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	355031	A. BUILDING _____ B. WING _____	C 10/21/2019

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 10/15/19 and concluded 10/21/19.	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 review of facility policy, and resident,	F 561	The care plan for R36 was updated to	11/24/19

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

Electronically Signed | 11/08/2019

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F 561	Continued From page 1 family, and staff interviews, the facility failed to honor resident choices for 2 of 9 residents (Resident C and D) from the group interview, one sampled resident (Resident #36), and a family member (AA). Failure to honor resident choices related to sleeping and waking times does not allow the residents the right to choose their own schedule. Findings include: Review of the facility policy titled "Resident Rights" occurred on 10/17/19. This undated policy stated, ". . . You have the right : To be offered choices and allowed to make decisions important to you, To expect the facility to accommodate individual needs and preferences . . ." During an interview on 10/15/19 at 10:06 a.m., a family member (AA) stated, "They [facility staff] get her [the resident] up way too early. There should be no reason she has to get up that early. Then I find her sleeping all the time with her head hanging down or leaned back in her wheelchair. She's up in her wheelchair from 5:30 [a.m.] until 8:30 [p.m.] when they put her to bed." During the group interview on 10/16/19 at 9:00 a.m. with residents identified by the facility as interviewable, Resident C stated staff get her up earlier in the morning than she chooses. If I don't get up "they [staff] take my blanket and I get cold so I get up." Resident D stated staff make her get up earlier in the morning than she chooses. During a dressing change on 10/16/19 at 11:32 a.m. by an administrative nurse (#3), Resident	F 561	include preferred bedtime. Resident of family member AA was not identified. Resident C and Resident D were not identified. Chart audits of resident sleep preference were completed on 10/31/2019. Those who are able to verbalize or indicate preferences and had not updated preferences in the past two months were asked if they had a time they preferred for getting up or going to bed. Family members for those who are unable to voice preferences and whose preferences had not been made clear at admission were interviewed and care plans updated if indicated. Going forward the facility will validate preferences during care conferences, to ensure their residents usual preferences are identified. Care plans were updated for those that specified a time outside of the usual unit routines. The Director of Nursing or designee will provide education on resident rights and self determination to nurses and nursing assistants beginning the week of November 4th and completed not later than November 24, 2019. Education will include referring to the Kardex to review resident preferences and information on ensuring care is tailored to resident preferences and not governed by unit routine. The Administrator or designee will complete interviews of three residents	

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F 561	Continued From page 2 #36 stated, "Last night they [staff] wouldn't put me to bed, they made me sit here and sit here way over an hour and my back hurt." During an interview on 10/17/19 at 3:59 p.m., an administrative nurse (#1) stated she expected staff to allow residents to sleep in if they wanted.	F 561	weekly for twelve weeks. Interviews will include questions regarding staff honoring personal preferences for a.m. cares and h.s cares. Results of interviews will be submitted to the Quality Assurance committee for review and recommendations. The need to continue audits beyond the initial twelve weeks will be determined based on audit results and recommendations of the quality assurance committee.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		11/24/19

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F 582	Continued From page 3 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to provide the Centers for Medicare/Medicaid Services (CMS) Notice of Medicare Provider Non-coverage (NOMNC) form (CMS-10123) and/or Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form (CMS-10055) to 3 of 3 residents (Resident #15, A, and B) reviewed who were discharged from Medicare Part A services.	F 582	R15 remains in the facility for care and services. The DON provided a copy of the SNF ABN form to R15 and explained the right to appeal the decision when therapy or Medicare services end. The DON reviewed the form and demonstrated to R15 what areas to check to indicate an appeal is desired. This patient education was completed on November 8,2019. Residents R A and R	

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F 582	Continued From page 4 Failure to provide the correct notices upon termination of Medicare Part A services, the updated contact information for the intermediary review agency, and ensure the resident's received the option to appeal the termination of coverage has the potential to hinder the residents' right to an expedited review of a service termination. Findings include: Review of the Medicare Part A letters/notices for Resident #15, A and B occurred on the afternoon of 10/17/19. The records identified the following: * Resident A received the NOMNC form (CMS - 10123) on 08/08/19. The form lacked the updated contact information for the intermediary review agency. * The facility failed to provide Resident B with the NOMNC form (CMS - 10123) when all covered services ended. * Resident #15 received the SNFABN form (CMS-10055) on 05/06/19. The resident signed the form and returned it to the facility but failed to identify, by checking a box, whether they requested a demand bill. During an interview on 10/17/19 at 3:52 p.m., a business office staff member (#2) confirmed Resident B failed to receive the CMS -10123, the facility had failed to confirm if Resident #15 wanted to request a demand bill, and verified the CMS -10123 form lacked the updated contact information for the intermediary review agency.	F 582	B no longer reside at the facility. Residents who have Medicare care or services discontinued have the potential to be impacted by an incorrect or incomplete form CMS-110123 or form CMS-10055. The CMS-10123 form has been updated to include the correct intermediary review contact information. This was validated 11/05/19. Instructions for completing CMS 10055 and an example of a correctly completed form with needed boxes checked were presented to the Social Services Designee and Business Office Manager and MDS nurse to ensure understanding of process. This education was provided on 11/7/19. A binder was assembled for access to examples of correctly completed forms with clear instructions on completion of forms included. The Social Services Designee, Business Office Manager, Resident Assessment Coordinators, DON and Nurse Managers were educated on November 7th, 2019 by the Director of Clinical Reimbursement on completing the appropriate forms. Education included obtaining signatures and completing areas to indicate if the resident desires or does not desire to appeal the facility decision on termination of the Medicare benefit. Audits will be conducted by the Resident Assessment Coordinator or designee for both the NOMNC and SNF-ABN one time per week for 12 weeks to validate	

