooms (Resident #6, #16, #20, #26, #29, and #31) checked for water temperature. Failure to maintain an acceptable range for hot water temperature has the potential to cause burns to residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) has identified time and temperature relationships to serious burns, with water at 124 degrees Fahrenheit (F) potentially causing a 3rd degree burn within three minutes of exposure and water at 127 degrees F within one minute of exposure. Review of the facility policy titled "Safe Water Temperatures" occurred on 12/18/18. This policy, dated 12/17/18, stated, "It is the policy of this facility to maintain appropriate water	F 689	1) No resident were found to have been affected by the deficient practice. Corrective measures have been completed immediately. 2) It has been identified that all residents have the potential to be affected by this deficient practice. 3) To correct this deficient practice, the maintenance department has added Water Temperature Check form and checklist to monitor and record the temperature on a weekly basis. 4) The Maintenance Department will monitor and record the water temperature at several locations in the building and ask staff for concerns on a weekly basis. Results and any discrepancies of the water temperature monitoring will be reported to the QA committee. The locations are at the tub room, a resident	12/24/18

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F 689	Continued From page 10 temperatures in resident care areas. . . . 5. Water temperatures will be set to a temperature of no more than 110 [degrees] F . . ." On 12/16/18 at 1:30 p.m., during a random check of water flowing from Resident #26's bathroom sink faucet, the water felt very hot to the surveyor's hands. Observation on 12/16/18 at 3:22 p.m., showed a certified nurse assistant (CNA) (#3) assisted Resident #6 to use the restroom. After the resident finished using the restroom, the CNA (#3) turned the hot water on for the resident to wash her hands. The CNA stated, "Be careful now that water gets hot, might have to turn cold on too." Resident #6 put her hands under the water and stated, "Oh that is hot." The CNA then turned on the cold water. On the afternoon of 12/16/18, surveyors checked the water temperature in the following residents' sinks: * Resident #6 = 124.7 degrees F * Resident #16 = 126.5 degrees F * Resident #20 = 124.8 degrees F * Resident #26 = 124.5 degrees F * Resident #29 = 125.5 degrees F * Resident #31 = 124.3 degrees F After informing an administrative nurse (#1) of the high water temperatures on 12/16/18 at 5:50 p.m., this nurse asked maintenance staff to check and adjust the water temperature. Random measurement of the above water sources on December 17-19 showed the temperature to be less than 111 degrees F.	F 689	room down the east hallway and a resident room down the west hallway. The maintenance staff also monitors and records the water heater temperature setting weekly. 5) The deficient practice has been corrected on 12/17/2018, and monitored weekly.	

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NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

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F 689	Continued From page 11 During an interview on 12/18/18 at 8:15 a.m., a maintenance staff member (#2) stated he checked resident bathroom sink water temperatures at least every month, had no concerns, and had not kept logs of the temperatures.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		1/16/19

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F 758	Continued From page 12 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 1 sampled resident (Resident #35) reviewed who received an as-needed (PRN) psychotropic medication. Failure to ensure the physician limited the use of PRN trazodone (an antidepressant with indication for treating insomnia) to 14 days or extended the order including rationale and duration and failure to attempt alternative interventions to promote sleep prior to administering the PRN trazodone may result in the resident receiving an unnecessary medication and experiencing adverse effects related to its use. Findings include:	F 758	1) Corrective action for concerns regarding Resident #35 included discussion with the physician regarding the resident□s medication regimen, on 12/19/18. The antidepressant medication prescribed prn for sleep (Trazadone) was discontinued immediately. 2) All residents have the potential of being affected by this practice. The interdisciplinary team (IDT) has met and reviewed all prn medication orders, with indications for use. This was completed on 1/10/19, with no other residents found to be affected. 3) To ensure the deficient practice will not recur, all licensed nursing staff will be educated on the facility□s practices	

