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	355052	A. BUILDING _____ B. WING _____	12/30/2015

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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 December 28, 2015 and completed on December 30, 2015, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed to the residents' responsible parties/designees within 30 days for 1 of 2 supplemental resident records reviewed (Resident #11). Findings include: Review of conveyance of funds following death occurred on 12/29/15 at 10/25 a.m. with a business office staff member (#1). The resident trust account information identified Resident #11 expired on 07/20/15. The facility issued a check for the remaining balance of $225.97 on 09/23/15, 65 days later.	F 160	1). No current residents were identified by this deficiency. 2). All residents have the potential to be affected by this finding. 3). The Care Center Ward Clerk/Receptionist has been educated re: the federal requirement on 12/31/15 and has now initiated a midmonth (on the 15th) and end of month (on the 30th)check of all discharges and a list of residents who have personal funds deposited with our facility. She will report her comparisons to the CFO	12/31/15

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

Electronically Signed | 01/15/2016

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F 160	Continued From page 1 During an interview on 12/29/15 at 10:33 a.m., the staff member (#1) agreed the facility failed to refund the residents' funds within 30 days of death.	F 160	and will initiate the conveyance of funds for any applicable resident who has been discharged in that time period. 4). Date of correction = 12/31/15. 5). A list of all residents who have personal funds deposited with the facility will be maintained by the Care Center Ward Clerk/Receptionist and updated on the 15th and the 30th day of every month. In addition, A Monitor will be completed by the Ward Clerk/Receptionist to verify the discharges which have occurred during the past 15 days and verification if these same residents have funds deposited in the facility. This will be reported to the CFO/designee on the 15th and 30th to ensure monitoring oversight during that time period and will be an ongoing process for all discharges.In addition, the "Notification of Change of Status form" completed by the Care Center when a resident is transferred, discharged, admitted, or expired will now also be sent to the CFO to to inform the business office of the current census will now include the CFO to enable a comparison and verification of the monitor results with	

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F 160	Continued From page 2	F 160		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/18/14	F 278	the census form. 1. A review of the MDS, Care plan, Nurse aide documentation and CNA worksheet records for Resident #7,	1/29/16

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F 278	Continued From page 3 Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 3 of 9 sampled residents (Resident #4, #7, and #8) regarding turning/repositioning schedule. Failure to correctly code items on the MDS does not provide an accurate assessment of the residents' current status and may affect the accurate development of the comprehensive care plan. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Page M-38 (M1200C Turning/Repositioning Program), stated, "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours)." - Review of Resident #7's medical record occurred on December 29-30, 2015. The resident's quarterly MDS, dated 12/05/15, identified a turning and repositioning schedule. The resident's current care plan stated, ". . . Interventions: Bed Mobility: The resident requires extensive assistance by 1X [one] staff to turn and reposition in bed every 2-3hrs [hours] and as necessary. . . ." The medical record failed to identify an individualized, resident specific turning and repositioning program. - Review of Resident #4's medical record	F 278	Resident #4,and Resident #8 was completed. Their MDS's and care plans have been updated to reflect their current clinical condition based on what their assessed needs are. The Nurse Aid documentation sheets are being upgraded with definitions regarding specific positioning and documentation areas related to body parts/areas involved to verify what is individually assessed for each resident. The CNA worksheets for these residents will also indicate what actions are to be taken individually and specifically for each resident based on their assessment. 2). All residents have the potential to be affected by this finding. 3). The MDS, Care Plan, Nurse Aide documentation and Aide worksheets have been reviewed for all residents and individually reflect the specific actions to be taken when repositioning (as noted in #1 above). The DON will conduct Nurse Aid and Nurse meetings scheduled for 01/20/16 which will inform and educate staff of the survey findings and "individualized resident specific turning and repositioning schedules", as well as the changes made to the required documentation, electronic health record, nurse aide worksheets and resident care plans. The updated sheets and information will be added to the facilities orientation program for applicable staff. 4). This deficiency will be corrected for all care plans, aide work sheets and documentation in the electronic medical record by 01/29/16.	

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F 278	Continued From page 4 occurred on December 28-30, 2015. Resident #4's quarterly MDS, dated 12/07/15, identified a turning and repositioning schedule. The resident's current care plan stated, ". . . Interventions: Bed Mobility: The resident requires extensive assistance by 2X [two] staff for bed mobility . . . Reposition every 2-3 hrs and PRN [as needed] . . ." The medical record failed to identify an individualized, resident specific turning and repositioning program. - Review of Resident #8's medical record occurred on December 29-30, 2015. Resident #8's quarterly MDS, dated 12/02/15, identified a turning and repositioning schedule. The resident's current care plan stated, ". . . Interventions: Bed Mobility: The resident requires extensive assistance by 1X . . . The resident has potential impairment to skin integrity. . . . Turn and repo [reposition] every 2-3 hrs and PRN. . . ." The medical record failed to identify an individualized, resident specific turning and repositioning program. During an interview with an administrative nurse (#9) on 12/30/15 at 10:51 a.m., the nurse agreed the medical record lacked an individualized, resident specific turning/repositioning schedule.	F 278	5). The DON and/or designee will review the care plans and aide documentation to monitor the individualized cares provided by the aides/applicable staff to verify compliance with their assigned patients and individualized specific care plans and worksheets. Monitors will be done daily as per assigned aides and staff to ensure all staff are correctly providing individualized care as per their identified needs and documentation accurately reflects those cares. Monitors will be completed weekly until 100 % compliance is maintained. The MDS's for Resident #4, Resident #7 and Resident#8 have been reviewed and updated. MDS's will be monitored weekly with all care conferences and continue every week and/or as needed when a resident's status/care needs change. Quarterly monitors will be done by the DON/designee of same. Random monitors for nurse aide documentation, MDS's and CNA worksheet records will continue to be completed by the DON/designee over the next three months and every shift to verify continued compliance. In addition, any time a change in status or cares occurs, the DON/designee will monitor the cares provided to ensure the changes are being followed. New staff will be instructed as part of their orientation program and included in the ongoing monitors. Monitors will also cover all shifts and days of the week to ensure compliance is maintained by all staff. Monitors will also be developed to ensure documentation by	