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F 582	Continued From page 5	F 582	compliance. Audits will be initiated the week of 11/12/19. The results of these audits will be submitted to Quality Assurance committee for review and recommendations. The need for extending audits will be determined base on results of audits and on the Quality Assurance committee's review and recommendations.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 8/16/18. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) reflected residents' status for 1 of 18 sampled residents (Resident #9) and 1 closed record (Resident #65). Failure to accurately complete Section A (Identification Information) does not allow each resident's assessment to reflect their current status/needs and may result in the development of an inaccurate care plan. Findings include: The Long-Term Care Facility RAI Manual, revised October 2018, Section A: Identification Information, stated the following:	F 641	R 9 MDS assessments that were incorrectly coded have been corrected to accurately reflect PASSR level 2 results with services recommended. R 9 care plan was reviewed and was found to accurately address needs related to PASSR recommendations. R 65 MDS assessment was corrected to accurately reflect discharge destination. This practice has the potential to affect residents who have a PASSR level 2 with services recommended and those that have MDS discharge assessments completed. An audit of PASSR Level 2 assessments was completed by the MDS nurse or designee by 11/24/2019. Results of the audit were correlated with MDS entries to validate these were coded correctly for current residents. Care plan for those with services recommended	11/24/19

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F 641	Continued From page 6 * pages A-18 to A-20, "A1500: Preadmission Screening and Resident Review (PASRR) . . . All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID) . . . /developmental disability (DD), or related conditions . . . Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. . . . Coding Instructions: . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . ." * page A-29, ". . . A2100: Discharge Status . . . Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation service for injured, disabled, or sick persons. . . ." - Review of Resident #9's medical record occurred on October 15-17, 2019. A Level 1 PASRR, dated 02/11/16, included Ascends' (contracted service provider for screening process) outcome, "Level II is required. Positive Level I." The PASRR Summary of Findings (Level II), dated 02/27/16, stated, "[Name of resident] meets PASRR Mental Illness inclusion criteria with the primary diagnosis of Major Depressive	F 641	were reviewed and validated. An audit of discharge MDS assessments for the past quarter will be completed on or before 11/24/2019. Results of audit will be correlated to validate the correct discharge destination was noted on the MDS. Corrections will be made if indicated based on findings of the audit. The Regional Case Mix Consultant or designee completed education with the IDT on completing MDS entries accurately. Education was presented on 11/5/2019. Audits will be conducted by the RCMD and /or designee one time per week on three random resident charts for twelve weeks to assure complete and accurate information. Any errors found will be corrected. The results of these audits will be submitted to the QAPI team for review and recommendation. The need for extending audits will be determined based on results of audits and on QAPI review and recommendations.	

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F 641	Continued From page 7 Disorder. . . ." The findings included recommendations for supportive care in the nursing facility. Resident #9's annual MDS, dated 04/21/19, identified diagnoses of depression (not bipolar) and psychotic disorder (other than schizophrenia) and coded item A1500: "Is the resident currently considered by the state level II PASRR process to have a serious mental illness . . ." as "0. No." The facility coded A1500 "no" on all Resident #9's comprehensive assessments since the admission MDS, dated 03/09/16. During an interview on 10/17/19 at 12:35 p.m., an administrative nurse (#1) agreed staff should have coded A1500 "yes" per the MDS coding directions. - Review of Resident #65's medical record occurred on 10/17/19. The discharge assessment - return not anticipated MDS, dated 08/16/19, identified the resident was discharged to an acute hospital; however, the resident's medical record showed Resident #65 was discharged to another skilled facility. During an interview on 10/17/19 at 3:24 p.m., an administrative nurse (#5) agreed she coded the MDS incorrectly.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657		11/24/19

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F 657	Continued From page 8 (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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 8/16/18 AND THE COMPLAINT SURVEY COMPLETED ON 6/11/19. Based on observation, record review, and review of facility policy, the facility failed to review and revise a care plan to reflect the resident's current needs for 1 of 18 sampled residents (Resident #61). Failure to review/revise the care plan to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care for the resident.	F 657	R61 has been referred to speech therapy services and began speech therapy on November 6,2019. R 61 care plan was updated to include speech therapy and NPO status. Residents who are currently NPO, those that receive thickened fluids or pureed diets or those that are receiving speech therapy services and are considered at risk for aspiration have the potential to impacted by this practice. Residents with enteral nutrition, thickened liquids, pureed diets and those with speech therapy	

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F 657	Continued From page 9 Findings include: Review of facility policy titled "Care Plans - Comprehensive" occurred on 10/17/19. This policy, dated December 2016, stated, ". . . An individualized, comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, psychological needs is developed for each resident. . . ." Review of Resident #61's medical record occurred on all days of survey. The record indicated the resident was hospitalized on September 10-14, 2019 and again on September 15-23, 2019 with diagnoses including aspiration pneumonia during both stays. The hospital discharge orders indicated Resident #61 to be NPO (nothing by mouth) status and for speech therapy to evaluate and treat. The facility failed to identify interventions/recommendations for aspiration pneumonia, NPO status, and speech therapy on Resident #61's care plan.	F 657	orders for dysphagia were reviewed and care plans updated or revised with interventions for aspiration risk on 10/30/2019. Education was provided by the Director of Nursing or designee to Nurses and interdisciplinary team members who assist with care plan development on the need to develop and revise care plans based on resident needs and potential risks. Education was initiated November 7, 2019 and will be completed no later than November 24, 2019. The DON or designee will complete audits of three residents care plans per week for 12 weeks. Audits will focus on residents who have been identified as having new changes in condition or newly identified risks. DON or designee will validate needed changes were completed and care plan is accurate. The results of these audits will be submitted to the Quality Assurance team for review and recommendations. The need for extending audits will be determined based on results of audits and on the Quality Assurance review and recommendations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		11/24/19

