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	355031	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/09/17 and completed on 01/12/17, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		2/16/17

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

Electronically Signed | 02/09/2017

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure timely notification of family members for 2 of 14 sampled residents (Resident #7 and #10) who experienced a change. Failure to notify a residents' family of a fall with a head injury (Resident #7) and a room change (Resident #10) limited the family members ability to make an informed decision regarding the resident's care and may affect the residents quality of life. Findings included: Review of the facility policy "Transfer, Room to Room," occurred on 01/12/17. The policy, dated 09/12, stated, ". . . 3. Prior to the room transfer,	F 157	Notifications were completed for Resident #7 on 09/06/16 for the fall that occurred on 08/31/16. Notifications and the concern process were followed for resident #10 on January 2, 2017 for the room move that occurred on January 1, 2017. Residents who experience a fall or a change in their room assignment have the potential to be impacted by lack of timely notification of changes to their family or responsible party. These residents are currently being tracked and notifications are being validated on a daily basis. Residents who experience a change in	

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F 157	Continued From page 2 the resident, his or her roommate (if any), and the resident's representative (sponsor) will be provided with information concerning the decision to make the room transfer. . . . 6. Documentation of a room transfer is recorded in the resident's medical record. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease. Resident #7's nursing progress notes identified the following: * 08/31/16 5:44 a.m. "Resident was found on floor next to bed in her room by a CNA [certified nursing assistant]. . . . Resident is noted to have a golf ball size hematoma to R) [right] forehead. Ice applied. . . . Neuro [neurological] checks initiated at time of fall et [and] completed per facility protocol. . . . Will have oncoming shift notify resident contact of incident. * 09/06/16 4:39 p.m. "Contacted son . . . Son voices concern and questions if resident was hit in the face as they had someone here yesterday and she had bruises on her face. Explained that these bruises occurred when she fell out of bed on 08/31 . . ." * 09/06/16 5:11 p.m. Attempted to contact daughter, [name], to update on events and validate she was made aware of fall on 08/31/16. No answer . . ." Resident #7's medical record lacked evidence facility staff notified Resident #7's family on 08/31/16 of the fall. During an interview on 01/12/17 at 12:15 p.m. an administrative nurse (#2) stated the facility did	F 157	condition could also be impacted by a lack of timely notification of changes. These residents have been and are currently reviewed during the interdisciplinary meetings held each weekday as part of the facility QA process and notifications are validated and tracked through this process. Residents who experience falls or have a change in room assignments have been added to this review process as well. The DON or designee has or will be presenting education to licensed nurses regarding the timely notification of families or responsible party of falls or changes in room assignment including temporary reassignments. Educational sessions were or will be held on February 7,8, and 9. Supplemental education was or will be provided using the article from the Winter 2017 edition of Long Term Care Highlights regarding detecting and reporting changes in condition during these same meetings. Daily validation of notifications will be completed as outlined. In addition to this the DON or designee will audit five notifications of family or significant others for like residents weekly for eight weeks, then twice weekly for eight weeks, and then complete five random audits monthly for two months. Audits were initiated the week of January 23, 2017.	

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F 157	Continued From page 3	F 157		

not have a policy on calling the family regarding a resident's change in condition as this would be a standard of practice.

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included severe chronic obstructive pulmonary disease, dementia and anxiety.

Progress notes, dated 12/15/16 at 5:00 p.m., stated the resident "Returned from outing with family." The next entry in the progress notes occurred on 01/09/17 at 4:44 p.m. which stated, "Follow up with son regarding temporary room move completed on January 1st [Sunday] and discussed through concern process on 01-02-17 with son. At that time son was informed the heating repair would be completed by January 12th and that consideration would be made to return [resident] to his room once repair was completed. . . ."

A "RESIDENT CONCERN FORM" identified the resident's son addressed this concern with a supervisory nurse (#5) on 01/02/17 or 01/03/17 (illegible). The son "Expressed concern that [resident] was moved from his previous room (due to non-functioning heater) and no one notified his family. Questions if he would be moved back to his former room when heat is fixed." The follow-up, dated 01/03/17, stated "Explained to [son] a meeting will be held on 01-03-17. Explained that moving him back to his former room after heat [sic] is fixed may not be in [resident's] best interest. Will f/u [follow-up] once heat [sic] is repaired." The concern form stated, in relation to "RESOLUTION OF CONCERN" "IDT [interdisciplinary team] undecided regarding

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F 157	Continued From page 4 transferring back to old room as heating unit repair has been delayed. Will monitor for changes in mood/behavior." During interview on the morning of 01/12/17, a supervisory nurse (#5) stated nursing staff are expected to notify the family of a room change. The facility failed to inform a family member of Resident #10's room change. With the resident's medical diagnoses, the change could have affected the resident's anxiety level and increased confusion. The facility recognized the need to monitor the resident for a change in the resident's mood/behavior. Failure to notify the family does not allow them to provide support the resident may have needed due to the change.	F 157		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accommodate the dining needs during 3 of 5 meals observed for a resident (Resident #3) requiring a wheelchair tray table. Failure to place the left arm tray table on the resident's wheelchair during meals did not allow the resident easy access to her food. Findings include: Review of Resident #3's medical record occurred	F 246	Resident #3 is provided with the left arm tray and this is offered at meals. She has been using this device most of the time during meals but does refuse the use of the tray at times. Staff have been instructed to document refusals. Residents who require adaptive devices to assist with meal intake have the potential to be impacted by this practice. These residents were identified through	2/16/17

