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 _____	01/18/2018

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 01/16/18 and concluded 01/18/18.	F 000		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to notify the appropriate State Mental Health authority for 1 of 1 sampled resident (Resident #30) reviewed with Pre-Admission Screening and Resident Review (PASARR) services. Failure to notify the appropriate authorities when a resident with a mental disorder (MD) or intellectual disability (ID) has a significant change in status in their physical or mental condition created the potential for needed mental health services to be unidentified and/or not provided. Findings included: Review of the facility policy titled "PASSRR" occurred on 01/18/18. This undated policy, stated, " . . . Level 1 screening results remain valid for the individuals stay in a NF [nursing facility] unless a change in status occurs. . . ."	F 646	1) Corrective measures have been completed for resident #30. A level 1 was submitted for review for significant change due to her diagnosis of unspecified psychosis. 2) All residents□ diagnoses have been compared to their level 1. If there was a significant change or an improvement, a new level 1 was submitted to DDM. This process has been completed for all residents. 3) New policy has been implemented with new measures of notifications for any significant changes for either a major decline or improvement in a resident□s status. Measures of notification are: 1. Discussion will take place 5 days a week at the IDT meeting. Discussion will include any changes that have occurred with the residents. Social Service staff will	2/8/18

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

Electronically Signed | 02/15/2018

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 646	Continued From page 1 The Long-Term Care Facility RAI 3.0 User's Manual, October 2015, page 2-28 stated, ". . . Guidelines for Determining When A Significant Change Result in Referral for a Preadmission Screening and Resident Review (PASARR) Level II Evaluation: If a SCSA [Significant Change in Status Assessment] occurs for an individual known or suspected to have a mental illness, intellectual disability . . . or related condition . . . a referral to the State Mental Health or Intellectual Disability/Development Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASARR evaluation must promptly occur. . . ." Record review for Resident #30 occurred on all days of survey. Diagnoses included psychosis and history of traumatic brain injury. The resident had a PASARR level one screening on 05/24/16. A SCSA Minimum Data Set (MDS) occurred on 11/25/17. The facility failed to contact the SMH/ID/DDA for a possible level II PASARR evaluation.	F 646	determine if the changes are a decline or an improvement in a residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions and the decline is not considered self-limiting meaning the condition will normally resolve its self without any further intervention or by staff implementing standard clinical interventions to resolve the condition. If the change is significant a new level 1 will be submitted. 2. Doctor□s rounds will be monitored and a summary of rounds will be given to the Social Service staff. This will insure if any significant changes occurred, the changes will be reviewed to determine if a new level 1 needs to be submitted. 4) QA will be completed weekly times 4 weeks, then monthly times 3 months, then as needed. QA will be monitored by Social Service Director and staff. The QA will be discussed monthly in QAPI and quarterly in facility QA meetings. QA monitoring has been begun as of 2-1-2018. QA will monitor all significant changes in the mental or physical condition of a resident to determine if a new level 1 needs to be submitted. 5) All charts have been reviewed and corrected as of the Date of 2-08-2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		2/13/18

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F 657	Continued From page 2 §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, policy/procedure review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 12 sampled residents (Resident #6, #17, and #30). Failure to revise the care plan limited 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 resident□s #6, #17, & #30 to reflect their current health status and verification of documentation in their medical records to validate the correct development and current reflection of resident□s health status within Care Plans. 2) All residents in the facility have the potential to be affected by inaccurate and	

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F 657	Continued From page 3 Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 01/18/18. This policy, dated September 2017, stated, ". . . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: . . . The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. . . . The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [minimum data set] assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. . . . The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. . . ." - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included reflux, spinal stenosis, and reduced mobility. Resident #6's physician's orders included ". . . Consistent Carbohydrate	F 657	outdated information within the Care Plan. 3) The Co-DON along with the Resident Care Coordinator will review and update all Resident Care Plans and Documentation, along with the support from other departments Managers (MDS Coordinator, Activities, Social Work, and Dietary). This information will be gathered from the most recent documentation, orders, and health status of all residents. This information will help create a Comprehensive Care plan that will help residents attain or maintain the highest practicable physical, mental and psychosocial well-being. Professional Nursing Staff and Department Managers will be educated on updating and the revision of care plans at the scheduled Feb 2018 meeting. The Co-DON has developed a committee consisting of DON□s, MDS Coordinator, Activities, Dietary and SSD personal to meet, discuss, review and update Care Plans on an on-going basis. This committee will be noted as the IDT Committee. This will ensure prompt changes/updating of all resident care plans. Each Supervisor/Manger will be in charge of updating their areas of concern. The MDS Coordinator will be able to update all areas of concerns in the event that a manager is not available or in their absence. If significant changes are noticed/flagged in a resident current condition, the IDT team will meet to discuss resident status and determine appropriate interventions and goals to reflect an updated resident care plan. If	