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F 658	Continued From page 10 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/16/18. Based on observation, record review, professional reference, and staff interview, the facility failed to follow professional standards of practice regarding compliance with physician's orders for 2 of 2 sampled residents (Resident #12 and #36). Failure to follow physicians's orders for a dressing change (Resident #12) and notification of elevated blood sugars (Resident #36) may result in adverse health effects. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 68, stated, "Nurses are expected to analyze procedures and medications ordered by the physician. . . . It is the nurse's responsibility to seek clarification . . . the nurse is responsible for carrying it out. . . ." - Observation on 10/15/19 at 5:41 p.m. showed Resident #12 had a kerlex dressing to his right hand. Review of Resident #12's medical record occurred on all days of survey. A nursing progress note, dated 10/05/2019 at 10:44 a.m., stated, "CNA [certified nursing assistant] reported resident bumped his right hand to the corner of the heater box in his room. Resident was noted to have a self inflicted injury on his right hand, sustained a skin tear (inverted L shape) measuring 3.4 cms [centimeters] x [by] 3.0 cms.	F 658	R 12 MD notified of missed treatment order on 10/16/2019 and examined patient with no treatment order required for skin tear. R 36 MD was notified for current parameters and an updated order was given to change parameters for notifications. Residents with new orders have the potential to be impacted by this practice and those with blood glucose parameters requiring MD notification have the potential to be impacted by this practice. The DON implemented a double check process for new orders that requires a second nurse to check new orders against the computer based entry and to then check the computer based entry on the Medication Administration Record or the Treatment Administration Record. The facility Diabetic Management Guidelines were reviewed and will be placed at each nurses station and parameters for MD notification were reviewed for diabetic patients and modified if indicated. The DON or designee provided education and competencies on transcribing and validating orders, monitoring blood glucose parameters and physician/family notification of results outside of parameters. Education was provided to licensed nurses and started on November 6th, 2019 and will be completed no later than November 24, 2019. The DON or designee will be complete	

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F 658	Continued From page 11 Resident was so resistantduring [sic] the cleaning of the affected area so it was not well approximated. This nurse cleaned it with NS [normal saline], covered with paper tape to keep the skin together, covered with non adherent dressing, then a foam dressing to hold the non adherent dressing and wrapped with Kirlix [sic]. . ." A MD (medical doctor)/Nursing Communication sheet faxed to the MD, dated 10/05/19, stated the above information and "Would you like to continue same dressing. Please advise. . . .," to which the MD responded "continue [with] above dressing." Review of Resident #12's treatment record occurred on 10/16/19 and failed to identify an order for a right hand dressing or the frequency staff needed to change the dressing. During an interview on the morning of 10/16/19, an administrative nurse (#1) stated staff failed to carry over the dressing change treatment to the treatment record. - Review of Resident #36's medical record occurred on all days of survey. A physician's order, dated 07/07/19, stated, "Notify MD by fax if blood glucose is greater than 140 fasting or greater than 180 post prandial [after a meal]." Review of Resident #36's blood glucose levels for October 1-16, 2019 showed the resident's fasting blood glucose greater than 140 on eight occasions and post prandial glucose level greater than 180 on eight occasions. The facility failed to notify the physician of the elevated glucose levels	F 658	audits of order transcription on a minimum of three residents per week. A variety of orders will be reviewed including treatment, medication, and admission orders if applicable. Audits of blood glucose results on a minimum of three residents per week will be reviewed and will include checking for MD notification if indicated based on blood glucose results. Audits will be completed for twelve weeks. The results of these audits will be submitted to the Quality Assurance committee for review and recommendations. The need for extending audits will be determined based on results of audits and on review and recommendations by the Quality Assurance committee.	

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F 658	Continued From page 12 as ordered. During an interview on 10/17/19 at 1:54 p.m., an administrative staff member (#3) confirmed the staff failed to notify the physician as ordered.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident, family, and staff interviews, the facility failed to provide activities of daily living (ADL) assistance to 1 of 8 sampled residents (Resident #17) and 1 supplemental resident (Resident #51) who required staff assistance for toileting/check and change. Failure to provide assistance in a timely manner to residents who cannot independently carry out ADLs may result in poor grooming/hygiene and decreased self-esteem. Findings include: Review of the facility policy titled "Incontinence Prevention Program" occurred on 10/17/19. This undated policy stated, "To provide the appropriate bowel and bladder continence interventions based upon individualized evaluation of residents. . . . Routine toileting (ADL based) - A scheduled bladder management program will be designed to toilet an incontinent patient/resident when a voiding pattern cannot be established or for a patient/resident who is	F 677	R 17 care plan was updated to reflect care and comfort routines upon arising in a.m. before or after meals, naps, at HS and on scheduled rounds at night. R 51 is no longer in the facility. Residents who require assistance with toileting and incontinence care have the potential to be impacted by this practice. Assignment sheets have been modified to include a toileting worksheet where staff will work in teams to ensure toileting is provided as assigned to each resident. This worksheet will be referenced by team members to validate toileting is completed for each resident as assigned. This worksheet will be implemented the week of November 18, 2019. The DON or designee will provide education to nursing assistants on using toileting worksheets and documenting each time resident is toileted or checked and changed in the electronic medical	11/24/19

