STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 03/07/16 and completed on 03/10/16, the sampled included five (5) residents for complete review, 22 residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		3/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/07/2016

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F 156	Continued From page 1 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with	F 156		

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to post the names, addresses, and/or telephone numbers of State advocacy groups (State Survey and Certification Agency, Protection and Advocacy Project, and the Medicaid Fraud Control Unit) on 4 of 4 days of survey. Failure to provide this information has the potential to limit residents' and their families' access to these agencies. Findings include: Observation on March 07-10, 2016, showed the facility's display board failed to list correct phone numbers and names, and lacked addresses for the State Survey and Certification Agency, the Protection and Advocacy Project, and Medicaid Fraud Control. On 03/09/16, a social service staff member (#9)	F 156	The facility communication board has been updated to provide the correct names, addresses and phone numbers for the State Survey and Certification Agency, the Protection and Advocacy Project, and the Medicaid Fraud Control. This information was obtained from the NDDOH, and was sent to printing to have the information correctly displayed. All residents have the potential to be affected by having incomplete and outdated information on the communication board. As information is received from above agencies on changes with addresses, phone numbers, and contact information, the communication board will be updated.	

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F 156	Continued From page 3 confirmed the facility posting lacked the required information as observed.	F 156	The Board will be reviewed monthly and the QI data will be submitted quarterly. The Communication Board was updated on March 29, 2016. Ongoing responsibility of maintaining current information on the board belongs to the Social Services Director.	
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident group interview, individual interview and staff interview, the facility failed to provide mail delivery on Saturdays for 7 of 7 residents interviewed. Failure to provide mail delivery on Saturdays infringes on the rights of all residents in the facility. Findings include: The resident group interview occurred on 03/08/16 at 10:00 a.m. and included six residents (Resident B, C, D, E, F, and G), identified by the facility as interviewable. When asked about mail delivery on Saturdays, two Residents (C and E) stated they do not receive mail on Saturdays and the other residents confirmed the statement. Resident (C) stated they had mail service on Saturday's but the hospital no longer picks up the mail at the Post Office on Saturday and therefore	F 170	Trinity Health mailroom was contacted to start delivering mail on Saturday mornings by 11:00 am to the Trinity Homes Activities Room, located on first floor. All residents who receive their own mail have the potential to be affected. Once the mail is delivered to the Activity Room, the activity staff will check the list of residents who are able to receive their own mail, and deliver it to the floor of the resident. Any mail that is for residents that do not receive mail will be left in the mail bag and be picked up by the Business Office on Monday morning for their normal mail processing. The Business Office will be responsible for	3/19/16

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F 170	Continued From page 4 the facility no longer has mail delivery on Saturdays. During an interview on 03/08/16 at 11:25 a.m., a social service staff member (#9) and two business office staff members (#40 and #41) confirmed the residents do not receive mail on Saturdays as the hospital stopped picking mail up from the Post Office on Saturday. During an interview on 03/09/16 at 5:25 p.m., Resident #9 stated that residents do not receive mail on Saturdays.	F 170	training the Activities Staff. QA will consist of two parts: 1. Mail is delivered to Trinity Homes Activities room on Saturday mornings 2. Mail is delivered to all residents who are able to receive mail by the end of Saturday. QA audits began March 19th and will be done weekly until compliance achieved 100%, and then will be done quarterly until compliance achieved for 4 consecutive quarters. Date for completion of training is March 17th with mail delivery starting on Saturday, March 19th. Individuals responsible for the process are Business Office Director and OT/Activities Director.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 5 sampled residents (Resident #22) observed in a rock-n-go wheelchair remained free of physical restraints. Failure to assess the chair that prevented rising as the least restrictive option, obtain a physician's order, and obtain the family's consent, placed Resident	F 221	Resident #22: Nurse will complete an initial safety assessment and initial device assessment to determine appropriate device for position and comfort. All residents have the potential of being affected if they are placed in a rock-n-go if the device is used for positioning.	4/21/16

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F 221	Continued From page 5 #22 and all residents using a rock-n-go wheelchair at risk of injury and loss of mobility. Findings include: Review of the facility policy titled "Restraints," occurred on 03/10/16. This policy, revised January 2016, stated, "POLICY: It is the policy of Trinity Homes to use the least restrictive device, for the shortest time period possible, with the consent of the resident. If the resident is unable to make an informed decision, then sequence of North Dakota informed consent law will be followed . . . The resident will be free from any physical restraint imposed for purposes of discipline or convenience and not required to treat the residents medical symptoms. PROCEDURE: 1. . . . For any device that has the effect of restraining or restricting the resident's access, a physician's order will be obtained and a restraint consent form will be signed. . . ." Review of Resident #22's medical record occurred on March 09-10, 2016. Current diagnoses included dementia and Parkinson's disease. An annual Minimum Data Set (MDS), dated 01/16/16, identified the resident usually understood others and made himself understood by others, required extensive assistance of two persons for transfers and walking, and experienced one fall with no injury and two falls with injuries since the prior assessment. The current care plan stated, ". . . Problem: AMBULATION - extensive assistance (wt. [weight] - bearing) required, has inconsistent walking ability . . . Approach: Ambulatory - Walks with a gaitbelt and assist of 2 as tolerated. . . .	F 221	Our initial safety and device assessments have been revised to meet the standard. Initial safety and device assessments will be completed for all residents using the rock-n-go to determine potential needs utilizing the least restrictive device to prevent loss of mobility. OT and PT will evaluate residents for positioning devices, including devices that will prevent the feet from dangling. QI will be done by the Nurse Manager for all residents using the rock-n-go. QI will monitor that assessments are done timely and that OT/PT are involved in assessment. QI will be done weekly X4 weeks, monthly X3, and quarterly until compliance is achieved. This will be completed by April 21, 2016. This is the responsibility of the DON.	

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F 221	Continued From page 6 Problem: SAFETY - at risk for falls, at risk for falls r/t [related to] impaired decision making skills, Resident is in a hi-lo [high-low] bed and has a bed alarm . . . Approach . . . Call light within reach, Hi-Lo Bed, Falls Precautions, Rock-n-go chair, Bed alarm . . . Problem: TRANSFERRING - self care deficit - requires extensive assistance . . . Approach . . . Transfers with a gaitbelt and assist of 2. . . . Problem: WHEELCHAIR MOBILITY - one person assistance . . . Approach: Ensure foot pedals in use, Rock-n-go chair used for mobility propelled by staff." Review of Resident #22's fall documentation showed the following responses to the question, "What adjustments are being made?" *01/16/16: "escorted off the floor and put in his chair to be monitored" *12/31/15: "Resident continues to be monitored by staff frequently. Resident is reminded to call for assistance before standing up from his rock n go chair." *11/22/15: "Resident is in a rock-n-go, he has a hi-lo bed and silent alarm when in bed -- apparently he must always have supervision when up." Observations throughout the day on 03/08/16 and throughout the morning on 03/09/16 showed Resident #22 seated in a reclined rock-n-go wheelchair. Resident #22 leaned forward in the chair and his feet/legs dangled with no foot support provided. Observations on 03/10/16 showed Resident #22 seated in a rock-n-go wheelchair in the reclined position. The resident's feet dangled with no foot support provided.	F 221		