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F 246	Continued From page 5 on all days of survey. Diagnoses included Parkinson's disease, scoliosis, and a history of a stroke. A significant change Minimum Data Set, dated 11/01/16, identified limited assist of one person for eating and extensive assist for all activities of daily living. The current care plan stated, ". . . variable meal intakes . . . Adaptive equipment food in bowls . . . Plate on arm rest for indepandence [sic]." Observation on 01/10/17 from 8:13 a.m. to 8:55 a.m. showed Resident #3 seated at the dining room table in her wheelchair, her upper body leaning over the left side of the wheelchair, and no left arm rest tray in place. The cereal, eggs, ham, and coffee cake had been placed in individual bowls on the table. The resident's arm rest tray was located in the back pocket of her wheelchair. During this time, the resident used a spoon to eat a few bites of the cereal. A staff member (#3) asked the resident twice if she needed anything to which the resident stated no. At 9:00 a.m. staff placed the left arm rest tray on the wheelchair and propelled the resident back to her room. Observation on 01/11/17 from 8:15 a.m. to 8:42 a.m. showed Resident #3 seated at the dining room table with her upper body leaning over the left side of the wheelchair, and no arm rest tray in place. On the table in front of the resident was a bowl of cereal and a plate containing scrambled eggs and sausage. A staff member (#4) fed the resident a few bites of food and then the resident attempted to feed herself a few bites of food. When the resident was finished, the staff member propelled the resident, still leaning over the left side of the wheelchair, out into the hallway.	F 246	the dietary report for adaptive equipment and Kardexes were or will be reviewed to ensure the information is included on the Kardex. The DON or designee has or will be providing education to licensed nurses and CNAs on ensuring adaptive equipment is available and used for residents as care planned. The DON or designee has or will be educating licensed nurses and CNAs on the need to document refusals of adaptive equipment. Education was or will be provided on February 7, 8, and 9. The DON or designee will complete audits to validate the use of adaptive equipment and/or documentation of refusal through direct observation of five residents for eight weeks then two residents weekly for eight weeks and then five residents monthly for two months. Results of audits will be forwarded to the QAPI committee for review and recommendations. Audits were initiated the week of January 23, 2017	

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F 246	Continued From page 6 Observation on the morning of 01/12/17 showed Resident #3 seated in her wheelchair in her room with breakfast items placed on an over-the-bed tray table. This tray table sat high enough that the resident had to reach up to grab a bowl of food. Observations on 01/10/17 at 12:20 p.m. and on 01/11/17 at 12:36 p.m. showed Resident #3 seated at the dining room table in her wheelchair with the arm rest tray in place. The resident grabbed each bowl/plate/glass from the table, placed it on the arm rest tray, and fed herself. Staff failed to consistently place the resident's arm rest tray during meals to accommodate the resident's left-sided weakness. During an interview on 01/12/17 at 10:40 a.m., an administrative staff member (5) agreed staff should consistently encourage usage of the arm rest tray during all meals.	F 246		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 280		2/16/17

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F 280	Continued From page 7 amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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.	F 280		

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F 280	Continued From page 8 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 1 of 14 sampled residents (Resident #3). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for residents. Findings include: Review of the facility's policy titled "Care	F 280	Resident #3's care plan was updated on 01/11/17 and the use of the recliner for sleep was resolved. Further review and updates if needed were completed on 01/16/17. Residents who experience changes in the level of care and services due to declines following an illness, injury, or hospitalization or due to improvements in overall status have the potential to be negatively impacted by this practice.	

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F 280	Continued From page 9 planning" occurred on 01/12/17. This undated policy stated, "The facility will use the results of a resident's assessments to develop, review and revise a resident comprehensive care plan. . . . The care plan describes those services furnished for the resident to attain or maintain the individual resident's highest practical physical, mental and psychosocial wellbeing. . . . The care plan will be updated and revised as needed per individual resident changes. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included left hip fracture, pressure ulcers, stroke, Parkinson's disease, and scoliosis. The current care plan stated, ". . . Transfer with two assist with gait belt; weight bearing as tolerated . . . provide assistance with toileting . . . use absorbant [sic] products as needed . . . use pillows/positioning devices as needed . . . Resident prefers to sleep in her recliner for comfort and does not use her bed for sleep at this time. . . ." Observations during survey showed the following: * 01/10/17 at 9:40 a.m. - Resident toileted in her bathroom with assist of two certified nurse aides (CNA) (#6 and #7). A small positioning pillow was located on the left side of wheelchair seat. * 01/10/17 at 11:42 a.m. - Resident toileted in her bathroom with assist of two CNAs (#6 and #7) who removed the pillow and failed to replace it when transferring the resident back into the wheelchair. * 01/10/17 at 3:42 p.m. - A CNA (#9) moved the commode chair from over the toilet in the	F 280	These residents were identified through interdisciplinary review and/or review of census for hospitalization and return entries. Care plan updates for these residents were made if indicated and are validated through the interdisciplinary meetings held as part of the facility's QA process. This update process has been modified to ensure that items that are no longer relevant to the resident's care are removed from the care plan. The DON provided education on February 3,2017 to the interdisciplinary team regarding care plan updates when changes in status are noted and on reviewing these during the interdisciplinary meeting. The DON or designee provided or will provide education to licensed nurses regarding care plan updates with changes in care needs during post survey education sessions held on February 7,8, and 9. The DON or designee will audit care plans for five residents with changes in status weekly for eight weeks, then for two residents weekly for eight weeks, and then for five residents monthly for two months. Results of audits will be forwarded to the facility QAPI committee for review and recommendations. Audits were initiated the week of January 23, 2017	

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F 280	Continued From page 10	F 280		

bathroom to the resident's bedside. The CNA placed a bedpan on the commode chair instead of the proper fitting device (a bucket that slides in place under the lid of the commode seat).
* 01/11/17 at 9:40 a.m. - Two CNAs (#3 and #6) toileted the resident in her bathroom. A clean pull-up brief was not available, so the CNA (#6) took an incontinence product (not a pull-up brief) from the roommate's closet. The CNAs did not offer to place the pillow in the resident's wheelchair.
* During all days of survey staff did not place the resident in the recliner. The recliner remained full of the resident's various personal items.

The care plan and the CNA's care guide failed to address the resident's current care needs regarding how/where staff should toilet the resident, type of incontinence product to use, when and how the pillow should be used for wheelchair positioning, and that the resident sleeps in her bed, not the recliner.

During an interview on 01/11/17 at 10:15 a.m., a CNA (#3) stated Resident #3 uses incontinence products with tape closures not pull-up briefs and is always toileted in the bathroom.