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F 657	Continued From page 4 diet [CHO] . . . 12/5/17 Mechanical soft meats. . . . Hoyer lift for all transfers. . . ." Resident #6's care plan stated, ". . . Resident has his own teeth poor dentition noted . . . CHO Diet. . . . Serve diet as ordered. . . . The resident . . . transfers using standing lift. . . ." Staff failed to address Resident #6's need for mechanically altered meats and use of a Hoyer lift. During an interview on the afternoon of 01/18/18, an administrative nurse (#1) confirmed Resident #6's care plan should reflect the interventions staff are currently utilizing. - Review of Resident #17's medical record occurred on all days of survey. Medical diagnoses included major depressive disorder. Resident #17's physician's orders included "Mirtazapine (anti-depressant medication) 7.5 milligrams (mg). Give 1 tablet by mouth at bedtime related to Major Depressive Disorder." Resident #17's care plan does failed to address the resident's depression or the use of an anti-depressant medication. During an interview on the afternoon of 01/18/18, a social service staff member (#5) confirmed staff had not included Resident #17's depression and use of an anti-depressant medication. - Review of Resident #30's medical record occurred on all days of survey. Medical diagnoses included history of traumatic brain injury and psychosis. The current care plan stated, "[Resident name] has an ADL [activity of daily living] self care performance deficit . . . TOILET USE: The resident requires extensive	F 657	they are significant changes identified, notification will occur to the provider as needed to address concerns in relation to residents overall health status. Nursing and Staff education will include a policy review of the facilities Comprehensive Care Plan policy, to help ensure that realistic, achievable goals, and interventions of all residents and for their areas of concern. 4) The Interdisciplinary Team will meet daily 5 of 7 days to review documentation and reports. From this point the IDT will discuss all residents in regards to their dietary needs, health, and activities status. This meeting will help ensure that all areas of concern in relation to resident centered care plans is discussed and help validate accurate representation of resident care plans. The Medical Provider will be notified in the event of a Significant Change in a resident to assess and evaluate any changes. The DON/designee will complete a QA monitor on resident care plans in relation to up-to-date care plan information that currently reflects a resident overall health status, as well as monitor interventions implemented by facility staff per facility policy to ensure compliance. 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 X 2 weeks, and if 100% compliance is achieved, three of seven days X 2 weeks followed by one of seven days X 1 month with 100% compliance. If 100% compliance is	

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F 657	Continued From page 5 assistance by 1X staff for toileting. Resident able to ambulate to bathroom with assistance . . ." The CNA care guide stated, "Assist of 1 w/gait [with gait] belt . . ." Observation on 01/16/18 at 2:29 p.m. showed a CNA (#4) assisted Resident #30 off of the toilet using a sit to stand lift. Observation on 01/16/18 at 4:43 p.m. showed an unidentified CNA transported Resident #30 in a wheelchair to the dining room. During an interview the CNA stated she used a sit to stand lift to transfer the resident from the bed to the wheelchair. During an interview on 01/18/18 at 9:38 a.m., an administrative nurse (#1) stated Resident #30's care plan required updating as staff did utilize the correct transfer method of sit to stand lift.	F 657	achieved by the above schedule, then random monitoring will be completed as directed by the DON/designee. The IDT care plan team 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. Reports will be provided to the facilities QA committee quarterly by the DON/designee to address any additional concerns and ensure ongoing compliance.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #6) observed eating/drinking in bed	F 684	1) Corrective action for concerns regarding Resident # 6 includes a mandatory in-service with a Speech-Language Pathologist from Altru	2/21/18