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F 221	Continued From page 7 During an interview on 03/09/16 at 10:56 a.m., a certified nursing assistant (CNA) (#32) stated Resident #22's wheelchair was in a reclined position "So it's not as easy for him to jump up." The CNA also stated, "He [Resident #22] can still walk," and "He tries to get up." Resident #22's medical record lacked evidence the facility considered the rock-n-go wheelchair as a restraint. During an interview on the afternoon of 03/10/16, an administrative nurse (#2) confirmed the facility did not consider the rock-n-go wheelchair as a chair that prevented Resident #22 from rising. Failure to assess the chair that prevented rising as a restraint, obtain a physician's order and obtain the family/guardian's consent, placed Resident #22 and all facility residents using this type of wheelchair at risk of injury and limited mobility.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to thoroughly investigate a potential abuse or neglect incident for 1 of 1 sampled resident (Resident #11) who sustained a fall from a mechanical lift. Failure to thoroughly investigate a fall, including an interview with the resident,	F 226	Resident #11 was transferred promptly to the ER to be evaluated for injury by the ER Physician. Staff did not interview the resident before transfer; priority was her physical well being, and it was not in our policy to interview residents. Abuse	4/5/16

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F 226	Continued From page 8 has the potential to place all residents at risk for abuse and neglect. Findings include: - Review of Resident #11's medical record occurred on all days of survey. The facility identified the resident as interviewable. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes with neuropathy (nerve damage) and weakness. Medications included Tramadol (pain medication) 50 milligrams (mg) two times a day and Tylenol 1,000 mg two times a day. The quarterly Minimum Data Set (MDS), dated 01/04/16, identified cognitively intact and total assistance of two persons required for transfers. The current care plan identified total assist with transfers using a hoyer lift (full body mechanical lift) and assistance of two. Nursing progress notes identified the following: * 05/04/15 10:02 a.m. - "Resident was been [sic] Hoyer from bed to wheel chair when the right leg strap came out of the hook. She fell out of the Hoyer onto the Hoyer's legs across her right chest. She then hit the back of her right [sic] head. Large swollen area to the back of the head. All of the neuro [neurological] check so far have been with in normal limits. Resident complain of sevre [sic] chest pain and right arm pain. Moving her right arm increases her pain. Breathing incease [sic] her chest pain. Also complain of lower back pain. Her skin is intact at this time. I called her family member [name] and told him about fall. Provider [nurse practitioner name] came up and wrote order to have x-rays done of chest and right shoulder."	F 226	investigation was completed and sent to NDDOH with no further recommendations. Staff involved in incident were retrained on proper Hoyer use. Resident has passed away so unable to interview. All residents have the potential to be affected if policy is not changed to include interviewing resident. The Abuse and Neglect Policy has been updated to read that all interviewable residents will be interviewed when there is an allegation of abuse and a statement written up. Each Social Worker will be required to interview the resident involved, if the resident is able to provide a statement. The Social Service Director will review all abuse investigations to assure interviews are completed. QI monitoring will be done on each allegation, and will be reported monthly at the QI meeting for 3 months, and then quarterly. This policy was changed on April 5, 2016 and education provided to all staff on policy change. This is the responsibility of the Social Service Director and DON.	

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F 226	Continued From page 9 A nurse practitioner's progress note, dated 05/05/15, stated, ". . . right fifth and seventh rib fractures. . . ." A physicians progress note, dated 06/03/15, stated, ". . . We have been adjusting her pain medications, especially after a mechanical fall with right-sided rib fracture . . ." During an interview on 03/09/16 at 2:00 p.m. a supervisory staff member (#9) stated the facility interviewed the two staff members involved in the incident but failed to interview Resident #11.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide care for 6 of 27 sampled residents (Resident #4, #10, #12, #14, #18, and #25), 3 supplemental residents (Resident #32, #33, and #34), and 1 confidential resident (Resident A) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors or wait for a reply before entering a resident's room (Resident A, #14, #18, #25, #34), and failure to maintain resident's facial hair (Resident #18, #32, and #33), failure to maintain confidentiality	F 241	All staff were re-educated on the issues found deficient in dignity and respect of residents: Failure to knock on doors/wait for a response, maintaining facial hair, maintaining confidentiality and addressing residents needs in a dignified manner. Residents #18,32,33 had their facial hair removed. All residents have the potential to be affected if care provided to the residents is not dignified or respectful.	4/21/16

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F 241	Continued From page 10 (Resident #12), and failure to address residents needs in a dignified manner (Resident #4) does not promote residents' dignity or enhance their quality of life. Findings include: - During initial tour on the morning of 03/07/16 an unidentified staff member failed to knock before entering Resident #14's room. - During initial tour on the morning of 03/07/16 an unidentified certified nursing assistant (CNA) entered Resident #34's room without knocking or identifying herself. - During a confidential interview on the morning of 03/08/16 Resident A stated, staff knocked on the door and walk right into the room. - During an observation on 03/08/16 at 08:45 a.m. a certified medication aid (CMA) (#1) entered the room of Resident #18 and failed to knock prior to entering. Observation on 03/09/16 at 09:40 a.m., revealed two certified nursing assistants (CNAs) (#3 and #4) enter Resident #18's room and failed to knock prior to entering. - During a dressing change on 03/08/16 at 10:10 a.m. an unidentified staff member knocked on Resident #10's door and immediately opened the door without waiting for a response. - Observation on 03/10/16 at 10:28 a.m. showed Resident #25 in her bathroom and two CNAs (#6 and #7) providing cares. The CNAs had just	F 241	Privacy, dignity and respect are expected of all staff in resident interactions. Staff has been reeducated on knocking on resident doors and waiting for a response, facial grooming, confidentiality and providing cares to meet resident needs promptly and respectfully at all times. Staff nurses will do QI by monitoring: 1. Knocking on resident doors and waiting for response. 2. Checking females to insure facial grooming is done. 3. Confidentiality 4. Providing cares to meet resident needs/requests. These audits will be done weekly X4, quarterly X 3, and until compliant. Education for this will be completed by April 21, 2016. This is the responsibility of the DON and Housekeeping Director.	