During an interview on 01/12/17 at 10:40 a.m., an administrative staff member (#5) agreed the care plan does not reflect the resident's current care:
* Resident #3 can now use the bathroom not a bedside commode. Staff failed to use the proper device when using the commode. Staff should place a bucket that slides under the commode and not use a bedpan
* The resident uses a pull-up brief. Staff should not use the roommate's incontinence products

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F 280	Continued From page 11 * The pillow belongs to the resident and she can decide when to use it * Since the resident's hip fracture (10/21/16), she sleeps in her bed, not the recliner.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure necessary care and services for 2 of 6 sampled residents (Resident	F 309	Residents #9 and #11 did not develop any complications related to this practice. Verbal review of survey results was completed the day of exit for each shift	2/16/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 #9 and #11) observed receiving fluids. Failure to ensure proper positioning for fluid intake has the potential to affect the residents' overall swallow safety, putting them at risk for aspiration pneumonia. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, page 125 stated, ". . . During the oral intake of . . . liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . ." - Review of Resident #11's medical record occurred on January 11-12, 2017. Diagnoses included dysphagia and muscle weakness. Observation on 01/11/17 at 4:15 p.m. showed two certified nursing assistants (CNAs) (#12 and #13) completed cares for Resident #11 and provided the resident a drink of water with the head of the bed at approximately a 30 degree angle. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia and history of a cerebrovascular accident. During observation on 01/10/17 between 8:52 a.m. and 9:00 a.m., a CNA (#6) provided Resident #9 a drink of water after transferring the resident into bed. The CNA provided the water while the head of the bed was elevated at approximately a 30 degree angle.	F 309	and staff were reminded of the need to either offer drinks when the resident was seated in the chair or elevate the head of the bed to 90 degrees. Residents residing in the facility have the potential to be negatively impacted by this practice. Staff were verbally reminded following survey that when offering fluids residents must be properly positioned. The DON or designee provided or will provide education to licensed nurses and CNAs on the need to properly position residents when offering fluids. Written education and review was or will be provided during post survey educational sessions on February 7,8, and 9. The DON or designee will complete audits through direct observation of cares being provided to five residents weekly for eight weeks then two residents weekly for eight weeks and then five residents monthly for two months. Results of audits will be forwarded to the facility's QAPI committee for review and recommendations. Audits were initiated the week of January 23, 2017.	

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F 309	Continued From page 13 During interview on the morning of 01/12/17, a supervisory staff member (#5) stated she would expect staff not to provide residents fluids while reclined in bed. Failure to elevate Resident #9's and Resident #11's head of bed to an approximate 90 degree angle prior to offering liquids places those residents at risk of aspiration.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (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 record review and staff interview, the facility failed to provide the necessary care and services to prevent the worsening of current or development of new pressure ulcers for 1 of 2 sampled residents (Resident #3) receiving treatment for pressure ulcers. Failure to place a dressing on a pressure ulcer and apply Prevalon	F 314	Resident #3 continues to receive wound care as scheduled. Her wounds continue to progress towards healing and she has not developed new areas of skin breakdown. Staff have been instructed to ensure wound is covered with a dressing prior to applying incontinence products.	2/16/17

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F 314	Continued From page 14 boots has the potential of increasing the healing time and developing new pressure ulcers. Findings include: Review of Resident #3's medical record occurred during all days of survey. Diagnoses included a left hip fracture, Parkinson's disease, scoliosis, and pressure ulcers. The current care plan stated, ". . . At risk for complications r/t [related to] fracture (left hip . . . Initiated:10/25/16 . . . Prevalon boots bilaterally . . . Float heels as able, heel lift boots placed upon return from hospital . . . has suspected deep tissue injury to sacral area. . . ." Review of Resident #3's progress notes showed the following: * 10/28/16 - ". . . Recent hospital stay for surgical repair of hip fracture. Returned from hospital with unstageable wound to sacral area and a large blister to her left heel . . . Blister to heel remains intact and measures 3 cm [centimeters] x [by] 2 cm . . . Heel lift (prevalon) boots were implemented upon return form [sic] hospital. . . ." 01/10/17 - Sacrum pressure ulcer ". . . Previous wound dressing had been removed and was not observed by this staff. Wound continues to have yellow/green slough and wound base is not visible, nurses have reported moderate exudate to foam dressing . . . Continue with tender wet dressing and change daily. . . ." Review of Resident #3's Treatment Administration Record for January 2017 showed Prevalon boots on at all times bilaterally while in bed. Review of the resident's physician's order review for December 2016 showed the heel	F 314	Resident #3 is offered Prevalon boots and has been noted to frequently refuse the use of Prevalon boots. Her physician was updated and changed the order for Prevalon boots to PRN as resident tolerates. Her care plan has been updated to include offering the boots or floating heels as permitted by the resident. Residents with pressure related skin breakdown and those who require the use of Prevalon boots have the potential to be impacted by this practice. These residents were identified through record review or direct observation. Treatment orders, preventive measures and availability of preventive measures were validated for these residents. The DON or designee provided or will provide education to licensed nurses and CNAs on offering and applying preventive measures as ordered or care planned, documenting refusals and alerting the nurse, and on ensuring wounds have protective dressings in place as ordered. Post survey education sessions were or will be held on February 7,8 and 9. The DON or designee will complete direct observation of wound care and/or use of preventive measures. These audits will be completed for five residents weekly for eight weeks, two residents weekly for eight weeks, and five residents monthly for two months. Results of audits will be forwarded to the QAPI committee for	

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F 314	Continued From page 15 blister as healed. Observations on 01/10/17 showed the following: * 9:10 a.m. - Two certified nurse aides (CNA) (#6 and #7) toileted the resident in her bathroom and noted the sacral dressing had started to peel off. After the CNAs completed incontinence cares, they transferred the resident back to the wheelchair and into bed. The CNAs failed to put the Prevalon boots on. * 10:25 a.m. - Two CNAs (#6 and #7) toileted the resident in her bathroom and called the nurse to show the partially adhered sacral dressing. The nurse (#14) removed the old dressing but was unable to find a new dressing. Without a dressing in place, the CNAs completed incontinence cares, transferred her into her wheelchair, and propelled her to an activity. * 11:40 a.m. - Two CNAs (#4 and #6) toileted the resident in her bathroom. No dressing covered the sacral pressure ulcer, and one CNA (#6) stated, "It [pressure ulcer] has been without out it [dressing] before." The resident's brief was dry. The CNAs transferred the resident to the wheelchair and into bed. * 11:55 a.m. - New dressing applied by nurses (#14 and #5). Staff failed to put Prevalon boots on resident while in bed and failed to cover an unstageable draining pressure ulcer to provide protection from incontinence. During an interview on 01/12/17 at 10:40 a.m., an administrative staff member (#5) agreed the nurse should have covered the pressure ulcer with a protective covering in case of incontinence. The staff member stated the	F 314	review and recommendations. Audits were initiated the week of January 23, 2017.	