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F 758	Continued From page 13 Review of Resident #35's medical record occurred on December 17-19, 2018. A physician's order for trazodone, dated 11/21/18, stated, "Give 50 mg [milligrams] by mouth as needed for difficulty sleeping take at bedtime. May repeat x [times] 1 before 3 a.m." The record lacked an order to extend the trazodone after 14 days. The record showed staff administered trazodone to Resident #35 six times after December 5th without an order to continue the psychotropic medication. The staff assessed the trazodone to be effective only on three occasions. The record lacked evidence the staff tried alternative methods to aid sleep prior to giving trazodone on five occasions. The facility failed to develop a care plan to address Resident #35's insomnia. During an interview on 12/18/18 at 3:56 p.m., an administrative nurse (#1) stated the staff did not complete sleep assessments on the residents and agreed psychotropic medications are not to be used indefinitely on an as-needed basis.	F 758	regarding the use of psychotropic drugs. This will occur at a staff meeting on 1/16/19. A new policy has been written to address and provide guidance on this deficiency: Psychotropic Drug Use. A copy of the regulations regarding unnecessary drugs/unnecessary psychotropic medications, and the new policy, was provided to the physician as a resource. This should reduce the likelihood of a prn order being missed in the future, and particularly on future admissions. 4) The Director of Nursing Services, or designee, will complete random weekly audits for six consecutive weeks, to review any new prn medication orders and ensure that appropriate indications for use are documented clearly in the medical record, and reviewed as indicated per policy, for psychotropic medications specifically. Subsequently, bi-weekly audits will be done for another six weeks, then monthly audits for three more months, for a total of six months of monitoring. Audit records will be reviewed at monthly Quality Assurance/Performance Improvement (QAPI) meetings. Pending findings of adequate/consistent compliance on evaluation, audits may continue, at the recommendation of the QAPI committee, until the end of 2019. 5) Corrective action will be completed on 1/16/19, when the guidelines and new	

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F 758	Continued From page 14	F 758	policy will be shared with licensed nursing staff.	
F 812 SS=C	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) Food Code 2017, and staff interview, the facility failed to store, clean, and sanitize equipment and utensils under sanitary conditions in 1 of 1 kitchen. Failure to ensure dishware is free from dust/debris has the potential to result in foodborne illness to residents, staff and visitors. Findings include:	F 812	1) No resident were found to have been affected by the deficient practice. Corrective measures have been completed immediately. 2) It has been identified that all residents have the potential to be affected by this deficient practice. 3)The current fan has been removed. A fan that does not osculate has been ordered and will be mounted permanently facing the dirty side of the dish room.	1/18/19

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F 812	Continued From page 15 Review of the 2017 Food and Drug Administration (FDA) Food Code, Protection of Clean Items, F-901.11, page 151, stated, ". . . After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining . . ." Review of the 2017 FDA Food Code, Annex 3 - Public Health Reasons/Administrative Guidelines, 4-903.12, page 572, stated, "The improper storage of clean and sanitized equipment, utensils . . . may allow contamination before their intended use. Contamination can be caused by . . . dust, and other materials. . . ." A tour of the kitchen occurred on 12/16/18 at 12:08 p.m. Observation showed a fan with dust adhered to it blowing directly onto two separate racks of dishware at the clean end of the dishwasher. During an interview, the dietary aides (#7 and #8) stated the facility uses the fan to assist in drying the dishware. When asked how often the fans get cleaned, the dietary aide (#7) stated fans are cleaned as needed and was not aware of when the fan was last cleaned. Observation of the kitchen on 12/18/18 at 2:19 p.m., showed one dusty/greasy fan blowing directly onto two racks of clean dishware at the clean end of the dishwashing area. During an interview, a dietary supervisor (#6) stated the fan is used to assist in drying the clean dishes and cooling the kitchen area. The dietary supervisor (#6) stated staff is expected to clean fans on a regular basis. Failure to ensure clean and sanitized equipment	F 812	This fan will be in a fixed position. 4)Dishroom will be checked for proper facing direction of the fixed fan and for portable fans brought into the room. The monitors will be 5 times weekly for 2 weeks, weekly for 2 months, every other week for 2 months , and monthly for 4 months. Please see attached monitoring worksheet. 5)Date fan will arrive and be installed 1/18/2019. Education in service for Dietary staff to educate on the reason for this F812 will take place on 1/16/2019.	