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F 241	Continued From page 11 transferred the resident to her wheelchair when an unidentified housekeeping staff member entered the room. The unidentified staff member failed to knock before entering the room. The unidentified staff member saw Resident #25 in the bathroom and exited the room. Resident #25 washed her hands when an unidentified housekeeping staff member entered the room. The unidentified staff member failed to knock before entering the room. - During initial tour on 03/07/16 at 10:20 a.m. observation identified a female resident (Resident #32) with facial chin hairs. - During initial tour on 03/07/16 at 10:55 a.m., a female resident (Resident #18) seated in a recliner outside of the 2 South nurses station was noted to have facial chin hairs. - An observation on 03/08/16 at 08:01 a.m., identified a female resident (Resident #33) in the dining room with facial chin hairs. During an observation on 03/09/16 at 09:40 a.m., a female resident (Resident #33) was observed with facial chin hairs. - Observation on 03/08/16 at 3:30 p.m. showed a CNA (#8) provided personal cares. The CNA tidied up Resident #12's room and an unidentified staff member knocked, peeked her head in the room, and stated, "[CNA #8] when your done [name of another resident] wants to get up." The CNA opened the door without waiting for a response. - Observation in the dining room occurred on	F 241		

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F 241	Continued From page 12 03/08/16 at 11:14 a.m. Resident #4 stated to the the surveyor, "Help me. I have to go poop. I have to go potty." The surveyor alerted a certified nursing assistant (CNA) (#32), who stated, "She has to go 100 times a day." The CNA failed to offer toileting assistance to Resident #4. A few minutes later, Resident #4 again stated, "I have to go potty. Help me." At 11:23 a.m., two CNAs (#32) and (#36) took Resident #4 to the bathroom. Observation showed Resident #4's brief was dry, and she voided/stooled in the toilet. A CNA (#32) stated, "She really had to go this time." Failure to honor residents' requests and provide cares in a respectful manner does not maintain residents' dignity or enhance their quality of life.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to meet the individual needs for 2 of 6 sampled residents (Resident #13 and #14) identified with limited upper extremity range of motion. Failure to ensure Resident #13 and #14's ability to access the call light system has the potential to affect the quality of each	F 246	Call lights will be placed in reach and on unaffected sides of residents who have limited mobility. Residents #13 & 14: Hourly monitoring of call light positioning initiated every day X 1 month. This has the potential to affect all	4/21/16

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F 246	Continued From page 13 resident's life. Findings include: - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included fracture of right hip, anxiety, weakness, fatigue, osteoarthritis, and dementia. The admission Minimum Data Set (MDS), dated 03/03/16, identified extensive assistance of two or more persons for bed mobility, transfers, and toilet use and extensive assistance of one person for dressing, eating, and personal hygiene. The current care plan stated, ". . . Problem . . . SAFETY- Fell at home and fractured [right] hip; potential for further injury from falls due to trying to get up alone- is confused at times at [night] and does not remember she broke her hip . . . Approach . . . Call light within reach . . . Problem . . . COGNITIVE DEFICITS . . . intermittent confusion . . . Approach . . . Able to use call bell - place within reach . . ." An X-ray result, dated 06/28/15, stated, ". . . XR [X-ray] Shoulder Complete Left . . . Clinical History/Indication: Fall with left shoulder pain. . . . Impression: 1. Severe degenerative changes of the left shoulder, including calcific tendinitis [pain and stiffness of tendon]. 2. Possible nondisplaced inferior glenoid rim fracture [fractured shoulder]. . . ." Review of Resident #13's occupational therapy evaluation, dated 02/25/16, stated, ". . . Left UE [upper extremity] AROM [active range of motion] limited . . . Left UE . . . limited shoulder ROM [range of motion] due to arthritis . . . Strength - Left . . . poor movement with gravity eliminated [unable to lift arm] . . ."	F 246	residents who have limited/no mobility of arms, shoulders, hands. Resident needs are assessed and staff are trained and instructed to follow plan of care and care guide to meet individual needs of each resident. Staff nurse will monitor for proper placement of call lights. QI's will be done weekly X4, monthly X3, and then quarterly until compliant. Education will be completed and QI's will be done by April 21, 2016. This is the responsibility of the DON.	

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F 246	Continued From page 14 Observation on 03/08/16 at 9:25 a.m. showed two certified nurse assistants (CNAs) (#22 and #28) transferred Resident #13 from her chair to the bed utilizing a Hoyer lift (mechanical lift). Staff placed the call light on the left bedside rail without regard for her left arm limited ability. Observation on 03/08/16 at 11:25 a.m. showed two CNAs (#22 and #28) transferred Resident #13 from her bed to the chair utilizing a Hoyer lift. The CNA placed the call light on the bed rail positioned on the left side of Resident #13's chair, and exited the room. The resident's chair was greater than an arm length away from the bed. When asked to reach for the call light, Resident #13 could not move her left arm or reach the call light. During an interview on 03/08/16 at 11:30 a.m., an administrative nurse (#29) stated she lacked awareness of Resident #13's limited range of motion in her left upper extremity, and that she could not access the call light with her left arm. The facility failed to provide access of a call light accommodating Resident #13's limited range of motion of her left arm. - Review of Resident #14's medical record occurred on all days of survey. Diagnoses included left sided hemiplegia and hemiparesis (left sided paralysis), cerebrovascular disease, and weakness. The quarterly MDS, dated 12/22/15, identified extensive assistance of one person for bed mobility, transfers, dressing, personal hygiene and extensive assistance of two or more persons for toilet use. The current care plan stated, ". . . Problem . . . BED	F 246		

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F 246	Continued From page 15 MOBILITY & ROM - extensive assistance (wt. [weight] bearing) required, weakness on left side r/t [related to] disease process . . . Approach . . . left arm is flaccid and left leg is very weak . . . Problem . . . COGNITIVE DEFICITS . . . Approach . . . Able to use the call bell - place within reach . . . needs to have it on the rt [right] side left arm is flaccid . . ." The Care Area Assessments (CAAs) titled, "ADL [activity of daily living] - Bed Mobility Assistance V03", dated 02/11/16, stated, ". . . 5. If other bed positioning assistance, specify: left arm is flaccid and left leg is very weak . . ." Observation on 03/08/16 at 9:33 a.m. showed two CNAs (#21 and #22) transferred Resident #14 from his wheelchair to his bed and positioned the resident on his right side with pillows wedged behind his back. The CNA placed the call light on the resident's left bedside rail. Observation on 03/08/16 at 12:03 p.m. showed Resident #14 laying in his bed with the call light placed on the left side rail. Observation on 03/08/16 at 2:08 p.m. showed Resident #14 laying in his bed with the call light placed on the left side rail. A wound care nurse (#26) performed wound care dressing changes, left the call light on the left side bed rail, and exited the room. The facility failed to provide the call light on Resident #14's right side for accessibility.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272		4/21/16

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F 272	Continued From page 16 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced	F 272		

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F 272	Continued From page 17 by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility staff failed to thoroughly assess each triggered Care Area Assessments (CAAs) for 2 of 27 sampled residents (Resident #1 and #25) reviewed. Failure to assess each triggered CAA limits the ability of the interdisciplinary team to thoroughly support the care plan decision making process. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, section V, page V-5, stated, ". . . For each triggered care area, indicate the date and location of the CAA documentation in the 'Location and Date of CAA documentation' column." Page 4-4 stated, ". . . Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making . . ." - Review of Resident #25's medical record occurred on March 09-10, 2016. The admission Minimum Data Set (MDS), dated 03/04/16, identified one fall with injury. The fall Care Area Assessment (CAA), dated 03/08/16, stated, "HISTORY OF FALLING . . . Analysis of Findings: Review indicators and supporting documentation and draw conclusions.	F 272	Residents #1 and #25-MDS nurse will address all falls and cares to assure that the MDS is completed appropriately and that we are doing everything possible to prevent falls. All residents have the potential to be affected if falls are not correctly addressed on the MDS. MDS Coordinator will attend Falls Committee weekly to assure completeness and accuracy. MDS Coordinator will monitor falls documentation in resident charts to assure that the MDS assessment is accurate. All MDS nurses will review with the MDS Coordinator the falls documentation to assure accuracy. MDS nurse will audit 2 resident records per week (residents who have had falls). This will be done weekly X4, monthly X3, and then quarterly until compliant. Education will be done and QI's will be started April 21, 2016. This is the responsibility of the MDS Coordinator.	