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F 314	Continued From page 16 resident sometimes refuses the Prevalon boots, but staff should always offer to put them on.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate	F 315		2/16/17

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F 315	Continued From page 17 treatment and services to restore as much normal bowel function as possible. 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 appropriate perineal cares for 1 of 5 sampled residents (Resident #9) observed during personal cares and with a history of a urinary tract infection (UTI). Failure to provide appropriate perineal cares may result in urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Incontinence Care" occurred on 01/11/17. This policy, revised 10/10, stated, "Purpose: The purposes of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . . . Preparation: . . . provided incontinence care with every change of brief. . . . Steps in the Procedure . . . Cleanses from front to back a. Female: Separate labia with one hand and cleanse the area with downward: Strokes . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia and history of UTIs. An annual Minimum Data Set (MDS), dated 11/07/16, and a quarterly MDS, dated 04/10/16, identified extensive assistance of one person with toileting and personal hygiene, and frequently incontinent of urine. The record identified the resident treated for a UTI in June, July and September of 2016. The organism identified for each UTI included group B beta hemolytic streptococci (June 2016),	F 315	Resident #9 has not developed s/s of UTI since survey exit on 01/12/17. Survey results were reviewed following survey exit with each shift and staff were verbally educated on the need to provide perineal care to residents correctly to reduce the risk for UTIs. Residents who require assistance with perineal care have the potential to be impacted by this practice. Education will be provided to caregivers on perineal care. The DON or designee has provided or will provide education to licensed nurses and CNAs on providing perineal care to residents including the risk of infection if care is not provided correctly. Post survey education sessions were or will be held on February 7,8, and 9. The DON or designee will complete direct observation audits of perineal care five times weekly for eight weeks, then two times weekly for eight weeks, and then five times monthly for two months. Results of audits will be submitted to the QAPI committee for review and recommendations. Audits were initiated the week of February 6, 2017.	

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F 315	Continued From page 18	F 315		

enterobacter aerogenes and escherichia coli (July 2016), and escherichia coli, resistant strain, and group B beta hemolytic streptococci (September 2016).

Observation on 01/10/17 at 8:52 a.m. showed Resident #9 urinated and had a bowel movement while seated on the toilet. Observation showed the resident wearing an incontinence brief (attends) and soiled on the front portion of the brief. A certified nursing assistant (CNA) #20 removed the brief, provided perineal cares to the posterior perineal area only and no frontal perineal care, and placed a new brief. Following the observation, the CNA stated the soiling in the brief "must of been from before" and stated it looked like "discharge."

During observation on 01/11/17 at 9:15 a.m. a CNA (#3), provided perineal cares for Resident #9 after toileting. The CNA performed frontal pericares with a back to front motion/stroke, then performed perineal cares to the rectal area, both completed utilizing toilet tissue. After providing the cares, the CNA noticed the resident's brief soiled with loose bowel movement on the back half of the brief. The CNA removed the brief, obtained a new brief, and repeated perineal cares to the rectal area and provided no frontal pericare. Upon placing the new brief, observation showed liquid stool running down the resident's left inner thigh. The CNA, utilizing an incontinence wipe, cleaned the stool off the inside of the resident's leg with the brief in place. Upon informing the CNA the stool may have leaked into the brief, the CNA pulled the brief down, and utilizing toilet tissue, wiped the rectal area.

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F 315	Continued From page 19 Failure to provide appropriate perineal cares may result in a UTI for Resident #9.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 2 of 8 sampled residents (Resident #7 and #8) and one supplemental resident (Resident	F 323	Resident #7, #8, and #18 did not experience adverse outcomes related to the improper use of a gait belt. Results of survey were reviewed with staff following survey exit and staff were reminded to	2/16/17

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F 323	Continued From page 20 #18) who required assistance with transfers using a gait belt. Failure to use gait belts properly during transfers placed the residents at risk of accidents and injury. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, muscle weakness, difficulty in walking and fracture of pelvis. The current care plan stated, " . . . At risk for complications due to muscloskeletal problems r/t [related to] fracture right pelvic fracture. . . . Provide assistive devices two assist and gait belt for all transfers. . . ." Observation on 01/10/17 at 11:40 a.m. showed two certified nursing assistants (CNAs) (#3 and #7) assisted Resident #7 onto the toilet. After applying a gait belt the CNA (#7) placed one hand on the gait belt and her arm under Resident #7's axilla. The CNA (#7) lifted with the gait belt and under the axilla area to assist the resident to a standing position. Observation on 01/11/17 at 9:15 a.m. showed two CNAs (#6 and #11) assisted Resident #7 onto and off the toilet. The CNA (#11) assisted the resident using the gait belt with one hand and her arm under Resident #7's axilla. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included muscle weakness and osteoporosis. The current care plan stated, ". . . ADL [activity of daily living] Self care deficit as evidenced by weakness . . . Transfer with 1 assist and gaitbelt.	F 323	grasp the gait belt and to avoid grasping the resident's clothing, extremities or other areas during transfers. Residents who transfer with the use a gait belt have the potential to be impacted by this practice. A review of current residents was completed to identify those that are transferred with a gait belt. A gait belt skills checklist was developed and will be used to validate skills with CNAs. The DON or designee provided or will provide education on the proper application and use of gait belts to licensed nurses and CNAs during post survey education sessions held on February 7,8, and 9. Education included methods to support the resident without grasping their clothing or extremities. The DON or designee will observe five transfers weekly for eight weeks, then two transfers weekly for eight weeks, then five transfers monthly for two months. Audits were initiated the week of January 23, 2107.	