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F 677	Continued From page 13 unable to communicate the need to void. . . . Goal: Keep the resident dry. . . Example schedule in care plan: 'Toilet the resident every 2 hours, before and after meals, at bedtime and once during the night.'. . . Check and Change . . . residents using briefs will be checked frequently as needed for incontinent episodes and removal/replacement of soiled briefs. . . . Perineal care will be provided after each incontinent episode. . . ." - Review of Resident #17's medical record occurred on all days of survey. The resident's current care plan stated, ". . . ADL self-care deficit as evidenced by requires assistance related to: decreased physical function . . . Check and change at routine times such as before and after meals, at HS [hour of sleep] and routinely throughout the night. . . . Transfer with full body mechanical lift, full body sling, two staff . . . Urinary incontinence r/t [related to] Disease process dementia . . . Incontinence care at routine times such as upon arising in AM, before/after meals, activities, naps, at bedtime and on scheduled rounds at night . . ." Observations on 10/16/19 showed Resident #17 seated in the wheelchair at the following times: * 9:55 a.m. - located in the commons area (following the breakfast meal) * 11:00 a.m. - located in the commons area during an activity * 12:08 p.m. - located in the dining room for the noon meal The nursing staff failed to toilet/check and change Resident #17 after the breakfast meal, before/after an activity, or before the noon meal	F 677	record in point of care. Education will be initiated the week of November 4th and completed no later than November 18, 2019. The DON or designee will audit toileting worksheets for five residents per week. Audits will consist of validating worksheet is completed and information documented in the electronic medical record correlates with the worksheet. These audits will be initiated the week of November 18, 2019 and will be completed for twelve weeks. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations. The need for extending audits will be determined based on results of audits and review and recommendation of the Quality Assurance committee.	

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F 677	Continued From page 14 as stated in the resident's care plan. - Review of Resident #51's medical record occurred on 10/15/19. The quarterly minimum data set (MDS), dated 09/25/19, identified the resident required extensive assistance of two staff for toileting, and the resident was always incontinent of bowel. Observations on 10/15/19 showed Resident #51 seated in the wheelchair in the resident's room at the following times: * 9:48 a.m. - Odor of BM (bowel movement). The resident stated, "I am not taken to a toilet. They just change me," and indicated last changed that morning. * 10:20 a.m. - Odor of BM. A certified nurse assistant (CNA) (#4) provided a snack and left the room. * 10:48 a.m. - Odor of BM * 11:18 a.m. - Odor of BM. During an interview on 10/15/19 at 10:06 a.m., a family member (AA) confirmed Resident #51 smelled like BM. The nursing staff failed to provide incontinence care in a timely manner for Resident #51. During an interview on 10/17/19 at 3:50 p.m., an administrative nurse (#13) stated she expected staff to follow each resident's toileting schedule and/or check and change at routine toileting times, and then defined routine toileting as, "every two to three hours, before/after meals, and at bedtime."	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		11/24/19

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F 692	Continued From page 15 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and record review, the facility failed to adequately assess the nutritional needs to restore/maintain adequate nutritional status for 1 of 3 sampled residents (Resident #61) who received a tube feeding. Failure to meet residents' nutritional needs through diet (tube-feeding), supplements, or other interventions contributed to the resident's weight loss. Findings include: Review of the facility policy titled "WEIGHT PROGRAM" occurred on 10/17/19. This policy,	F 692	R 61 has remained on weekly weights with stability in weight noted since 10/15/2019 with most recent weight demonstrating a gain of 3.8 pounds. R 61 was reviewed by dietitian on 10/29/2019 with stable weight and slight gain noted no changes were deemed necessary in current tube feeding orders. Residents who receive enteral feedings and those who demonstrate weight loss or gain of 3 or more pounds have the potential to be impacted by this practice. Review of weights for those on enteral	

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F 692	Continued From page 16 dated January 2017, stated, ". . . Request reweighs on residents with weight change of 3 pounds or greater . . . Residents who are tube fed via an electric or battery powered pump should maintain a stable weight. If the resident losses 3 lbs [pounds] or greater OR gains 3 lbs or greater, the dietitian [RD] and nurse should complete a comprehensive assessment on the resident and the doctor needs to be notified as soon as possible . . ." Review of Resident #61's medical record occurred on all days of survey. The current physician orders, dated 09/24/19, stated, ". . . Isosource 1.5 Cal [tube-feeding]. . . Run over 15 hours at 78 ml [milliliters]/hour start at 1700 [5:00 p.m.] and end when total volume 1170 ml infused . . ." A nutrition risk assessment, dated 09/24/19, identified the following ". . . wasting noted in face, decrease fat and muscle mass noted. Current diet order NPO [nothing by mouth]. Current feeding Isosource HN [high calorie tube feeding] . . . does not meet estimated need . . . Risk for Malnutrition: low with tube feeding support . . . Nutritional Goal Summary: wt 180-190# [pounds] . . ." The current care plan stated, "Nutritional status I have abeen [sic] losing wt [weight] gradually. Refuses to be weighed swallowing problems I receive nutrition and hydration via tube feeding Increased need for healing . . ." Review of Resident #61's weights identified the following: * 09/23/19 - 182.0 lbs	F 692	feedings was completed by the RD on or before 11/01/2019. Weekly at risk meetings were updated the week of 11/04/2019 to ensure residents experiencing weight loss are reviewed by the IDT. This will be an ongoing process. The DON or designee will provide education by 11/24/2019 to nursing staff on the weight management program and the need to repeat weight if there is a 3 pound difference from the most recent weight. CNAs were educated on completing weights as assigned. Audits of weights on residents who receive tube feedings will be completed one time per week for twelve weeks, by the DON, Registered Dietician or designee. Audits will validate that weight changes of 3 or more pounds include notification of registered dietician, physician and responsible party if applicable. The results of these audits will be submitted to the Quality Assurance team for review and recommendations. The need for extending audits will be determined based on results of audits and on Quality Assurance review and recommendations.	