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F 272	Continued From page 18 13. Document: Description of problem, Causes and contributing factors; & Risk factors related to the care area. Triggers due to having a history of falls and requiring staff assistance to stablize. Risk factors include CHF [congestive heart failure], kidney disease, bring [sic] unsteady during transfers and having altered mental status. She was recently diagnosed with a light L1 compression Fx [fracture] and she is prescribed oxycotnin [sic] twice a day for pain. She also utilizes prn [as needed] medications. . . ." Facility staff failed to complete the first question titled "HISTORY OF FALLING." The facility failed to complete a thorough analysis of Resident #25's fall, including the date of the fall, location, and contributing factors. - Review of Resident #1's medical record occurred on all days of survey. The record identified the resident experienced nine falls from 08/07/15 through 10/13/15. The significant change MDS, dated 10/23/15, identified two falls with no injury and two falls with injury. The fall CAA, dated 10/28/15, stated, "HISTORY OF FALLING . . . (None of the Above) . . . Analysis of Findings: Review indicators and supporting documentation and draw conclusions. 13. Document: Description of problem, Causes and contributing factors; & [and] Risk factors related to the care area. 'Problem: Falls. Causes/contributing factors, advanced dementia, renal failure, cognitive impairment, mental processing slow, extensive assist to toilet and taking Tamsulosin [medication for urinary urgency]. He has a high low bed with no side rails, swim buddies [devise used to prevent	F 272		

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F 272	Continued From page 19 rolling out of bed], is on hourly rounding with a 'camping' mattress [air mattress] next to his bed. He remains a high fall risk.'" The facility failed to complete a thorough analysis of Resident #1's fall history, including dates of the falls, location, and contributing factors.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #22) after a significant change in the resident's condition. This limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches.	F 274	Resident #22-Decline in condition is not addressed in resident's care plan and care guide. MDS Correction for resident #22 not needed; the MDS currently reflects the resident care needs. All residents who have a change in condition that is not addressed in the MDS, care plan and care guide have the potential to be affected.	4/7/16

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F 274	Continued From page 20 Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement), . . ." Review of Resident #22's medical record occurred on March 09-10, 2016. Diagnoses included dementia and Parkinson's disease. Resident #22's quarterly Minimum Data Set (MDS), dated 10/16/15, identified limited assistance of one person with bed mobility, limited assistance of two or more people with walking in corridor, and independent with setup help only with eating. Resident #22's annual MDS, dated 01/16/16, identified extensive assistance of one person with bed mobility and eating, and extensive assistance of two or more people with walking in corridor. The medical record lacked evidence staff completed a SCSA following Resident #22's	F 274	MDS Coordinator will attend daily morning report and Nurse Managers are to notify MDS Coordinator if changes occur in resident condition prior to scheduled MDS. MDS team will monitor for any change of condition at report M-F and review with MDS Coordinator on schedule if there has been a decline/improvement or change in resident condition. MDS Coordinator will audit 2 MDS's per week to assure changes in condition are being addressed. QI's will be done weekly X4, monthly X3, and the quarterly until compliant. This is the responsibility of the MDS Coordinator and Nurse Manager.	

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F 274	Continued From page 21 decline in ADL's. During an interview on the morning of 03/10/16, an administrative nurse (#20) confirmed a SCSA should have been done.	F 274		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 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 care plans to reflect the residents' current status for 7 of 27 sampled residents (Resident #1, #2, #4, #7, #12, #13, and #27). Failure to ensure care plans reflected the	F 280	All residents identified have had their care plans and care guides reviewed and updated to reflect current plan of care and resident needs. All residents have the potential of being	4/21/16

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F 280	Continued From page 22 residents' current status and needs limited staff's ability to ensure consistency and continuity of care. Findings include: Review of the facility policy "Care Planning" occurred on 03/10/16. This policy, dated April 2015, stated, ". . . It is the policy of Trinity Nursing Care Facility that a written plan of care be developed and maintained for each resident in coordination with all services and individuals involved in the care of the resident. . . . D. PROGRESS RECORD . . . A. Each department head has the responsibility to see that their portion of the individual's plan is implemented and maintained. . . . C. . . . When a problem is resolved or a goal accomplished, it is deleted. If an approach or plan proves unsatisfactory, it is deleted and the problem and new approach are typed in. D. Care plans are to be revised according to the resident's condition. . . . CARE PLAN REVIEW a. On each shift the CNA's [certified nursing assistant] and Nurse review care plans and care guides so that each resident's careplan is reviewed by the three shifts monthly adding or deleting problems, goals, and approaches as appropriate. . . ." - Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, " . . . Problem: WHEELCHAIR MOBILITY - uses powered scooter . . . Approach: Uses manual wheelchair, Self-propels wheelchair, PRN [as needed] assist with long distances. " The current care guide stated, " . . . Uses powered scooter. . . . "	F 280	affected if care plans and care guides are not specific to resident needs and updated as changes occur. Training scheduled for April 13th for all nurses on updating/changing care plans. All nurses are expected to update care plans when care guides are reviewed monthly. Updates of care guides will be done monthly by staff nurse. Care plans and care guides will be monitored monthly for accuracy and follow through with resident cares by the staff nurse. QI will be done weekly X4, monthly X3, and quarterly until compliant. Education will be completed by April 21, 2016. DON is responsible.	