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F 323	Continued From page 21 Observation on 01/10/17 at 11:16 showed two CNAs (#4 and #10) transferred Resident #8 from the wheelchair onto the toilet. After applying a gait belt the CNA (#10) lifted under the resident's axilla causing the resident's shoulder to pull upward. Both CNAs (#4 and #10) assisted the resident off the toilet and into the wheelchair. One CNA (#4) lifted under Resident #8's left axilla. The other CNA (#10) lifted under the resident's right axilla as they assisted Resident #8 into bed. - A random observation on 01/10/17 at 8:38 a.m. showed a CNA (#17) transferred Resident #18 from the dining room chair to her wheelchair. The CNA (#17) applied a gaitbelt around Resident #18's waist and lifted under the resident's axilla as the resident attempted to stand. The resident sat back down in the dining room chair. The CNA then held onto the gaitbelt and Resident #18's pants and transferred the resident to her wheelchair. During an interview on 01/12/17 at 11:00 a.m. a supervisory nurse (#5) stated she expected staff to not lift under residents arms.	F 323		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (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-	F 327		2/16/17

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F 327	Continued From page 22 (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/04/16. Based on observation, record review, and staff interview, the facility staff failed to offer fluids to 1 of 5 sampled residents (Resident #7) dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration and urinary tract infections. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease and history of a urinary tract infection. The significant change Minimum Data Set, dated 12/08/16, identified short and long-term memory loss and extensive assistance for eating. The physicians orders, dated 12/27/16, identified nectar thick liquids. The current care plan stated, " . . . Focus: At risk for nutritional status change r/t [related to] poor intakes . . . Interventions: Encourage and assist as needed to consume foods and/or supplements and fluids offered. . . . Provide Nectar thick liquids. . . ." Observations identified the following: * 01/09/17 at 3:30 p.m. - Two certified nursing assistants (CNAs) (#4 and #11) assisted the resident on and off of the toilet. The CNA (#4) stated, there is no water. The resident wheeled herself out of the room propelling her wheelchair	F 327	Resident #7 now has thickened liquids available at bedside and staff have been instructed to offer these with cares. Residents who require thickened liquids have the potential to be impacted by this practice. These residents have been identified through record review and also receive thickened liquids at bedside. Thickened liquids have been added to the cart used to pass ice water and staff provide the liquids during routine ice water passes. The DON or designee provided or will provide education to licensed nurses and CNAs on February 7,8, and 9 regarding hydration for residents on thickened liquids. The DON or designee will complete direct observation audits of the availability and assistance with intake of thickened fluids during cares. Audits will be completed five times weekly for eight weeks, twice weekly for eight weeks then five times monthly for two months. Results of audits will be forwarded to the facility QAPI committee for review and recommendations. Audits were initiated the week of January 23, 2107.	

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F 327	Continued From page 23 with her feet. The CNA (#10) stopped the resident in the hallway and gave her a few bites of a magic cup (fortified snack). The staff failed to offer Resident #7 fluids during cares. * 01/10/17 at 11:40 a.m. - Two CNAs (#3 and #7) assisted the resident on and off of the toilet. The staff failed to offer Resident #7 fluids during cares. * 01/11/17 at 3:50 p.m. and 01/12/17 at 8:20 a.m. identified no thickened water at the resident's bedside. During an interview on 01/12/17 at 11:00 a.m. a supervisory nurse (#5) stated she expected staff to offer water with cares and to keep thickened water at Resident #7's bedside.	F 327		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in	F 329		2/16/17

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F 329	Continued From page 24 paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 8 of 14 sampled residents (Resident #1, #2, #3, #4, #11, #12, #13, and #14) who received as needed medications (PRN). Failure to determine indications for use of a medication, provide non-pharmacological interventions prior to medication administration, and failure to monitor the effectiveness of the medication placed residents at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "PHARMACY SERVICES CONTROLLED MEDICATIONS" occurred on 01/12/17. This policy, revised April 2014, stated, ". . . C. When a controlled medication is administered, the licensed nurse or licensed medication aid . . . administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature/initial of the nurse or medication aid administering the dose. . . ." Review of the facility policy titled "Behavioral Assessment, Intervention and Monitoring" occurred on 01/12/17. This policy, revised March 2015, stated, ". . . Management . . . 10. When medications are prescribed for behavioral	F 329	Resident #1,#2, #3,#4, #11,#12, #13 and #14 were reviewed. Medications that are given routinely but ordered PRN were identified and requests to schedule medications were sent. The interdisciplinary team identified approaches to help manage anxiety for resident #14 and updated the care plan. Resident #13 has received education on sleep management and is being assisted with completing a seven day sleep diary and will have sleep patterns recorded for one week. Residents who receive PRN medications for pain or anxiety have the potential to be impacted by this practice. A system to flag MARs to alert nurses of the need to complete follow up documentation on PRN medications has been implemented on each nursing unit. Comfort containers were placed on each nursing unit with a supply of aromatherapy lotion, coloring books, hand held games and crossword books to provide distraction or reduce anxiety. The DON or designee has provided or will provide education to nursing staff on the use of the comfort boxes and the importance of attempting non-pharmacological approaches to manage anxiety or enhance pain management. The DON or designee has provided or will provide education to	

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F 329	Continued From page 25 symptoms, documentation will include: a. Rationale for use . . . h. Monitoring for efficacy and adverse consequences . . ." Review of the facility policy titled "Documentation of Medication Administration" occurred on 01/12/17. This policy, revised April 2007, stated, ". . . 3. Documentation must include, as a minimum . . . g. Resident response to the medication, if applicable (e.g. [example given], PRN, pain medication, etc.)." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included quadriplegia, autonomic dysreflexia (sudden onset of excessively high blood pressure, more common in people with spinal cord injuries), and anxiety. The annual Minimum Data Set (MDS), dated 12/07/16, identified intact cognition. Physician's orders included Dilaudid (narcotic pain medication) 4 milligrams (mg) every four hours PRN for pain or chills and Ativan (antianxiety medication) 1 mg every six hours PRN for anxiety. The current care plan stated "Focus: The resident uses . . . anti-anxiety medication . . . Interventions/Tasks . . . Monitor/document/report PRN adverse reactions to medications. . . . Focus: at risk for pain . . . r/t [related to]: disease process, impaired mobility . . . Interventions/Tasks: Administer pain medication per MD [medical doctor] orders . . . Focus . . . At risk for autonomic dysreflexia. Interventions/Tasks . . . Monitor VITAL SIGNS PRN. Notify MD of significant abnormalities. Observe for Sweating, Shaking, and changes in VS [vital signs.] . . ." Review of Resident #4's MARs for December 21,	F 329	licensed nurses regarding the system to flag MARs, complete documentation in the narcotic log, the resident MAR, and PRN medication log. Education was or will be provided during post survey education meetings held on February 7,8, and 9. The DON or designee will complete audits five times weekly for eight weeks, twice weekly for eight weeks, and weekly for eight weeks to validate PRN medications are documented and include indications for use, response to medication, and that non-pharmacological interventions are attempted prior to use of anti-anxiety medications. Results of audits will be forwarded to the facility's QAPI committee for review and recommendations. Audits were initiated the week of February 6, 2017	