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F 692	Continued From page 17 * 10/01/19 - 175.6 lbs (failed to re-weigh and notify RD) * 10/07/19 - 176.8 lbs * 10/15/19 - 173.4 lbs (failed to re-weigh and notify RD) The weights identified a 4.8% weight loss in less than one month while receiving a tube-feeding. The facility failed to follow their policy regarding re-weighs, complete a comprehensive assessment, and notify the doctor as soon as possible. Failure to promptly re-evaluate Resident #61's nutritional status and adjust the tube feeding as needed resulted in continued weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 residents (Resident #24) observed with continuous oxygen and/or bi-level positive airway pressure (BiPAP) use. Failure to provide humidification and utilize correct oxygen liter flow may complicate the resident's respiratory status.	F 695	R 24 oxygen humidification system was checked by the DON upon learning that the container was empty. The container was refilled, and the oxygen liter flow was validated. The MAR/TAR was updated immediately to have nurses check humidifier bottle every six hours. Residents who use supplemental oxygen	11/24/19

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F 695	Continued From page 18 Findings include: Review of facility policy titled "Oxygen Administration" occurred on 10/17/19. This policy, dated June 2017, stated, ". . . PURPOSE: To deliver oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. . . . PROCEDURE: . . . 1. Check with physician's order for liter flow and method of administration . . . 3. . . . h. If a bubble-type humidifier is ordered/used fill it with sterile water. . . . 8. Precaution: Constant flow of oxygen can cause drying and thickening of normal secretions resulting in laryngeal ulceration [sores on the vocal cords]. . . . 10. At regular intervals, check liter flow contents [sic] of oxygen, fluid level in humidifier . . ." Review of Resident #24's medical record occurred on all days of survey. Diagnoses included obstructive sleep apnea (temporary stoppage of breathing during sleep), chronic obstructive pulmonary disease (COPD - constriction of airways resulting in difficulty in breathing), acute respiratory failure with hypoxia (deficient oxygen) and hypercapneia (excessive carbon dioxide in the blood stream), atelectasis (partial collapse of the lung), and dependence on supplemental oxygen. The current physician's orders showed, ". . . BiPap [a device that helps with breathing] at HS [bedtime] . . . with 4 LPM [liter per minute] oxygen bleed [delivery of oxygen with one end of oxygen tubing attached to the oxygen concentrator and the other end of the tubing attached to the BiPAP unit], every day and night shift for Sleep apnea . . . O2 [oxygen] at 3L [liters] per NC [nasal cannula]	F 695	have the potential to be impacted by this practice. An audit of residents currently residing in the facility was completed by Director of Clinical Services on November 1, 2019 to assure oxygen was on the correct setting. The MAR/TARs were updated if indicated to reflect the most current order for oxygen liter flow. Any new admissions requiring a humidifier bottle will be added to the MAR/TAR to be filled every six hours. Education was on going by the Regional Director of Education/designee from/ to November 5-24, 2019 on the oxygen policy and the need to assure proper setting to the nursing assistants and the nurses. Nurses are to check the settings every shift for all residents who receive oxygen. The DON or designee will complete direct observation audits three times weekly for 12 weeks, three residents will be reviewed to validate oxygen setting is correct and humidification bottles are filled if applicable. The results of these audits will by submitted to the Quality Assurance committee for review and recommendations. The need for extending audits will be determined based on results of audits and on Quality Assurance committee review and recommendations.	

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F 695	Continued From page 19	F 695		

every day and night shift for shortness of breath, COPD, respiratory failure . . . must wear nightly BIPAP during the day if napping. . . ."

The current care plan stated, ". . . Interventions . . . Administer oxygen per MD [physician] orders. While not on BIPAP have oxygen concentrator at 3 LPM . . . BIPAP per MD orders. While on BIPAP set oxygen concentrator at 4 LPM . . ."

Observations for Resident #24 showed the following:
* 10/15/19 at 9:53 a.m. - Laid in bed with nasal BiPAP on, with oxygen at 3 LPM (should be 4 LPM). The humidifier jar on the concentrator contained no water.
* 10/15/19 at 10:23 a.m. - Sat at the edge of the bed with nasal BiPAP on. The humidifier jar on the concentrator remained empty.
* 10/15/19 at 12:30 p.m. - Sat at the edge of the bed with nasal BiPAP on while eating. The humidifier jar on the concentrator remained empty and oxygen set at 3.5 LPM (should be 4 LPM).
* 10/15/19 at 4:57 p.m. - Rested in bed with nasal BiPAP on. The humidifier jar on the concentrator remained empty.
* 10/16/19 at 8:06 a.m. - Laid in bed watching television with nasal BiPAP on. The humidifier jar on the concentrator remained empty.
* 10/16/19 at 9:56 a.m. - Rested in bed with nasal BIPAP on. The humidifier jar on the concentrator remained empty and oxygen now set at 4 LPM (the correct setting)