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F 280	Continued From page 23 Observations throughout the survey showed a powered scooter in Resident #7's room. The facility failed to revise Resident #7's care plan regarding her wheelchair mobility. - Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: NUTRITION/FEEDING - independent if set-up, Strength of good appetite, Selected meal pattern per Res. [resident] Res has had gradual wt [weight] gain since admit, family brings in treats Res refuses monthly weights Last weight allow (9-16-14). . . ." The medical record identified Resident #12's weight on 03/01/16 was 220.8 pounds. The facility failed to update and revise Resident #12's care plan to include his most recent weight. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included a right hip fracture. The physical therapy documentation notes, dated 03/04/16, stated, ". . . Resident had recent fall and [right] hip FX [fracture] . . . Therapist recommended a hip abductor wedge for [name of resident] and therapist explained proper placement of wedge to nurse and CNA with good understanding. . . ." Review of Resident #13's current care plan and care guide sheet failed to identify the need for an abductor wedge required during bedrest. Observation on 03/07/16 at 11:50 a.m., showed an abductor wedge placed in a chair in Resident #13's room and Resident #13 laying in bed with no abductor wedge in place.	F 280		

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F 280	Continued From page 24 During an interview on 03/09/16 at 8:54 a.m., an administrative staff (#5) stated she expected staff to implement Resident #13's abductor wedge when the resident is laying in bed. The facility failed to update and revise Resident #13's care plan to include the use of an abductor wedge. - Review of Resident #27's medical record occurred on all days of survey. Diagnoses included chronic kidney disease, and a history of urinary tract infection (UTI). Resident #27's progress notes revealed a UTI identified on 01/28/16. The current care plan stated, ". . . Urinary Tract Infection . . . Approach: Oxygen saturations PRN [as needed] (Started January 28, 2016 - continuing). Orthostatic Vitals PRN (Started January 31, 2016 - continuing). . . ." The care plan failed to identify approaches relevant to Resident #27's UTI. - Review of Resident #4's medical record occurred on all days of survey. The resident's current care plan identified: ". . . AMBULATION - ambulates with walker and assist of 1 . . . Approach . . . on own; staff help as needed . . ." A physician's progress note, dated 02/25/16, stated, ". . . Nursing staff reports that [Resident #4] has continued to be nonambulatory since returning from her hip fracture back in November. . . ." Observations throughout the survey showed Resident #4 seated in a rock-n-go wheelchair and transferred with staff assistance using a pivot transfer.	F 280		

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F 280	Continued From page 25	F 280		

During observation of cares on 03/08/16 at 8:17 a.m., a CNA (#32) stated, "She used to walk. She was really quick."

The facility failed to revise Resident #4's care plan to reflect her current mobility status.

- Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "SAFETY . . . camping mattress [air mattress] . . . another matress [sic] agaisnt [sic] the air mattress . . . TRANSFERRING . . . Transfers with hoyer lift [full body mechanical lift] . . . BATHING . . . No bag baths! Basis soap and water only! . . ."

Observation on all days of survey showed the following: a bed mattress, not an air mattress, next to Resident #1's bed; facility staff transferred the resident with a gait belt and assist of two staff members, not a hoyer; facility staff used a bag bath, not Basis soap and water, to wash the resident.

During an interview on the afternoon of 03/10/16, the unit manager (#33) stated the facility stopped the air mattress last week; staff are expected to use soap rather than the bag bath because of Resident #1's dry skin; and the facility stopped utilizing the hoyer for the resident's transfers in July.

- Review of Resident #2's medical record occurred on all days of survey and identified an infection of Clostridium difficile colitis (C. diff), requiring staff members to wash their hands with soap and water before exiting the room and not

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F 280	Continued From page 26 use hand sanitizer. The current care plan stated, "Infection Precaution - MRSA [Methyicillin-Resistant Staphylococcus Aureus] and VRE [Vancomycin Resistant Enterococci] . . ." The CNA care guide stated, ". . . Contact Precautions." Contact precautions requires staff members to either use hand sanitizer or wash with soap and water. Failure to revise Resident #2's care plan may result in inadequate hand hygiene by staff members and has the potential to spread infection to other residents and staff members.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: PAIN MANAGEMENT 1. Based on observation, record review, and staff interview, the facility failed to provide necessary care and services to manage pain for 1 of 1 sampled resident (Resident #3) who experienced pain due to hemorrhoids. Failure to assess and monitor Resident #3's hemorrhoids and pain may have resulted in delayed treatment and avoidable discomfort.	F 309	Resident #14 wears an Isotoner glove and is encouraged to keep it on. Nurse documents refusals. Pain management, resident #3-Nurse will use hemorrhoid medication as ordered from standing order. Medication can be given for 5 days, the physician to be notified if problem persists. All residents have the potential to be	4/7/16

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F 309	Continued From page 27 Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. A nurse's note, dated 12/13/15, identified blood in Resident #3's urine and hemorrhoids which had burst. The note also identified the certified nursing assistant (CNA) told the nurse Resident #3 complained of pain for the past two days when he wiped the resident. The note indicated the initiation of Anusol cream four times per day for five days per standing order. Resident #3's as needed (prn) treatment administration record (TAR) identified the following administration of Anusol: *12/13/15: two times *12/14/15: four times *12/15/15: two times *12/16/15: four times *12/17/15: two times *01/22/16: one time Physician's progress notes, nurses' notes, and the care plan failed to identify additional assessment or treatment of Resident #3's hemorrhoids. Observation on 03/08/16 at 9:03 a.m. showed a CNA (#36) assisted Resident #3 in the bathroom. The resident stated "Oww" and "Ouch" repeatedly throughout the observation. As the CNA wiped Resident #3, the resident stated, "It hurts," and the CNA replied, "I know it does. I'm sorry." The CNA then stated, "She has really bad	F 309	affected if adaptive devices and pain medications are not being used, and if staff does not communicate resident issues. Nurse will assist with Isotoner glove, instruct resident on reason needed, and encourage resident not to remove glove himself. Pain medication will be administered as needed from standing orders up to 5 days, and physician will be notified if necessary. This information will be review with C.N.A.'s and Nurses at the Meetings April 6 & 7th, 2016. Staff nurses will monitor resident wearing glove as ordered, and pain management. QI will be done weekly X4, monthly X3, and quarterly until compliant.	

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F 309	Continued From page 28 hemorrhoids." Resident #3's medical record failed to identify notification of or assessment by the nurse related to Resident #3's complaints of pain/hemorrhoids. During an interview on the morning of 03/10/16, a supervisory nurse (#2) stated the CNA should have alerted the nurse to Resident #3's pain, and she would expect them to update the doctor. HAND EDEMA 2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #14) with edema requiring the use of an Isotoner glove. Failure to ensure and/or encourage the use of the Isotoner glove may contribute to increased edema of the resident's left upper extremity. Findings include: Review of Resident #14's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis (partial paralysis of one side). The current care plan stated, ". . . Problem . . . BED MOBILITY & ROM [range of motion] - extensive assistance [weight bearing] required, weakness on left side r/t [related to] . . . HEMIPLEGIA AND HEMIPARESIS . . . Approach . . . left arm is flaccid and left leg is very weak; Isotoner glove to left hand worn during the day - off at HS [night] . . ." The quarterly Minimum Data Set (MDS), dated 12/22/15, identified extensive assistance of one person for dressing, transfers, bed mobility, and personal hygiene.	F 309		

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F 309	Continued From page 29 Observation on 03/08/16 at 8:05 a.m. showed Resident #14 seated in his wheelchair at the dining room table with no Isotoner glove present on his left hand. Observation on 03/08/16 at 9:33 a.m. showed two certified nursing assistants (CNAs) (#21 & #22) assist Resident #14 with transfers, pericares, and positioning. Observation showed no Isotoner glove noted on left hand. The CNAs failed to offer or encourage the resident to use the glove. Observation on 03/08/16 at 12:03 p.m. showed two CNAs (#21 & #22) assist Resident #14 with dressing and transfers. No Isotoner glove noted on left hand. The CNAs failed to offer or encourage to the glove. Observation on 03/08/16 at 2:08 p.m. showed Resident #14 in his bed during a wound care dressing change with no Isotoner glove present on his left hand. Observation on 03/10/16 at 9:05 a.m. showed Resident #14 seated in his wheelchair at the dining room table with no Isotoner glove present on his left hand. During an interview on 03/08/16 at 4:43 p.m., an administrative staff (#5) stated Resident #14 used the ordered Isotoner glove to control the edema of his left hand. She expected nursing staff to provide and encourage Resident #14 to utilize the Isotoner glove.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		4/21/16