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F 329	Continued From page 26 2016 through January 11, 2017 identified the following: * On 60 occasions staff administered PRN Dilaudid. On 31 occasions staff failed to determine indication for use and on 35 occasions staff failed to assess the efficacy of the medication. * On 19 occasions staff administered PRN Ativan. On ten occasions staff failed to determine indication for use and on twelve occasions staff failed to assess the efficacy of the medication. Review of Resident #4's "CONTROLLED SUBSTANCE RECORD" showed staff signed off 10 doses of PRN Dilaudid and failed to document the administration on the MAR. Facility staff failed to determine indication for use and assess the efficacy of the medication. - Review of Resident #14's medical record occurred on 01/12/17. Diagnoses included anxiety. The annual MDS, dated 12/10/16, identified moderate impaired cognition. Physician's orders included Ativan 0.25 mg twice a day PRN for muscle spasm or anxiety and Ibuprofen 400 mg every four hours PRN for pain. The current care plan stated "Focus: The resident struggles with anxiety r/t financial concerns, unable to sleep at night. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Provide emotional support through one on one interaction. Involve family as able to provide emotional support and assistance with stressors. . . ." Review of Resident #14's MARs for December 21, 2016 through January 11, 2017 identified the	F 329		

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following:
* On 14 occasions staff administered PRN Ibuprofen. On four occasions staff failed to determine indication for use and on six occasions staff failed to assess the efficacy of the medication.
* On eight occasions staff administered PRN Ativan and failed to attempt non-pharmacological interventions prior to administering the medication on all eight occasions. On three of the eight occasions staff failed to determine indication for use and failed to assess the efficacy of the medication.

Review of the Nursing 2015 Drug Handbook, page 1407, stated, "tramadol hydrochloride . . . Indications & Dosages . . . Moderate to moderately severe pain . . . give 50 to 100 mg P.O. [by mouth] every 4 to 6 hours p.r.n."

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included stiffness of joint, ankle and hand contractures, muscle weakness, and difficulty walking. Physician orders included tramadol 50 mg two times a day as needed for pain. The current care plan stated, "Focus . . . Pain as evidenced by VPS [verbal pain scale] related to disease process, impaired mobility . . . Interventions/Tasks . . . administer pain medication per physician orders . . ."

Review of Resident #2's MARs for December 21, 2016 through January 10, 2017 identified the following:
*On seven occasions staff administered PRN tramadol. On three occasions staff failed to determine indication for use, on three occasions

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staff failed to assess the efficacy of the medication, and on one occasion gave the medication three hours after the previous dose.

- Review of Resident #13's medical record occurred on January 11-12, 2017. Diagnoses included hip fracture, bipolar disorder, anxiety, and insomnia. Physician orders included hydroxyzine pamoate 50 mg for anxiety PRN and zolpidem 5 mg PRN for insomnia. The current care plan stated, "Focus . . . Sleep cycle issues as evidenced by sleeplessness r/t insomnia . . . Interventions/Tasks . . . Adapt environment related to noise levels, light, etc.; Administer medications as ordered; Limit caffeinated products during the day and eliminate after evening meal . . . Focus . . . At risk for changes in mood r/t depression, anxiety, bipolar disorder . . . Interventions/Tasks . . . Administer medications per MD [medical doctor] orders . . . Assess for physical/environmental changes that may precipitate change in mood . . ."

Review of Resident #13's MARs from December 21, 2016 through January 10, 2017 showed the following:
* On two occasions staff administered PRN hydroxyzine pamoate. On both occasions staff failed to determine the indications for use, identify the time given, and assess the efficacy of the medication.
* On six occasions staff administered zolpidem. On six occasions staff failed to determine the indications for use, identify the time given and assess the efficacy of the medication.

A progress note dated 12/08/16, stated, "General Note: Note text: back from appointment from

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[clinic name], follow up on bipolar disorder, anxiety, and insomnia, patient stable on current medication, may consider decreasing Ativan in future, rtc [return to clinic] . . ." Failure of nursing staff to document the indications for use and the resident's response to these medications hinders the practitioners ability to monitor effectiveness and determine if the medications should be continued.

- Review of Resident #11 medical record occurred on January 11-12, 2016. Diagnoses included spinal stenosis, unspecified pain, osteoarthritis, and pressure ulcer to buttock. Medications included tramadol 50 mg three times a day, fentanyl patch 50 mcg/hr topically, and Tylenol 500 mg every 6 hours as needed for pain. The current care plan stated, "Focus . . . At risk for pain due to musculoskeletal problems . . . Administer medication per physicians order.

Review of Resident #11's MAR from December 20, 2016 through January 12, 2017 showed the following:
* On 21 occasions staff administered PRN Tylenol for left knee and/or left buttock pain. On 20 of those occasions staff failed to assess the efficacy of the pain medication.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included thoracic vertebra compression fracture, pain, and chronic obstructive pulmonary disease. PRN pain medication included Voltaren Topical gel 1%. Apply 2 grams for back pain up to 4 times daily and Tylenol 325 mg 2 tablets every 6 hours for back pain.

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Review of Resident #1's MAR from December 20, 2016 to January 12, 2017 showed the following:
* Staff administered Tylenol 650 mg on four occasions. Staff failed to assess the efficacy of the medication on four occasions and failed to document indications for use on two occasions. Tylenol changed to scheduled on 12/23/16.
* Staff administered Voltaren Topical gel on 22 occasions. Staff failed to assess the efficacy of the medication on 13 occasions and failed to document indications for use on two occasions.

- Review of Resident #3's medical record occurred all days of survey. Diagnoses included left hip fracture, pressure ulcers, scoliosis, and chronic pain. PRN pain medications included Tylenol 500 mg 2 tablets every 12 hours for pain and Tramadol 50 mg every 6 hours for pain.

Review of Resident #3's MAR from December 20, 2016 to January 12, 2017 showed the following:
* Staff administered Tylenol 500 mg 2 tablets on eight occasions. Staff failed to assess the efficacy of the medication on four occasions and failed to document indications for use on three occasions.
* Staff administered Tramadol 50 mg on four occasions. Staff failed to assess the efficacy of the medication on four occasions.