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F 812	Continued From page 16 and utensils is free from dust/debris may increase the risk of contamination and may affect all residents.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		1/21/19

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F 880	Continued From page 17 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility's policy, and staff interviews, the facility failed to follow infection control practices for 1 of	F 880	1) All licensed nursing staff that are employed/contracted by Nelson County Health System have been re-educated on	

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F 880	Continued From page 18 1 sampled residents (Resident #23) on contact precautions. Failure to follow standard infection control practices of shared medical equipment has the potential for transmission of communicable diseases and infections to resident and staff. Findings include: Review of the facility policy titled, "Contact Precautions" occurred on 12/19/18. This policy, dated June 2016, stated, ". . . resident on contact precautions will have a dragonfly magnet applied to room door frame to identify this precaution . . . wash hands . . . wear gown if likely clothing may be soiled . . . wear gloves when entering room. Change after contact with infectious material . . . remove gown and gloves before leaving the room and immediately wash hands with antibacterial soap . . . after removing gloves and gown, and after handwashing, avoid contact with the patient's/resident's environment . . . limit use of noncritical care equipment to single patient/resident . . . wash hands on leaving room . . . infections requiring contact isolation . . . include Shingles . . . zoster . . ." Review of the facility policy titled, "Patient/Resident Care Equipment" occurred on 12/19/18. This policy, dated October 2016 stated, ". . . equipment will be disinfected at the site of use with approved hospital grade disinfectant . . . ensure that reusable equipment is not used for the care of another patient/resident until it has been cleaned . . . electronic thermometers, blood pressure cuffs, blood pressure machines are cleaned after each use using sanicloths . . . "	F 880	facility□s Infection Control Policies which include Hand Hygiene, Contact Precautions, and Routine Cleaning of Patient/Resident Care Equipment. 2) The facility has determined that all residents have the potential to be affected. 3) The facility□s Infection Preventionist has reviewed facility□s policy for contact precautions, cleaning of resident care equipment, and routine cleaning schedule. The facility Routine Cleaning policy was reviewed and revised to include standing lifts. All personnel will be in-serviced on the facility□s Infection Control Practices. The in-service will include reviewing of facility□s policies for hand hygiene, contact precautions, and cleaning of equipment. In-service training will include direct observation of nursing personnel performing hand hygiene procedures, in-person demonstration of donning and removing of PPE, and cleaning of shared resident care equipment. Resident shared equipment included but not limited to: vitals machine, standing/hoyer lifts, thermometers, and stethoscopes will be reviewed. Cleaning and uses of hospital grade cleaning solutions will also be discussed at this in-service. 4) The Director of Nursing Services (DNS), or designee, will complete random validation checklists of nursing personnel and the timing and technique of hand hygiene procedure and cleaning &	

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F 880	Continued From page 19 Review of Resident #23's medical record occurred on all days of survey. The physician's order included contact precautions for shingles (herpes zoster) . . . and acyclovir tablet (an antiviral) 800 mg [milligrams], give one tablet by mouth five times a day. Observation on 12/16/18 at 3:40 p.m., showed a staff nurse (#4) entered Resident #23's room with the facility shared vitals cart and completed a vital signs assessment of the resident (blood pressure, temperature, oxygen saturation). The nurse touched the resident's body, skin, clothing, bed, and table. The nurse #4 failed to perform hand hygiene before/after resident cares, failed to don gloves/gown, and failed to disinfect the vitals equipment after use. During an interview the morning of 12/19/18, a staff nurse (#4) acknowledged he/she did not follow the facility policy and procedures on contact precautions and infection control.	F 880	disinfection of equipment. This is to ensure nursing personnel are performing the procedure in accordance with our facility□s policy and random monitoring will occur each week for the next 6 months. The scheduled will be as follows: 4 times per week X 1 month, 3 times per week X 1 month , 2 times per week X 1 month, 1 time per week X 1 month and 5 times randomly X 2 months. As needed QA on this citation can be done at any time to ensure compliance is getting met after the 1st 6 months. This QA will also help and be part of nursing personnel yearly evaluations. 5) Corrective action will begin on 1/16/19 with a mandatory staff in-service. This meeting will cover this Citation F880 and all other citations. Plans of Correction as well as policy review, demonstrations and skills checklist will be initiated at this time. QA monitors will be started and initiated on 1/21/2019. Findings of this audit/QA monitor will be discussed with the Resident Council at this March Meeting. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	