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F 314	Continued From page 30 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to provide interventions to prevent the development/deterioration of pressure ulcers for 1 of 5 sampled residents (Resident #4) with a pressure ulcer. Failure to consistently implement pressure ulcer prevention interventions (repositioning, moisture barrier cream) may result in the deterioration of Resident #4's pressure ulcer and the development of additional skin breakdown. Findings include: Review of the facility document "Basic Wound Care Suggestions for All Nursing Staff" occurred on 03/10/16. This undated document stated, ". . . Aloe Vesta Skin Protectant #3 - should be used on every bottom that does not get Calmo [calmoseptine, a moisture barrier cream] . . . Reminders . . . Turning and repositioning happens every two hours - most important factor in preventing pressure ulcers. . . ."	F 314	Moisture Barrier cream is to be applied to resident with every toileting to prevent skin breakdown. Resident is also repositioned every 2 hours and this is documented. All residents have the potential to be affected if pressure ulcer prevention orders are not followed. Pressure ulcers will be treated with recommended treatments, wound care nurse will evaluate weekly, and provider will be notified if there is a change in resident skin condition. Nurse will monitor skin care in observations and will check that residents are repositioned and documentation is complete. QI's will be started April 6-12th. QI will be done weekly X4, monthly X3, and then quarterly until compliant. This is the responsibility of the DON.	

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F 314	Continued From page 31	F 314		

Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia and a Stage III sacral pressure ulcer. The resident's current Minimum Data Set (MDS), dated 02/13/16, identified short and long term memory problems, severely impaired daily decision making skills, extensive assistance from one person for bed mobility, and one unstageable pressure ulcer not present upon entry which measured 1.5 centimeters (cm) by 0.5 cm.

Resident #4's current care plan identified: ". . . SKIN INTEGRITY - Skin impairment r/t [related to] pressure ulcer to sacrum; potential for further skin impairment related to incontinence- request 3N1 [moisture barrier cream] with every BR [bathroom] visit. . . . Approach . . . Turn and reposition resident q2h [every two hours] and prn [as needed] . . ."

Facility staff first measured Resident #4's sacral ulcer on 01/07/16. The measurements showed the following:
*01/07/16: Stage II, 1 cm x 1.3 cm
*01/28/16: Unstageable, 2 cm x 0.7 cm
*02/04/16: Unstageable, 1.6 cm x 0.9 cm
*02/11/16: Unstageable, 1.5 cm x 0.5 cm
*02/19/16: Stage II, 1.1 cm x 0.6 cm x 0.1 cm
*02/25/16: Stage II, 1.1 cm x 0.5 cm x 0.1 cm
*03/03/16: Stage III, 0.7 cm x 0.5 x 0.1 cm

Observation on 03/08/16 at 7:58 a.m. showed Resident #4 seated in a rock and go wheelchair. At 8:17 a.m., two certified nursing assistants (#32 and #46) assisted Resident #4 to the bathroom but failed to apply moisture barrier cream after toileting and perineal care. Observation showed

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F 314	Continued From page 32 a dressing on the resident's sacrum. A CNA (#32) stated the resident did not have a pressure ulcer, and the dressing was there to protect her skin. Observation showed Resident #4 remained seated in her wheelchair until 11:23 a.m. (approximately three hours later). Staff toileted the resident at that time and again failed to apply moisture barrier cream. Observation on 03/08/16 at 3:16 p.m. showed two CNAs (#48 and #49) toileted Resident #4 and failed to apply moisture barrier cream. The CNAs then transferred Resident #4 to her wheelchair. At approximately 6:00 p.m., the survey team left the facility and observation showed Resident #4 remained seated in her wheelchair, eating dinner in the dining room. Observation on 03/09/16 at 7:58 a.m. showed Resident #4 seated in her wheelchair. At 10:49 a.m., an unidentified CNA brought the resident to the dining room for lunch. During an interview on 03/09/16 at 10:56 a.m., a CNA (#32) stated she assisted Resident #4 out of bed for breakfast "maybe around 6:40 [a.m.]." The CNA confirmed Resident #4 had been in her wheelchair since that time. Failure to reposition Resident #4 every two hours as care planned may have resulted in the deterioration of the resident's sacral ulcer, and failure to apply moisture barrier cream with toileting may result in additional skin breakdown.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		4/6/16

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F 315	Continued From page 33 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility protocol, the facility failed to provide services for 1 of 15 sampled residents (Resident #25) treated for a urinary tract infection (UTI). Failure to ensure prompt treatment of a UTI may result in unnecessary discomfort, increased behaviors, and/or sepsis. Findings include: Review of the facility protocol titled "URINARY TRACT INFECTION SUSPECTED PROTOCOL" occurred on 03/10/16. This undated protocol stated, ". . . Notify provider to obtain urine culture order. Notify provider of urine culture results. . . ." Review of Resident #25's medical record occurred on March 09-10, 2016. Diagnoses included UTI. The current care plan stated, ". . . Problem: Urinary Tract Infection - at risk for falls r/t [related to] confusion . . . Approach . . . Macrobid 100 mg [milligrams] Oral Capsule q12h [every 12 hours] for 7 days . . ." A physician's progress note, dated 02/26/16, stated, ". . . PLAN . . . Will also do a UA	F 315	Resident #25 was treated with antibiotics and UTI resolved with no complications. All residents have the potential to be affected if diagnosed with UTI and treatment not initiated in timely manner. Nurse will notify provider of C&S results of UA. If no response within 3 hours notify provider again, or notify Medical Director to initiate treatment. Nurses will be educated of this process at the monthly nurse meeting. Nurse will monitor UTI reports of C&S positive results and initiate appropriate treatment and report to QI. QI will be done weekly X4, monthly X3, and then quarterly until compliant. QI's will begin during April 6th. This is the responsibility of the DON.	