- Review of Resident #12's medical record occurred on 01/12/17. Diagnoses included anxiety. The quarterly MDS, dated 10/26/16, identified moderate impaired cognition. Physician's orders included Ativan 0.5 mg twice a day PRN for anxiety. The current care plan

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F 329	Continued From page 31 stated, "Focus: At risk for adverse effects related to: use of antianxiety . . . medication . . . Focus: Episodes of anxiety as evidenced by picking at nose, ears, eyes, and anus r/t: cognitive impairment Interventions: Administer medications as ordered, Engage in relaxation techniques such as massage, breathing, guided imagery, Identify and decrease environmental stressors, Offer choices to enhance sense of control, Remove to quiet area and reassure . . ." Review of Resident #12's MARs for December 21, 2016 through January 11, 2017 identified staff administered PRN Ativan on three occasions. The record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on all three occasions. During an interview on 01/10/17 at 12:35 p.m., an administrative nurse (#2) stated she expected staff to follow-up on the effectiveness of the PRN medication on the back of the MAR. During an interview on 01/11/17 at 11:40 a.m., an administrative staff nurse (#5) identified the facility held nurse training on December 14, 19, and 20, 2016 to address identified problems with timely signing of MARS and follow-up (response) to PRN medications. The facility expectation is for staff to document the indication for use of PRN medications and to assess the resident in one to two hours to monitor the response to the medication given.	F 329		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		2/16/17

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F 441	Continued From page 32 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 33 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 SURVEY COMPLETED ON 05/04/16. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 7 of 14 sampled residents (Resident #3, #5, #6, #8, #10, and #11) observed during cares requiring hand hygiene. Failure to follow infection control practices of hand hygiene during toileting/personal hygiene (Resident #6, #8, #9, #10, and #11), dressing change (Resident #5), and meal assistance	F 441	Resident #3, #5, #6, #8, #10, and #11 have not demonstrated any adverse outcome related to improper hand hygiene. Staff were informed of survey results upon survey exit and the importance of hand hygiene for both residents and staff and the need to maintain infection control measures when handling glassware were verbally reviewed. Residents who receive care or are	

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F 441	Continued From page 34 (Resident #3) has the potential to spread infection to other personnel, residents, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 01/12/17. This policy, revised August 2017, stated, ". . . This facility considers hand hygiene the primary means to prevent the spread of infections. . . . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. . . . Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visible soiled . . . Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: . . . g. Before handling clean or soiled dressings, gauze pads, etc; . . . j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; . . . m. After removing gloves; . . . p. Before and after assisting a resident with meals; . . ." - Observation of a dressing change for Resident #5 occurred on 01/10/17 at 2:35 p.m. The nurse (#1) washed her hands, donned gloves, removed a dressing soiled with bodily fluids, cleansed the wound, removed the soiled gloves, donned new gloves, applied the clean dressing, then removed the gloves, and washed her hands. The nurse failed to perform hand hygiene after removing the soiled dressing, and before donning clean gloves	F 441	assisted with placing beverages within reach have the potential to be impacted by this practice. A campaign to increase awareness of the need for hand hygiene was initiated and CDC posters on hand hygiene have been posted in employee break room and bathrooms to remind staff of the importance of hand hygiene. CDC posters regarding asking your care provider if they have washed their hands have been posted at wheelchair height in various locations throughout the facility as well. A skills checklist for the use of hand sanitizer and hand washing was also developed post survey and will be used to validate staff follow hand washing procedures. Additionally, managers on duty in dining areas were reminded to observe handling of glassware during meal service. The DON or designee provided or will provide education to licensed nurses and CNAs regarding the proper handling of glassware, proper hand hygiene, and offering and assisting residents with hand hygiene after toileting and as needed. Post survey education sessions are scheduled for February 7,8, and 9. The DON or designee will complete direct observation audits of hand hygiene during cares. Audits will include offering hand hygiene to residents and completing hand hygiene and changing gloves appropriately during cares.The DON or designee will complete direct observation of meal service to validate that glassware	

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F 441	Continued From page 35 as per policy. - During observation on 01/11/17 at 8:40 a.m., a CNA (#20) prompted Resident #10 to go to the bathroom for toileting. Resident #10 pulled his pants and incontinence brief down, sat on the toilet and urinated. Upon completion of the toileting, the CNA failed to offer Resident #10 hand hygiene. During observation on 01/11/17 at 11:15 a.m., a CNA (#20) assisted Resident #10 to the bathroom for toileting. The CNA pulled down the resident's pants and incontinent brief. The resident urinated, and upon completion, stood up and proceeded to pull up his pants and incontinence brief. The CNA failed to offer Resident #10 hand hygiene after completion of toileting. The CNA then ambulated with the resident in the hallway, and after noticing nasal drainage coming from the resident's nose, the CNA offered the resident a Kleenex tissue at which time the resident blew his nose. Neither at that time nor after the resident returned to his room, did the CNA offer the resident hand hygiene. During an interview on the morning of 01/12/17, a supervisory nurse (#5) stated she would expect staff to offer/provide hand hygiene for residents who assist with toileting, and stated the facility had no specific policy stating this. - Observation on 01/10/17 at 11:16 a.m. showed two CNAs (#4 and #10) assisted Resident #8 onto the toilet. After voiding, the resident cleansed her frontal perineal area with toilet tissue and the CNA (#4) performed perineal care	F 441	is handled correctly. These audits will be completed five times weekly for eight weeks, twice weekly for eight weeks, then weekly for eight weeks. These audits were initiated on January 23,2107.	

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F 441	Continued From page 36	F 441		

and removed her gloves. The two CNAs (#4 and #10) assisted the resident into bed. The CNA (#4) left the room without performing hand hygiene and staff failed to offer hand hygiene to Resident #8.

- Observation on 01/11/17 at 4:15 p.m. showed two CNAs (#12 and #13) provided perineal cares for Resident #11 who was incontinent of a large loose stool. The CNAs removed their gloves, donned new gloves and without performing hand hygiene, the CNA (#12) performed frontal cares and removed her gloves. Both CNAs continued to assist Resident #11 by adjusting the blankets, the bed controls, moved the television remote, and placed the foley catheter bag on the side of the bed. Both CNAs failed to perform hand hygiene after providing perineal care and before completing other tasks.

During an interview on 01/12/17 at 11:00 a.m. a supervisory nurse (#5) stated after providing perineal care containing stool she expected staff to remove their gloves and perform hand hygiene.