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F 684	Continued From page 6 received the necessary care and services to ensure his safety. Failure to properly position Resident #6 in bed and/or provide cueing has the potential to negatively affect Resident #6's overall swallow safety and placed him at risk of aspiration. Findings include: The facility failed to provide a copy of their policies addressing dysphagia and/or feeding assistance when requested. Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included diabetes, reflux, and gastrointestinal hemorrhage. The quarterly Minimum Data Set (MDS), dated 11/28/17, identified intact cognition and no loss of liquids/solids, holding food [pocketing], coughing/choking, or difficulty/pain with swallowing. The current physician's orders identified, ". . . Consistent Carbohydrate diet . . . Mechanical soft meats. . . ." The current care plan also identified, ". . . [Resident #6] requests his meals be served in his room. . . ."	F 684	Hospital, to be held 2/19/18. She was asked to cover proper positioning for eating, drinking, taking meds, thicknesses of liquids, when a SLP referral should be made, etc. Also, a policy was written on 2/2/18 on Aspiration Precautions, and has been sent to administration for review and approval. Resident education was given as well. 2) All residents have the potential to be affected by this practice. Residents who are at particular risk for aspiration will be identified by licensed nursing staff during the weekday morning IDT meetings. 3) A systemic change to avoid recurrence of this deficient practice will be the weekday morning IDT meeting, during which dietary needs, changes in condition resulting in swallowing difficulties, any coughing or choking episodes that have occurred, decreased ability to sit upright and feed self, etc., will be discussed. This will tie in with the care plan revision portion of this meeting. CNA□s providing direct care to any identified at-risk residents will be informed of changes as they are identified. The IDT will see that any concerns are addressed by the most appropriate person for the individual case (medical provider, dietician, SLP via physician referral) or, in some cases, a nursing-directed trial downgrade in diet. At-risk residents will be attended during meals and med passes, with proper upright positioning for any po intake. The care plan for any resident deemed by the IDT to be at	

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F 684	Continued From page 7 Observation showed the following: * On 01/16/18 at 1:29 p.m., Resident #6 laid in bed, with the head of his bed reclined to an approximate 30 degree angle. An unidentified LPN (licensed practical nurse) entered Resident #6's room to administer his medications. She left Tylenol and a glass of fresh water on his bedside table. Resident #6 drank some water and began coughing. The LPN failed to raise the head of the bed to a 90 degree angle before offering Resident #6 a drink of water. * On 01/18/18 at 8:45 a.m., Resident #6 laid in bed, leaning heavily to his right side, with the head of his bed in a reclined position. A certified medication assistant (CMA) (#3) entered Resident #6's room to administer his medications. She raised the head of Resident #6's bed to an approximate 45 degree angle, before pouring his pills onto the bedside table next to his water glass. Resident #6 took a drink of water after each pill. He coughed immediately and again after swallowing the last pill. The CMA (#3) failed to raise the head of the bed to a 90 degree angle and failed to cue Resident #6 to readjust his position toward midline before offering him his medications and/or a drink of water. During an interview on the afternoon of 01/18/18, an administrative nurse (#1) confirmed residents should be seated as close to 90 degrees as possible before introducing food and/or liquids.	F 684	increased risk for aspiration will be updated, along with updating the CNA worksheets accordingly. Likewise, any changes as a result of a physician visit or SLP referral will be made in the care plan. All direct care staff will be observed for proper positioning during feeding and medication passes. 4) Evaluation and maintenance of these, and any other solutions that are decided upon, will be incorporated into the IDT□s morning meetings. Once a significant change or an at-risk-for-aspiration resident has been identified and the appropriate action taken (notification of M.D., referrals or diet changes made) a co-DON or designee will review the care plan to ensure changes were made and are being followed through. He/she will monitor these residents to ensure compliance with appropriate aspiration precautions. A QA study will be done on Resident #6, and on any other residents noted by the IDT to have the potential to be affected by this deficiency in practice. The same frequency of checks will be carried out □ 5/7 days for two weeks, 3/7 days for two weeks, and 1/7 days for four weeks. A DON or designee will continue with random monitoring for the remainder of the year, with discussion at the monthly QAPI meeting and quarterly reports to the QA committee. The IDT will discuss rates of compliance weekly. 5) Corrective action began 2/1, and was completed 2/21/18. This included direct staff observation and beginning QA	