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F 278	Continued From page 5	F 278	staff accurately reflects the care provided, as well as the references to all residents through one quarter to ensure accuracy of each area. Reporting of the monitors will be incorporated into the facilities QA/PI program and reported quarterly.	
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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the use of assistive devices to prevent accidents for 1 of 6 sampled residents (Resident #8) observed during transfer. Failure to use proper equipment for transfer, such as a gait belt, increased the risk of a fall or injury to the resident. Findings include: Review of facility policy titled "Standards of Practice-Routine Care" occurred on 12/30/15. This policy, undated, stated, ". . . Transfer/Locomotion . . . Use gait belt with all assisted transfers and ambulation unless otherwise specified. . . . Use mechanical lift as indicated in the care plan. . . . "	F 323	1. The facility policy was reviewed with the nurses aides caring for Resident # 8, and review of the processes and proper procedure for transfer and ambulation was completed. A dedicated gait belt has been placed in the resident's room and wheelchair bag to ensure it's availability for use by staff. 2. All resident's have the potential to be affected by this finding. 3. The DON will conduct Nurse aid and nurse meetngs scheduled for 01/20/16 to educate and inform staff of our policy re: the use of gait belts for applicable transfers and ambulation. A review of the gait belt supply indicates it is adequate for all staff to utilize as needed and the location of these gait belts will be included	1/29/16

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F 323	Continued From page 6 - Review of Resident #8's medical record occurred on December 29-30, 2015 and included a history of falls. Observation on 12/29/15 at 1:15 p.m. showed a Certified Nursing Assistant (CNA) (#3) and a contracted agency CNA (#2) reposition Resident #8 in the wheelchair without a gait belt. Both staff members (#2 and #3) pulled under the resident's arms and on the back of his pants to assist the resident to a sitting position after sliding down in the wheelchair. During an interview on 12/30/15 at 12:05 p.m., two administrative staff members (#4 and #5) identified they would expect staff to use a gait belt or a lift for Resident #8's repositioning.	F 323	in the educational meeting to ensure all staff have an awareness of how to obtain and utilize for their residents as needed. 4. Date of correction = 01/29/16. 5. The DON/designee will monitor all nurse aides re: their transfers for assigned residents to ensure gait belts are utilized appropriately. Monitors will contiue daily until 100% compliance is reached, and then weekly x2 and monthly X 1 until 100% compliance is consistently obtained. After ongoing compliance is maintained, random monitors will be completed by the charge nurse or DON designee for all shifts at least quarterly. Monitors will also be done for each new employee as noted above to verify compliance and their understanding. These monitors will initially be completed by the DON/designee. Once their compliance is verified, they will be included in the monitor schedule as noted above. Care plans and aide worksheets will be reivewed by the DON/designee to indicate which residents require assistance with transfers and willl be updated if a change occurs by the MDS Nurse. Reporting of the monitors will be incorporated into the facilities QA program.	
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.	F 441		1/29/16

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F 441	Continued From page 7 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of facility contact isolation guidance, and staff interview, the facility failed to maintain an infection control program to prevent the	F 441	1. The facility policies for Handwashing specific, Contact precautions, and the Resident specific Facility Form for Contact isolation was reviewed and is	