- During observation on 01/10/17 at 10:12 a.m. a CNA (#17) provided perineal cares for Resident #6 who was incontinent of bowel movement. The CNA (#17) removed her gloves, transferred the resident to her wheelchair, donned gloves, emptied the garbage, removed one glove, and exited the room. The CNA (#17) disposed of the garbage and the other glove in the dirty utility room and hand sanitized. The CNA (#17) failed to perform hand hygiene prior to exiting Resident #6's room.

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	355031	A. BUILDING _____ B. WING _____	01/12/2017

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F 441	Continued From page 37 - During observation on 01/11/17 from 8:27 a.m. to 8:57 a.m. a CNA (#3) seated on a rolling stool in the dining area assisted Resident #3 and 2 random residents seated at two tables next to each other. Without hand hygiene the CNA stood up, picked up 4 glasses of fluids by the drinking rim and placed them within one of the resident's reach. The CNA then proceeded to clear the empty tables. The CNA failed to place the 4 glasses of fluids in front of the resident without touching the drinking rim.	F 441		
F 467 SS=E	483.90(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC (h)(2) Be well ventilated; This REQUIREMENT is not met as evidenced by: Based on observation, an inspection report, and staff interview, the facility failed to ensure 1 of 2 nursing units (first floor) remained free of offensive odors and hazards by ensuring the proper functioning mechanical ventilation (air vents) in resident bathrooms, and determining if a pungent (strong foul) odor within the first floor conference room and adjacent offices, could be potentially hazardous and offensive for residents, visitors and staff. Findings include: - Upon entrance on 01/09/17 at 10:30 a.m., the survey staff, as well as administrative staff accompanying the survey staff, identified a pungent odor in the first floor conference room, located across from resident rooms. The administrative staff offered a container of	F 467	F-467 The finding of non-functioning bathroom ventilation on the first floor has been corrected by replacement of the roof-top exhaust motor belts. The compromised belt was replaced during survey on the evening of January 9th. The affected rooms 195, 194, 191, 198, and 176, are being monitored to assure proper ventilation. The nuisance odor in the conference room and adjacent office space is not a resident area and has been determined to be of a non-toxic source as preliminarily determined by the utility company on January 9th and confirmed by independent contractor TriMedia with a corresponding air quality report issued on January 11th. An additional exhaust	2/16/17

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F 467	Continued From page 38 Febreze, an air fresher, for use while working in the room. During an interview on 01/09/17 at 4:00 p.m., a maintenance staff member (#19) stated the cause of the odor in the first floor conference room and adjacent offices could not be determined. The staff member stated a plumber (who visited the facility on this day) did not think the odor was sewer gas, however also said the odor may be caused by a cracked vent tube in the sewer gas line. During an interview on 01/09/17 at 5:18 p.m., an administrative staff member (#5) stated the odor had been present for "quite some time" and the facility had a plumber and a contractor at the facility in the last month. The staff member stated the facility had not contacted the utility company or Fire Marshall to assess the odor to ensure it was not hazardous. During an interview on 01/10/17 at 7:40 a.m., an administrative staff member (#18) stated the fire department came to the facility and checked for toxic gases on the evening of 01/09/17 and found none. During an interview on 01/10/17 at 7:51 a.m., an administrative staff member (#5) stated the facility first noted the odor on 12/13/16. During a previous interview at 7:40 a.m. an administrative staff member (#18) stated on 12/13/16 the facility closed the conference room and adjacent office doors. On 01/11/17, the facility had a limited indoor air quality (IAQ) assessment completed to detect the	F 467	solution has been implemented to minimize the nuisance while a permanent solution is determined. The roof-top ventilation system has the potential to affect resident areas on both floors in the event of a disruption. The facility will conduct weekly ventilation tissue tests internally to assure proper ventilation and monthly roof-top motor and belt inspections to assure systems are properly functioning. The facility will implement a monthly safety committee to ensure monitoring of areas of concern is maintained. The administrator educated the maintenance director on the process for monitoring and completing audits of the exhaust system on February 8, 2017. The facility will implement weekly audits of exhaust fan operation through "tissue tests" in areas where exhaust fans are present. The maintenance director or designee will complete the tests and record the findings for submission to the QAPI committee for review and recommendation. This process will be ongoing in the facility to ensure that any failure of the exhaust system is promptly identified. These audits will be completed weekly on an ongoing basis. Additionally, monthly inspection of the roof top fan motors and belts will be an ongoing audit completed by the maintenance director or designee with results submitted to the QAPI committee for review and recommendations. Audits were initiated	

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F 467	Continued From page 39 cause of the odor. The "Summary Report" stated, ". . . During the limited IAQ . . . detected a septic like odor in the conference room and a septic mixed with a laundromat odor in the human resources office and the assistant director of nursing's office. . . . utility companies have responded to the odor complaint and could not determine the cause of the odor. . . . Based on the results of the assessment, the identified odor appears to be a nuisance odor. All reports indicate the odor to be of 'septic' or 'sewer' which is generally associated with hydrogen sulfide. . . . Continued investigation of the plumbing system, both active and abandoned, is warranted as the odor may be produced by liquid or vent gas leakage. . . ." - During the initial tour on 01/09/17 at 11:00 a.m. the survey team detected a strong odor, similar to urine, present on the first floor unit, north wing. On 01/09/17 at 4:11 p.m. the survey team detected/noted a strong musty odor in the bathroom of room 195. A check of the air vent within the bathroom identified no draw of air flow while placing a tissue to the vent cover. A random check, identified similar odors in the resident bathrooms for rooms 176, 191, 194, and 198. These rooms locations identified the odors present in three of four wings on the first floor. During an interview on 01/09/17 at 4:51 p.m., an administrative staff member (#18) confirmed the mechanical ventilation problem and stated the facility replaced the belts around Thanksgiving and would check to ensure they were functioning. On the morning of 01/10/17, the bathroom vent	F 467	the week of February 6, 2017	

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F 467	Continued From page 40 showed evidence of proper functioning by a check for return air flow. During the environmental tour on 01/12/17 at 10:00 a.m., an administrative staff member (#18) stated the facility replaced the ventilation belts on the evening of 01/09/17. The failure to ensure adequate ventilation within the facility, including in resident bathrooms, may adversely affect residents, family, staff and visitors from unmanaged odors. Failure to ensure a thorough and timely investigation of a persistent pungent odor to rule out the presence of toxic gases may have been a potential hazard to residents, visitors and staff.	F 467		