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F 684	Continued From page 8	F 684	monitoring.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent/minimize the potential for the development/worsening of pressure ulcers for 1 of 1 sampled resident (Resident #6) with pressure ulcers. Failure to consistently implement pressure relief interventions may result in the worsening of Resident #6's current foot/heel pressure ulcers or the development of new pressure ulcers. Findings include: The facility failed to provide a copy of their policies addressing pressure ulcers and/or repositioning residents when requested. - Review of Resident #6's medical record	F 686	1. Corrective action for deficient practice regarding Resident #6 and his pressure and vascular ulcers includes the following: The P&: for pressure ulcer prevention and treatment was reviewed and left as it. Nurses will chart when resident refuses to wear Rooke boots, and will then ensure and chart that heels are offloaded with uses of pillows under lower legs. CNA□s will be reminded, verbally and via memos in Point of Care and memo book in charting room, to make sure heels are not resting on mattress when they leave Resident #6□s room after cares. 2. All residents have the potential to be affected by this deficient practice, especially those with decreased mobility.	2/21/18

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F 686	Continued From page 9 occurred on all days of survey. Diagnoses included reduced mobility, edema, peripheral vascular disease, and an unstageable pressure ulcer to his right heel and an unspecified pressure ulcer to his left heel. The quarterly Minimum Data Set (MDS), dated 11/28/17, identified Resident #6 as at risk of pressure ulcers, having two unhealed, unstageable pressure ulcers and three vascular ulcers, requiring a wheelchair cushion, special mattress, ulcer cares, nutrition interventions, dressings, and ointments. The Skin Observation Tools identified the following: * 12/22/17, Resident #6 had a pressure ulcer to both heels, three pressure ulcers to the top of his right foot, and one to the right lateral leg. * 12/29/17, Resident #6 had a vascular ulcer to both heels and three vascular ulcers to the top of his right foot. * 01/12/18, Resident #6 had three pressure ulcers to the top of his right foot and one to the outer aspect of his right foot, and one vascular ulcer to the top of his right foot. A current physician's order identified, ". . . Rooke boots to both feet at all times . . ." An MDS Assessment, dated 11/28/17, identified, ". . . Occasionally refuses to wear his rooke boots . . ." The current care plan identified, ". . . Has 2 pressure areas to heals [sic] which are very slow at healing the skin breakdown to top of right ankle. . . . has an unstageable pressure ulcer [sic] right foot that was present on Admit. Left	F 686	Licensed nurses will monitor for any residents with a change in condition that might require pressure area prevention measures. 3. The Pressure Sore Prevention Measures and Pressure Ulcer Prevention and Treatment policies have been reviewed by nursing staff. Any resident identified as being at risk for pressure sores will have the appropriate intervention added to his or her care plan, such as more frequent repositioning, more assistance with repositioning, Rooke boots, Prevalon boots, or pillows provided for positioning as appropriate and needed. Medical providers will be notified of significant changes and any orders given will be added to the MAR or TAR and carried out. Any nursing interventions not requiring physician notification will be added to the TAR, so the intervention deemed appropriate per licenses nurses will be carried out or documented as refused. This will be discussed and followed at the morning IDT meeting. There is a mandatory Health Care Academy class on pressure ulcers, and observation of direct caregivers will be carried out. 4. Regarding monitoring and sustenance of performance, a co-DON or designee will c heck to ensure Resident #6 is regularly being positioned for proper offloading of heels, following a similar schedule as the other corrective actions thus far 5/7 days for two weeks, 3/7 days for two weeks, and 1/7 days for four	