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F 315	Continued From page 34 [urinalysis] and a urine culture . . ." Review of the nurse's notes showed the following: *02/26/16 at 10:50 p.m.: "General-Lab Test: Urinalysis and Culture Specimen collected and sent to lab . . . fridge" *02/27/16 at 1:52 a.m.: "Medications - Acetaminophen 650 mg . . . Location of pain: lower back . . . c/o [complaining of] pain, laying in bed on her left side . . . Verbal pain description . . . 'it's there' . . . Verbal Pain Scale . . . 'terrible' . . ." *02/28/16 at 10:25 p.m.: "Location of pain: back . . . Medications - Acetaminophen 650 mg . . ." *03/02/16 at 4:41 a.m.: "Location of pain: back . . . Medications - OxyCODONE . . ." *03/02/16 at 11:26 p.m.: "Received orders for UTI. Macrobid . . . faxed to pharmacy. . . ." *03/03/16 at 11:51 a.m.: "Received first dose of macrobid will monitor for adverse effects." Review of Resident #25's labs showed the facility received the urinalysis results on 02/27/16 and the urine culture results on 02/29/16. The medical record showed a telephone order, dated 03/02/16, stated, "May start on 3/3/2016 Macrobid 100 mg q [every] 12 hours x 7 days . . ." Failure of facility staff to act upon lab reports in a timely manner resulted in Resident #25 waiting three days before receiving an antibiotic.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		4/7/16

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F 323	Continued From page 35 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to provide adequate supervision and assistive devices for 5 of 16 sampled residents (Resident #1, #4, #15, #21, and #23) with a history of a falls. Failure of the staff to ensure proper use of gait belts, appropriate transfer method, and re-evaluate the use of a fall intervention has the potential for all residents to experience unnecessary falls, injury, and pain. Findings include: ASSISTANCE WITH TRANSFER Review of Resident #23's medical record occurred on March 09-10, 2016. Diagnoses included dementia and osteoporosis The November 2015 care guide identified the resident transferred with a hoyer lift and assist of 2 staff members. A nursing progress note, dated 10/11/16 at 08:23 a.m. stated, "Resident had an assisted fall at 0645 [6:45 a.m.] today. CNA [certified nursing assistant] was transferring him from bed to wheelchair, while trying to boost him on the wheelchair he slid down thus, CNA assisted him	F 323	Resident #23 is transferred with Hoyer and assist of 2. Disciplinary process followed after it was discovered C.N.A. did not follow care guide. Residents #1,4,15,21 and 23-Gait belts are used to facilitate safe transfers and prevent injuries to residents. Gait belts are used in transfers and staff were reinstructed in in proper use at C.N.A meeting April 6 & 7th and nurse meeting April 13th Resident #1-Air mattress was discontinued prior to survey. Resident has a mattress next to next to Hi-Low bed and is monitored to prevent injury. Any resident could potentially be affected by improper use of Hoyer and gait belts. Hoyer transfer policy and gait belt policy reviewed at C.N.A. meeting April 6 and 7, 2016. Nurse will observe hoyer transfers and gait belts for proper usage, complete QI audits and report to QI committee monthly. QI will be done weekly X4, monthly X3 then quarterly until compliant.	

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F 323	Continued From page 36 slowly to the floor where he ended up sitting down on his bottom. No injuries noted. . . ." During an interview on 03/10/16 at 1:10 p.m. a supervisory nurse (#12) confirmed the CNA failed to transfer Resident #23 as per the resident care guide. GAIT BELT TRANSFER Review of the facility policy titled "Body Mechanics" occurred on 03/10/16. The policy, dated April 2015, stated, ". . . Trinity Homes shall use correct body mechanics to provide safety for both the resident and staff, when lifting/transferring a resident. Purpose: A. To prevent injury when lifting residents. . . . STEPS IN PROCEDURE: D. Gait belt to be applied (unless otherwise stated on care plan/guide) on transfers requiring assist of one or two. E. Refer to Perry and Potter: Clinical Nursing Skills and Techniques, ed 8, Chapter 9-1, Canada, 2014, Mosby . . ." Perry & Potter's "Clinical Nursing Skills and Techniques," 8th ed., Mosby, Canada, 2014, pages 203-204, states, ". . . c . . . Transfer belt allows you to maintain stability of patient during transfer and reduces risk for falling . . . Grasp transfer belt along patient's sides. . . . Patients should never be lifted by or under arms. . . ." - Review of Resident #23's medical record occurred on March 09-10, 2016. Diagnoses included dementia and osteoporosis. The current care plan stated, ". . . Transferring - . . . trialing tranferring [sic] with gait belt and assist of 2 . . ."	F 323	This is the responsibility of the DON.	

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Observation on 03/09/15 at 5:15 p.m. showed two CNAs (#14 and #15) assisted Resident #23 from the bed into the wheelchair. Both CNAs held onto the gait belt with one hand and lifted under Resident #23's axilla with their forearm.

- Review of Resident #15's medical record occurred on March 07-09, 2016. Diagnoses included dementia and osteoporosis. The current care plan stated, ". . . Transferring - Transfer belt . . . Two person transfer . . ."

Observation on 03/08/16 at 11:40 a.m. showed two CNAs (#16 and #17) assisted Resident #15 onto the toilet. One CNA (#16) held onto the gait belt with one hand and lifted under Resident #15's axilla with the other arm.

Observation on 03/08/16 at 3:10 p.m. showed two CNAs (#18 and #19) assisted Resident #15 off the toilet. One CNA (#19) lifted under Resident #15's axilla and failed to use the gait belt around the resident's waist.

- Review of Resident #21's medical record occurred on March 09-10, 2016. Diagnoses included Parkinson disease, paralysis, and anxiety. The annual Minimum Data Set (MDS), dated 12/08/15, identified extensive assistance of two or more people for transfers. The current care plan stated, ". . . TRANSFERRING - self care deficit- requires extensive assistance . . . Approach . . . Transfers with assist of 1 and use of gaitbelt. Needs assist of 2 when slid [sic] part way out of recliner. . . ."

Observation on 03/09/16 at 5:10 p.m. showed two CNAs (#6 and #11) transferred Resident #21

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from the recliner to the wheelchair and from the wheelchair to the toilet. Both CNAs held on to the gaitbelt with one hand as one CNA (#6) wrapped her right arm around the resident's back, bearing the resident's weight to pivot stand the resident into her wheelchair from the recliner. Both CNAs (#6 and #11) transferred the resident to the bathroom and held onto the gaitbelt with one hand and lifted under Resident #21's axilla with their other hand to pivot stand the resident from the wheelchair onto the toilet. The CNA (#6) placed her left arm around the resident's back bearing Resident #21's weight as the CNA (#11) held the resident's gait belt to pivot stand the resident back onto the wheelchair.

During an interview on 03/10/16 at 10:30 a.m., an administrative nurse (#2) stated she expected staff to utilize the gait belt during transfers without holding residents under their axilla or using 'body parts' for support.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, osteoporosis, and a history of falls. The resident's current care plan identified: ". . . TRANSFERRING . . . requires extensive assistance . . . Approach . . . Transfer belt . . . Staff to physically pivot resident . . ."

Observation on 03/08/16 at 8:17 a.m. showed two CNAs (#32 and #46) assisted Resident #4 to the bathroom using a gait belt and pivot transfer. Upon completion of toileting, one CNA (#32) assisted Resident #4 off the toilet by lifting the resident under her arms while the other CNA (#46) provided perineal cares. The CNAs assisted Resident #4 to sit back down on the

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toilet and then changed her pants. As the CNAs assisted Resident #4 to stand and pivot to the wheelchair, they both lifted under Resident #4's arms with one hand and held the gait belt with their other hand.