During an interview on 10/16/19 at 5:25 p.m., an administrative nurse (#13) stated the facility does not have a policy on BIPAP use, and, "If the

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F 695	Continued From page 20 machine [BiPAP unit] has a reservoir they [facility staff] would fill it, rinse, drain, and clean it per standard of practice."	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on facility policy, and resident and staff interview, the facility failed to ensure the availability of sufficient nursing staff to promptly	F 725	R 36 was interviewed by the Executive Director on 11/6/2019 to review concerns with call lights. During meeting the ED	11/24/19

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F 725	Continued From page 21 respond to residents' needs for 5 of 9 confidential resident interviews (Resident C, E, F, G, and H) and 2 of 11 sampled residents (Resident #36 and #263) interviewed. Failure to provide sufficient staffing for assistance may result in residents experiencing falls and/or incontinence and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "Use of Call Light" occurred on 10/17/19. This policy, dated June 2017, stated, " . . . Answer ALL call lights promptly whether or not you are assigned to the resident. . . ." - During an interview on 10/15/19 at 3:37 p.m., Resident #36 stated regarding call lights, "I can have my call light on for up to two hours, especially when I want to go to bed." - During an interview on 10/16/19 at 8:12 a.m., Resident #263 stated regarding call lights, "Staff response time is so poor, it takes them 20-30 minutes easily. This happens almost every time I turn on the light, it takes that long." - During the resident group interview on 10/16/19 at 9:00 a.m., Resident C, E, F, G, and H (identified by the facility as interviewable) agreed they have to wait up to 30 minutes to an hour for their call lights to be answered, and staff frequently turn the call light off and take a long time to return. During an interview on 10/17/19 at 4:39 p.m., an administrative nurse (#1) stated she expected	F 725	discussed recent changes to include the implementation of temporary agency staff to provide additional assistance and the commitment of the facility leadership to successfully resolve this concern. R 263 is not currently in the facility. Residents have the potential to be negatively impacted by the practice. Additional incentives have been offered to staff to pick up shifts. Temporary use of agency staff has been implemented. Marketing strategies are being implemented to include attending job fairs and continuing to work with our corporate Human Resources office to review incentives and bonuses for both oncoming and existing staff members. The administrator or designee presented education on call light response to the interdisciplinary team on 11/6/2019. The DON or designee presented education to the nursing staff on call light response. Education included information on the expectation that staff from all departments will respond to call lights and that the call light will be left on and further assistance sought if the responding staff member cannot meet the resident's need. The Administrator or designee will complete call light audits and resident interviews three times weekly for twelve weeks to validate call light response times and improved customer satisfaction with call light response. The results of these audits will be submitted to the Quality	

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F 725	Continued From page 22 staff to answer call lights within 10 minutes or less.	F 725	Assurance committee for review and recommendation. Following the initial twelve weeks call light audits and resident interviews will be continued for a minimum of six months at a frequency recommended by the Quality Assurance committee following their review of the initial audits.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on information from the complainant, record review, review of professional reference, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 2 of 3 closed records reviewed (Resident #63 and #64). Failure of staff to administer medications as ordered may have a negative impact on a resident's health and quality of life. Findings include: Information provided by the complainant indicated the facility failed to administer medication as ordered by the physician. Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 760, stated, ". . . Parenteral Medications . . . intravenously (IV). Because these medications are absorbed more quickly than oral medications	F 760	The deficiency was found on two closed records and these residents no longer reside at the facility. This deficiency has the potential to affect other residents. The facility has implemented a process to check all New orders received daily by a second nurse, to assure they have been transcribed onto the Medication Administration Record or Treatment Administration Record this was completed on November 1, 2019. The Regional Director of Education, Director of Nursing and or designee provided education and competencies on Medication Errors, Medication Administration, Insulin, transcribing of orders, and physician/family notification, and process for order completion beginning on November 5, 2019.	11/24/19

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F 760	Continued From page 23 and are irretrievable once injected, the nurse must prepare and administer them carefully and accurately. . ." Page 791 stated, ". . . insulin a high-alert medication, meaning it can cause significant harm if used in error . . ." - Review of Resident #63's closed record occurred on 10/17/19. A nursing progress note, dated 07/01/2019 at 7:11 a.m., stated, ". . . This nurse was about to administer the Ceftriaxone [antibiotic] IV to this resident but found an empty bag of IV antibiotic Meropenem [treats a high risk infection] with tubing which was changed 06-30-19 with initials of [initials of nurse] on it, with a different resident's name [initials of resident]. This author immediately asked the patient how he felt. Patient is alert, no SOB [short of breath] noted, no s/s [signs and symptoms] of adverse reactions noted, vitals checked and WNLs [within normal limit], ambulatory, no changes in baseline. The IV bag and the tubing were removed, informed Supervisor, Director of Nursing and PCP [primary care physician] . . . Resident had NO KNOWN AILERGIES [sic]." During an interview on 10/17/19 at 4:15 p.m., an administrative nurse (#1) confirmed Resident #63 recieved another resident's IV medication. The facility failed to administer the proper medication and provided Resident #63 with a stronger antibiotic then needed for treatment. - Review of Resident #64's closed record occurred on 10/17/19. The nursing progress notes stated the following: * 12/4/2018 at 1:33 p.m. "This writer realizes pt [patient] was given incorrect patient's insulin at	F 760	Completion date is November 24, 2019. The Director of Nursing or designee will audit new orders three times weekly on three random residents by checking the chart order against the medication administration record or treatment administration record for accuracy, clarifications, insulin parameters, and review by second nurse. Audits will be completed for twelve weeks initially. The results of these audits will be submitted to the Quality Assurance team for review and recommendations. The need for extending audits will be determined based on results of audits and on Quality Assurance team review and recommendations.	