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F 686	Continued From page 10 heel pressure area noted 09/18/17. Right upper ankle skin breakdown. . . . Administer treatments as ordered . . . Pressure relieving boots on at all times - Rooke Boots. At times may not want boots on. Staff to encourage the use of these. Use of pillows to free float heals [sic] may be used. . . ." Observations identified the following: * On 01/16/18 at 4:03 p.m., Resident #6 laid in bed with his heels resting on a pillow. He was not wearing his Rooke boots at the time. * On 01/17/18 at 10:32 a.m., After changing Resident #6's dressings, a nurse (#2) covered him with a sheet, removed her gloves, and washed her hands. The nurse (#2) failed to put the Rooke boots on his feet and/or float his heels before exiting the room. * On 01/18/18 at 8:45 a.m., A certified medication assistant (CMA) (#3) administered Resident #6's medications. Resident #5's laid in bed with his heels resting directly on the bed, and a pillow laying to the left of his calves. He was not wearing his Rooke boots at the time. The CMA (#3) failed to put his Rooke boots on and/or float his heels before exiting the room. During an interview on the afternoon of 01/18/18, an administrative nurse (#1) stated staff should ensure Resident #6 is either wearing his boots or his heels are floated as careplanned.	F 686	weeks, with ongoing at-random checks. If compliance is satisfactory, random monitoring will continue for the rest of the year, with reports to the QA committee at its quarterly meeting. For at-risk residents, once the risk has been identified, intervention measures have been instituted and any new orders are in place, checks to ensure compliance with new interventions will be conducted at the same rate. The IDT will discuss the effectiveness of this plan weekly. If it is determined changes are necessary, they will be made and implemented, with weekly re-visitation and evaluation. 5. Corrective action began 2/1 and will be completed by 2/21/18. Ongoing QA monitoring will continue as above, to ensure continuing compliance.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		2/26/18

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F 730	Continued From page 11 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of performance evaluations, review of twelve months of education records, and staff interview, the facility failed to provide twelve hours of in-service education per year for 3 of 4 certified nursing assistants (CNAs) (CNA A, B, and C) based on their individual performance review. Failure to provide twelve hours of in-service education per year to CNA A, B, and C may result in staff being ill-prepared to provide care and services addressing special resident needs. Findings include: Review of staff performance evaluations and twelve months of education records occurred on 01/17/18. The records showed the facility failed to provide twelve hours of in-service education for 3 of 4 CNA files (CNA A, B, and C) reviewed. During interviews on 01/17/18 at 3:45 p.m. and 4:15 p.m., an administrative nurse (#1) confirmed the facility failed to ensure all staff members were provided and/or completed twelve hours of in-service education during the period between January 2017-January 2018.	F 730	F730 – NURSE AIDE PERMORMANCE REVIEW – 12 HOUR/YEAR INSERVICE 1) Three CNA's were found to be lacking in their education for last year. One was casual, rarely worked, and has since been removed from the CNA roster. Another has resigned, effective 2/22/18. The remaining CNA who was deficient in her education has been given a list of her 2017 Health Care Academy classes she lacked. She will be required to complete them by 2/26/18. All CNA's have been informed of the necessity of completing required annual training. Dates of compliance with completion have been posted, with probationary periods and no annual raise for lack of completion. 2) There is the potential for any employee to not complete his or her required education for that year. At the time of annual evaluations, the DON will evaluate education progress or lack thereof. Also, note will be made of anyone missing an in-service training and that employee will be required to make it up. 3) The IDT has developed an education notebook, in which in-service sign-in sheets will be placed. This will be monitored after each in-service and anyone who missed a training will be offered a recording or transcript of the training, along with a post-test, to complete and submit. HR has provided	

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F 730	Continued From page 12	F 730	the DON with a list of Care Center nursing department personnel's hire/anniversary dates. A month prior to the anniversary and evaluation date, education progress will be checked, and employees will be informed of any deficiencies in training, and will be expected to get up to date by anniversary date. Those employees who are not meeting requirements will be monitored more closely, with individual training and post-tests as appropriate. Notice of meetings and in-services will be posted at least one week in advance. The six-module Hand in Hand training is underway in our facility, is mandatory, and those who cannot attend the session will read the transcript and complete a post-test. A Resident Rights in-service is also being offered by our Social Service department, is mandatory, and likewise, anyone unable to attend will be educated and given a post test. A mandatory training on dysphagia, aspiration risk and precautions, various liquid thicknesses, etc. took place on 2/19/18, and was recorded for those unable to attend. A representative from Hospice has been contacted and will be scheduled to provide Hospice training. Health Care Academy classes are available for 2018 and employees have been given their login information and list of required classes. 4) To ensure ongoing monitoring and sustenance of education requirements, the list of employee hire anniversary dates will be reviewed monthly, those with	