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F 441	Continued From page 8 development of disease and infection regarding 3 of 10 sampled residents (Resident # 2, #4, and #8) observed during cares. Failure to perform hand hygiene after pericares (Resident #2 and #4) and failure to perform hand hygiene after providing cares and removing gloves (Resident #8) placed residents at risk of developing infections and illness. Failure to properly clean surfaces after contact with body fluids placed the residents at risk of transmission of infections. Findings include: Review of the facility policy titled "Handwashing Specifics" occurred on 12/30/15. This policy, dated January 2015, stated, ". . . When should your hands be washed? . . . 2. Before entering and leaving the patient/resident unit. 3. Before, between and after all physical contacts with the patient/resident. . . . 7. After handling . . . urinals . . . 9. On leaving the room of a patient/resident on isolation precautions. . . . 12. Note: When taking care of a patient/resident in isolation, remember that hands must be washed: . . . b. after removing the isolation gown. . . ." Review of the facility policy titled "Contact Precautions" occurred on 12/30/15. This policy, dated 12/31/14, stated, ". . . 2. Wash hands. . . .4. Wear gloves when entering room. Change after contact with infectious material. 5. Limit transport of patient/resident to essential purposes only. . . . 6. Remove gown and gloves before leaving the room and immediately wash hands with anti-bacterial soap (regular soap is not adequate). . . ." Review of the facility form titled "Contact Isolation	F 441	current. The information required to follow correct IC cares, along with their Care Plans and Nurse Aide worksheets for Resident #2, #4, and #8 was verified for accuracy.Each caregiver was informed of the deficient practice and IC policies were reviewed upon receipt of the 2567. Upon notification by the survey team of the findings at the exit conference, the nurse immediately replaced the cap the staff member did not replace on patient #8's catheter bag. All areas were cleaned appropriately. 2. All residents have the potential to be affected by this finding. 3. A notice was placed in the report room re: the IC handwashing, contact precautions and resident specific facility form for all staff to read and review, along with the IC policies. A meeting will be held by the DON/designee to review the survey results on January 20,2016 with all nursing and Nurse Aide staff. Education will be provided re: the IC policies, including the facilities correct practice of IC for resident cares, handwashing after perineal cares, and cleaning of hard surfaces for all categories of isolation as well as general policies and procedures. Demonstrations of the correct use of gloves, and review of handwashing will be done, along with appropriate cleaning of hard surfaces. 4. Date of correction = 01/29/2016. 5. Monitors will be developed for all IC practices and observed by the DON/Designee's to ensure all staff follow IC protocol. Monitors will be completed on	

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F 441	Continued From page 9 guidance for [Resident Name]" occurred on 12/30/15. This policy, dated 07/31/15, stated, ". . .6. Be sure to wash your hands well using soap and water after emptying his urine bag. . . ." - Review of Resident #8's medical record occurred on December 29-30, 2015. Physician's orders, dated 10/30/15, stated, "Contact isolation D/T [due to] CRE [Carbapenem Resistant Enterobacteriaceae]." The current care plan stated, "Colonized with Carbapenem resistant Pseudomonas aeruginosa in his urine. . . . Interventions: Cleanse his hands with alcohol gel prior to bringing him out of his room. . . . Contact isolation with cares. . . ." - Observation on 12/30/15 at 12:46 p.m. showed a Certified Nursing Assistant (CNA) (#3) entered Resident #8's room to empty the catheter bag. The CNA (#3) washed her hands using soap and water, then donned a gown and gloves. After removing the cap from the catheter port, the CNA swabbed the port with an alcohol swab, and unclamped the tubing to empty the catheter bag. While emptying the urine into the graduated cylinder, the CNA (#3) spilled urine on Resident #8's wheelchair footpedal and on the floor. The CNA (#3) used an alcohol swab to wipe the urine spill from the footpedal and paper towels to wipe the urine from the floor. At this time, the CNA (#3) stated she had dropped the cap for the catheter port on the floor, cannot use it, and threw it away. The CNA (#3) clamped the catheter tubing, wiped the port with an alcohol wipe, then removed her gown and gloves and disposed of them in the designated isolation garbage within Resident #8's room. The CNA (#3) wheeled Resident #8's to the lounge, then used hand sanitizer and	F 441	all Nurse Aide staff to ensure their compliance and understanding. After compliance is verified for all staff, random weekly monitoring will then occur X 4 and monthly X 2 to ensure continued compliance for all shifts. Monitors will be incorporated into the facilities QA/PI program and reported quarterly.	

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F 441	Continued From page 10	F 441		

donned new gloves. Two CNAs (#3 and #8) assisted Resident #8 per hoyer lift to a recliner. The CNA (#3) failed to perform hand hygiene prior to exiting Resident #8's room after emptying the catheter bag, failed to properly clean/sanitize the urine spills, failed to apply a new cap to the catheter drainage port prior to transferring the resident to a lounge recliner, and failed to cleanse Resident #8's hands before taking him out of his room.

- Observation on 12/29/15 showed a CNA (#8) assisted Resident #2 off the toilet after having a bowel movement. The CNA performed perineal care and removed her gloves. Using the sit-to-stand lift, the CNA assisted the resident into bed, positioned the resident in bed, removed the resident's glasses and shoes, opened the closet door to get a blanket, and then performed hand hygiene. The CNA (#8) failed to perform hand hygiene after providing perineal care and before completing other tasks.

- Observation on 12/29/15 at 8:50 a.m. showed two CNAs (#2 and #10) assisted Resident #4 to bed with a mechanical lift. Without wearing gloves, the CNA (#2) opened and touched inside Resident #4's brief when they rolled her from side to side to check for incontinence. The CNA (#2) stated Resident #4's brief was dry. Without washing her hands, the CNA (#2) then handed Resident #4 a glass of water to drink.

During an interview on 12/30/15 at 12:30 p.m., an administrative nurse (#4) stated she expected staff to perform hand hygiene after completing perineal care before doing other tasks.