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F 760	Continued From page 24 1300 [1:00 p.m.] this shift. Pt received 5 units of Humalog at 1300 on top of her previously scheduled insulin (8 units Novolog) that was given at 1100 [11:00 a.m.] this shift. Pt BG [blood glucose] obtained and noted to be 253. Pt asymptomatic and resting in bed in no apparent distress. . . . Will continue to monitor." *12/4/2018 at 1:55 p.m. "Pt BG re-checked and is currently 254. Pt remains asymptomatic . . ." *12/4/2018 at 10:33 p.m. "Resident is on follow up for: Resident was given another resident's insulin after lunch. The current status is Resident has no signs or symptoms of hypoglycemia [low blood sugar]. Her blood sugars have been 123, 61, and 89. . . Resident was given pudding and orange juice for the glucose level of 61. Recheck was 119."	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/16/18. Based on observation, review of facility policy, and resident interviews, the facility failed to serve foods at palatable temperatures for 6 of 7 sampled residents (Resident #15, #34, #36, #57,	F 804	R 34, 15, 57, 60, and 36 were interviewed by the dietary manager by 11/07/2019 regarding concerns with meal temperatures. Reviewed with residents that meal service protocol will be changed. R263 is no longer at the facility.	11/24/19

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F 804	Continued From page 25 #60, and #263) who received meal trays in their rooms. Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Meal Distribution" occurred on 10/17/19. This policy, dated May 2014, stated, ". . . The Food Service Director will ensure that all food items are transported promptly for appropriate temperature maintenance . . . temperature maintenance will be used to point of service dining . . ." Interviews on 10/15/19 with residents who received meal trays in their rooms identified the following: * 10:54 a.m. - Resident #34 - The food is "not always hot." * 11:42 a.m. - Resident #15 - "Sometimes a tray will have only parts of it cold and other parts warm. A lot of the time vegetables are cold," and at 4:51 p.m., "The brussel sprouts and the chicken in my Alfredo were cool. The Alfredo noodles were warm but not hot" for the noon meal. * 11:57 a.m. - Resident #57 - "95% or more [of the time] it [the food] is cold," and at 12:32 p.m., "The brussel sprouts barely warm. Chicken Alfredo cool" for the noon meal. * 12:29 p.m. - Resident #60 - "Not real warm" for the noon meal. * 12:31 p.m. - Resident #263 - "A little warm" for the noon meal, and at 4:36 p.m., the food here is "lukewarm, not hot." * 3:38 p.m. - Resident #36 - The food is "not hot" when receiving a meal tray in the room.	F 804	Residents who prefer in room meal service have the potential to be affected by this practice. The facility has changed the room delivery process to include the use of an insulated meal tray cart for delivery to rooms. In room trays are plated at the end of the meal service and then delivered to resident rooms. This will ensure meals are delivered timely and while still palatable. This change in practice will begin or before 11/24/2019 The Dietary manager or designee educated dietary staff on this change in practice on 11/5/2019 and the DON or designee will educated nursing staff on this change in practice by 11/24/2019. The dietary manager or designee will complete weekly audits of three room trays at time of preparation and again at time they are served to validate foods have maintained temperature from the point of preparation to the point of service. These audits will continue for twelve weeks. The Administrator or designee will interview three residents weekly regarding their satisfaction with food temperatures. These audits will continue weekly for twelve weeks. Results of audits will be submitted to the Quality Assurance committee for review and recommendations. The continuation and frequency of audits will be modified based on results of audits and recommendations of the Quality Assurance committee.	

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F 804	Continued From page 26 The surveyors received a noon meal test tray from the 1st floor on 10/16/19 at approximately 12:19 p.m. The test tray consisted of sausage, potatoes, and green beans. Four of four surveyors confirmed the food failed to maintain a palatable temperature. The surveyors received a noon meal test tray from the 2nd floor on 10/16/19 at approximately 12:40 p.m. The test tray consisted of sausage, potatoes, and green beans. Four of five surveyors confirmed the food failed to maintain a palatable temperature. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804		
F 880 SS=E	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	F 880		11/24/19

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F 880	Continued From page 27 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 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	F 880		

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F 880	Continued From page 28 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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 08/16/18 AND THE COMPLAINT SURVEY COMPLETED ON 06/11/19. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 7 of 10 sampled residents (Residents #5, #12, #17, #27, #28, #34, and #264) and three supplemental residents (Resident #2, #10, and #38). Failure to follow infection control practices of hand hygiene (Resident #2, #5, #12, #17, and #28), cleaning of transfer equipment (Resident #10), Foley catheter bag placement (Resident #27 and #264), and handling of collection devices (Resident #27, #34, #38) has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 10/17/19. This undated policy stated, ". . . Standard and transmission-based precautions to	F 880	R 27 and 264 catheter bags were replaced on 10/26 and 11/3/2019 MAR/TAR updated in the include weekly change of collection bags. R 27, 34, and 38 received new collection devices on 10/26, 11/2, and 10/31. R 2, 5, 12, 17, and 28 had the potential to be impacted by staff non-compliance with hand hygiene. Staff education was provided regarding the need to complete hand hygiene between clean and dirty tasks and when removing and before donning new gloves. Residents with catheters, those who required the use of mechanical lifts, and those that receive assistance with peri care from staff have the potential to be impacted by this practice. Foley catheter bags have been changed for residents and have added to the MAR/TAR for weekly exchange of collection bags. Mechanical lifts have been disinfected and storage bags added to the mechanical lifts to ensure access to and compliance with use of disinfectant wipes	