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F 730	Continued From page 13	F 730	upcoming evaluations will be reviewed for in-services attended and education completed, and CNA cares will be observed in the days/weeks leading up to their evaluations. This will be discussed at the IDT meetings, with feedback and suggestions made to possibly improve on the method(s) used to monitor compliance with training of all CNA's. QA will be done on the CNA's found to be deficient in their education. Monthly checks of CNA's Health Care Academy classes will be made for the remainder of this year, by a co-DON. Verbal reminders will be given if adequate, expected progress is not being made in completing the required classes. After each training or in-service, if any of these CNA's have not attended, he/she will be required complete the individual training. The IDT will discuss this at its first meeting of each month and pinpoint any problem persons or problem areas. A monthly monitor report will be made and reported as part of the QA process. Reports will be provided to the facility's QA committee quarterly by the DON/designee, to address any concerns and ensure ongoing compliance. While each employee will be responsible to complete his or her training, every effort will be made to accommodate any special needs and provide for making up missed training. Review will be made monthly on those whose evaluations come due. Those not meeting the requirements will have opportunity to get up to date on Health	

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F 730	Continued From page 14	F 730	Care Academy classes, and to do individual education and complete any post-tests for in-services missed. 100% compliance will be expected. 5) Corrective action began on 2/1/18 and will be completed by 2/26/18, for the CNA who is making up missed HCA classes. Ongoing monitoring, monthly, will be done through the end of this calendar year, regardless of level of compliance.	
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	F 880		2/21/18

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F 880	Continued From page 15 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.	F 880		

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F 880	Continued From page 16 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 the facility's policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 2 of 2 sampled residents (Residents #6 and #21) observed during dressing changes. Failure to follow appropriate infection control practice related to preparing a clean surface for dressing change supplies (Resident #6 and #21) and hand hygiene/glove use (Resident #6) may result in the spread of infection within the facility. Findings include: Review of the facility policy titled "Dressing Change - Non-Sterile" occurred on 01/18/18. This policy, dated January 2017, stated, ". . . It is the policy . . . to provide clean dressings as needed and as ordered, when sterile dressings are not necessary. . . . To absorb drainage, prevent infection, promote healing and assess healing process. . . . Wash hands. Assemble materials, prepare work area or surface. Don gloves. Remove old dressing, discard in plastic bag. Remove gloves, don clean ones. Cleanse area with prescribed cleaning solution. Apply any prescribed medication(s). Apply new dressing as ordered, secure with tape as needed. Remove gloves, wash hands. . . . Dispose of used gloves, soiled dressings appropriately. Wash hands. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included an unstageable pressure ulcer to his	F 880	1. Actions taken to correct these deficiencies regarding dressing changes and infection control on Residents #6 and 21 include the following: The Non-Sterile Dressing Change P&P has been changed by adding the words sanitize and (prepare work area or surface) in point 3 of the procedure. Education on proper changing of gloves and handwashing during multiple wound cares has taken place: A memo was posted for nurses on 2/9/18 regarding this, and nurses were educated at a meeting on 2/19/18. 2. Any resident requiring wound care has the potential to be affected by this deficient practice. 3. To ensure consistent compliance with proper dressing change procedures, nurses reviewed the Non-Sterile Dressing Change P&P at the 2/19/18 meeting. They have been observed doing a dressing change, with critiquing by an administrative nurse, following the P&P. Education will be given to all licensed nurses, and they will be expected to carry out the same procedure for each resident receiving wound care. Subsequent observation will be made at each nurse□s annual evaluation. Health Care Academy classes include Infection Control. 4. For ongoing monitoring of this practice, a co-DON or designee will observe dressing changes at regular intervals until all nurses have been found	

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F 880	Continued From page 17 right heel and an unspecified pressure ulcer to his left heel. The quarterly Minimum Data Set (MDS), dated 11/28/17, identified Resident #6 had two unhealed, unstageable pressure ulcers and three vascular ulcers, requiring ulcer cares, dressings, and ointments. The current physician's orders identified, ". . . Cover R [right] Heel Eschar area and Right Top foot areas with Silvadene Cream then Xeroform occlusive gauze and hold in place with use of ABD Pad and kling every day shift for pressure ulcers. . . ." Observation of dressing changes on 01/17/18 at 10:32 a.m. showed a nurse (#2) applied gloves before removing the soiled dressings from both of Resident #6's feet. The nurse (#2) then removed her soiled gloves, washed her hands, and regloved before applying Cavilon cream on both feet. The nurse (#2) removed her gloves, regloved without washing her hands, cut a piece of ABD pad, and placed it over Resident #6's left heel and secured it with gauze. The nurse (#2) cut three additional pieces of ABD pad and placed them directly on the bedside stand. The nurse (#2) cut and held three pieces of Xeroform in one hand as she dabbed Sulfadiazine Cream on each of the wounds on Resident #6's right foot with her other hand. The nurse (#2) then covered each wound with Xeroform and an ABD pad, and secured them with gauze. The nurse (#2) removed her gloves, washed her hands, regloved, and removed the soiled dressing around Resident #6's suprapubic catheter site. Without changing her gloves, she cleansed the site with saline wound cleanser, applied Bacitracin ointment, placed an Excilon drain	F 880	to be following proper procedures. This will be done monthly, according to the nurses schedule and when treatments are done. The co-DONs or designees will discuss progress toward educating the nurses weekly. Compliance of QA timetables will differ according to the nurses schedules. After initial observation of all nurses, any nurse found to be out of compliance will be monitored once weekly, per his or her scheduled shifts, for one month or until compliance is attained, then randomly. Compliance and QA will be reviewed and discussed by the DONs, and will be reviewed at the first monthly QAPI meeting at the Care Center. This will also be presented at the quarterly QA meetings. 5. All professional nursing staff have been observed and evaluated for proper infection control practices, with ongoing QA monitoring taking place for the duration of the year. Initial monitoring began 2/1 and was completed 2/21/18. The DONs will discuss results of monitoring 2/26 and will determine the need for further monitoring at that time. To ensure compliance is sustained, as part of the QAPI process, any identified noncompliance will be addressed immediately.	

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F 880	Continued From page 18	F 880		

sponge around the site, and secured it with tape. The nurse (#2) then covered Resident #6 with a sheet, removed her gloves, re-opened the blinds, and washed her hands.
The nurse (#2) failed to clean/disinfect the bedside stand prior to placing supplies on it, failed to change her gloves after attending to one foot and prior to attending to the other, and failed to remove her gloves, perform hand hygiene, and reglove after handling the soiled suprapubic dressing and prior to attending to the catheter site.

During an interview on the afternoon of 01/18/18, an administrative nurse (#1) confirmed staff should have followed the facility's policy when performing wound cares.

- Review of Resident #21's medical record occurred on all days of survey. Medical diagnoses included chronic venous insufficiency and recent right buttock lesion. Review of a Physician's Progress note, dated 01/12/18, stated ". . . ASSESSMENT: Right buttock lesion. It is really not clear what this is. It is not acting as if it is a bacterial infection or an abscess and now appears to potentially be something that is going to necrose. A neoplastic etiology is a concern. . . . It does not seem to be a pressure-caused lesion. . . ."

Observation of a nurse performing a dressing change on Resident #21's right buttock occurred on 01/17/18 at 10:04 a.m. The nurse (#2) brought in the dressing supplies and placed them directly on a bedside stand. The supplies included 2 x 2 inch gauze pads, which were not in packaging and a pair of scissors. The nurse failed to

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F 880	Continued From page 19 clean/disinfect the surface prior to placing the supplies on the stand. The nurse used gauze on the open wound, which was oozing clear/bloody fluid, and used the scissors to cut the medicated dressings, which were inside sterile packages. The nurse failed to follow the facility policy to prepare the work area or surface prior to the dressing change. During an interview, the morning of 01/18/18, the nurse (#2) confirmed she did not clean the surface prior to placing the supplies on the stand.	F 880		