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F 880	Continued From page 29 be followed to prevent the spread of infections. . . . Require that staff use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated. . . . Ensures that reusable equipment is appropriately cleaned, disinfected, or reprocessed . . ." HAND HYGIENE - Observation on 10/15/19 at 4:49 p.m. showed a certified nursing assistant (CNA) (#8) donned gloves and provided bowel incontinence care for Resident #2. The CNA (#8) cleansed the rectal area of BM (bowel movement), cleansed the frontal area and removed his/her gloves. Without performing hand hygiene the CNA applied a gait belt and transferred Resident #2 into the wheelchair. - Observation on 10/15/19 at 5:06 p.m. showed two CNAs (#8 and #9) donned gloves and provided bowel incontinence care for Resident #12. The CNA (#8) changed gloves and without performing hand hygiene removed the resident's pants, applied clean pants, applied a gait belt and transferred Resident #12 into the wheelchair. - Observation on 10/16/19 at 11:19 a.m. showed two CNAs (#6 and #7) donned gloves and provided bowel incontinence cares for Resident #5. The CNA (#7) changed gloves and without performing hand hygiene applied a clean brief and repositioned the resident in bed. - Observation on 10/16/19 at 11:39 a.m., showed two CNAs (#6 and #7) completed check and change for Resident #28. The CNA (#7) removed the soiled brief, cleaned incontinent BM with	F 880	following use. Hand hygiene checklists have been completed with direct care staff to ensure competency and understanding of how and when to complete hand hygiene. The DON or designee provided education to direct care staff on the infection control guidelines. Education included managing Foley collection bags, hand washing procedure including washing hands during and after peri-care, cleaning of urinals and graduate devices, and the washing of mechanical lifts between residents. Education was initiated by DON or designee beginning on November 5, 2019 and will be completed no later than November 24. 2019. The DON or designee will complete direct observation audits for compliance with handling of Foley bags, collection devices, hand hygiene, and disinfection of mechanical lifts three times weekly for twelve weeks. The results of these audits will be submitted to the QAPI team for review and recommendations. The need for extending audits will be determined based on results of audits and on QAPI review and recommendations.	

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disposable wipes, removed gloves, applied a clean pair of gloves, brushed Resident #28's hair, and put her glasses on. The CNA (#7) failed to complete hand hygiene between glove changes.

- Observation on 10/16/19 at 4:14 p.m., showed two CNAs (#9 and #12) completed a check and change for Resident #17. The CNA (#9) removed the wet brief, completed perineal cares, applied a clean brief, pulled the resident's pants up, placed a transfer sling under the resident, then removed the gloves. The CNA (#9) failed to complete hand hygiene after perineal cares and prior to the clean brief, resident pants and transfer sling applied.

DISINFECTING OF MECHANICAL LIFTS

- Observation on 10/16/19 at 8:52 a.m. and 11:22 a.m. showed a CNA (#4) transferred Resident #10 from the bathroom to the wheelchair using the mechanical stand lift. Following the transfer, the CNA (#4) placed the lift in the hallway and failed to disinfect the lift.

FOLEY CATHETER BAG PLACEMENT

- Observation on 10/16/19 at 9:13 a.m., showed two CNAs (#6 and #7) transferred Resident #27 from the wheelchair to the bed. The CNA (#6) secured the urine collection bag to right side of the bed frame. The urine collection bag rested directly on the floor. Observations at 9:40 a.m., 10:57 a.m., 2:49 p.m., and 3:35 p.m., showed Resident #27 in bed with the urine collection bag rested directly on the floor.

- Observation on 10/16/19 at 3:20 p.m. showed

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Resident #264 propelling the wheelchair throughout the facility with the urine collection bag placed in a pillow case and dragging on the floor.

COLLECTION DEVICES

- Observation on 10/15/19 at 10:51 a.m., showed a CNA (#10) emptied Resident #27's urine collection bag. The CNA drained the urine from the bag into a graduate container, emptied the graduate container into the toilet, and placed the container on the bathroom shelf. The CNA failed to rinse the container before storing it on the shelf.

- Observation on 10/15/19 at 4:28 p.m. showed a CNA (#9) emptied Resident #34's urine collection bag into a urinal. After emptying the urinal, the CNA (#9) failed to rinse the urinal with water.

- Observation on 10/15/19 at 5:04 p.m., showed a CNA (#11) emptied Resident #38's urinal. The CNA emptied the urinal containing urine into the toilet and hung the empty urinal container on the grab bar in the resident's bathroom. The CNA failed to rinse the container before hanging it on the grab bar.

- Observation on 10/15/19 at 5:20 p.m., showed a CNA (#11) emptied Resident #27's urine collection bag. The CNA drained the urine from the bag into a graduate container, emptied the graduate container into the toilet, and placed the container on the bathroom shelf. The CNA failed to rinse the container before storing it on the shelf.

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F 880	Continued From page 32 During an interview on 10/17/19 at 3:50 p.m., an administrative nurse (#13) stated she expected staff to complete hand hygiene upon entering and exiting resident rooms and between glove changes. The administrative nurse (#13) verified mechanical lifts should be disinfected between resident use, urine collection bags should be kept off the floor in a privacy bag below the level of the bladder, and urine collection equipment should be rinsed after each use to prevent odor and infection.	F 880		