Observation on 03/08/16 at 11:23 a.m. showed two CNAs (#32 and #36) assisted Resident #4 to the bathroom using a gait belt and pivot transfer. Upon completion of toileting, one CNA (#32) assisted Resident #4 to stand by lifting under her arms while the other CNA (#36) performed perineal cares.

Observation on 03/08/16 at 3:16 p.m. showed two CNAs (#48 and #49) assisted Resident #4 to the bathroom using a gait belt and pivot transfer. Upon completion of toileting, both CNAs assisted Resident #4 to stand by lifting under the resident's arms. The CNAs each lifted the resident under the arms with one hand while pulling up the resident's pants/brief with their other hand before pivoting the resident into the wheelchair.

During an interview on the morning of 03/10/16, a supervisory nurse (#2) stated staff should not lift residents under the arms and should lift with the gait belt instead.

AIR MATTRESS

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included weakness, dementia, and a left femur fracture. The quarterly MDS, dated 01/23/16, identified severe cognitive impairment, extensive assistance with two staff members for bed

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mobility and transfers, two falls with no injury, and two falls with an injury.

Resident #1's current care plan stated, "Problem: Safety . . . Hi-Lo Bed . . . No siderails, camping mattress [air mattress] at bedside . . . another matress [sic] agaisnt [sic] the air mattress . . ." (all initiated on 07/13/15).

Observation on all days of survey showed Resident #1's bed in the low position and a bed mattress (not an air mattress) next to the bed.

Review of Resident #1's progress notes, dated 08/07/15 through 03/06/16, identified 18 falls from his bed: five in August, three in October, four in December, four in January, and two in February. Facility staff found the resident on the floor, between the air mattress and the bed, on six of the 18 occurrences: 10/10/15, 10/13/15, 12/15/15, 12/24/15, 01/01/16, and 02/18/16.

A progress note, dated 10/13/15, stated "Found face down on floor between bed and mattress. Got another mattress to keep air mattress next to bed. Will talk to PT [physical therapy]." Resident #1 experienced four more falls between the bed and air mattress after this note.

During an interview on the afternoon of 03/10/16, the unit manager (#33) stated the facility discontinued the air mattress the week before because they felt it unsafe for Resident #1.

The facility failed to re-evaluate the use of an air mattress as a safety intervention until Resident #1 had experienced six falls between the bed and air mattress.

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/12/15. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #8) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Review of Resident #8's medical record occurred on all days of survey. Diagnoses included malaise/fatigue, weakness, tachycardia, anxiety, heart disease, and congestive heart failure. The admission Minimum Data Set (MDS), dated 09/17/15, identified extensive assist of one person for bed mobility, transfer, dressing, toilet	F 328	Resident #8-Oxygen is to be used per providers orders. C.N.A.'s are not to remove oxygen. All residents with special needs have the potential to be affected if provider orders and facility policy are not followed. Nurse will document that oxygen is in use, by observation, each shift. Special need interventions will be reviewed at the C.N.A. and Nurse Meetings, April 6th and 7th, 2016. Nurses will monitor O2, document, and observe. QI's will be done weekly X4 weeks,, monthly X3, and quarterly until compliant. This is the responsibility of the DON.	4/7/16

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use, and personal hygiene and oxygen as a special treatment. The physician order stated continuous oxygen.

Resident #8's current care plan stated, ". . . Problem . . . SAFETY - potential for injury . . . Approach . . . oxygen . . . Problem . . . CARDIAC FUNCTION ALTERATION . . . Approach . . . Oxygen - 2 LPM/NC [liter per minute/nasal cannula] . . ."

Observation on 03/08/16 at 8:39 a.m. showed Resident #8 seated in her wheelchair at the dining room table and not wearing her oxygen as ordered. The oxygen nasal cannula and tubing were wrapped around the wheelchair handle.

Observation on 03/08/16 at 11:47 a.m. showed Resident #8 laying in her bed with the oxygen nasal cannula in place running at 2 liters. Two certified nurse assistants (CNAs) (#22 and #30) removed the resident's oxygen tubing and laid it on the bed. The CNAs (#22 and #30) then transferred the resident into the bathroom, assisted her with dressing, and assisted with walking utilizing a gait belt and wheelchair to follow in the hallway. After walking a few feet, Resident #8 stated she felt weak and was taking deep breaths. She was seated in her wheelchair and taken to the dining room without oxygen. Resident #8 did not have her oxygen in place during her noon meal.

Observation on 03/09/16 at 8:17 a.m. showed Resident #8 seated in her wheelchair at the dining room table with the oxygen nasal cannula and tubing wrapped around her wheelchair handle. Staff failed to provide her oxygen as

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F 328	Continued From page 43 ordered. During an interview on 03/10/16 at 10:03 a.m., an administrative staff (#2) stated Resident #8's oxygen should be on at all times. The facility failed to provide and/or offer the continuous oxygen ordered for Resident #8.	F 328		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards for 1 of 1 sampled resident (Resident #2) observed receiving 18 medications two to three hours late. Failure to administer medications at the scheduled time placed the resident at risk for adverse health effects. Findings include: Berman, Snyder, Frandsen, Kozier, and Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 10th ed., Pearson Education Inc., New Jersey, 2016, page 773, stated, "Ten 'Rights' of Medication Administration . . . Right Time: Give the medication at the right frequency and at the time ordered . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included	F 333	Resident #2: Medications are given timely, within one hour of scheduled dose, and documented as administered. Medication error report was completed and resident had no complications/adverse reactions from med error. This has the potential to affect all residents when medications are not given timely and documented appropriately. Nurse who made med error was educated and disciplined on failure to follow medication policy in regard to one hour before/after scheduled time and appropriate documentation. All nurses will be reeducated on the medication policy with emphasis on timeliness of med pass and	4/21/16

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F 333	Continued From page 44 Alzheimer's disease, convulsions, glaucoma, depression, anxiety, gastric reflux, and diabetes. Resident #2's daily medications included: Tylenol three times a day (tid); Levothyroxine (thyroid) once a day (qd); Omeprazole (gastric reflux) twice a day (bid); Brimonidine Tartrate eye drops (glaucoma) bid; Benazepril (for high blood pressure) qd; Cetirizine (antihistamine) qd; Fenofibrate (for high triglycerides) qd; Glimepride (for diabetes) qd; Lasix (diuretic) qd; Lexapro (antidepressant) qd; Potassium qd; Vitamin D3 qd; Gabapentin (anticonvulsant) tid; Risperdal (antipsychotic) tid; Calcium bid; Metformin (for diabetes) bid; Ativan (antianxiety) bid; Divalproex (anticonvulsant) bid; Colestipol (for high cholesterol) bid; Aricept (anti-Alzheimer) qd; and Ferrous Gluconate (Iron) qd. A progress note, dated 03/09/16 at 8:30 a.m., stated, "Resident [#2] sleeping this am [a.m.] and writer attempted to waken her but resident stated 'just let me sleep.' Will hold 8 am lorazepam [Ativan] and Risperdal." Observation on 03/09/16 at 8:15 a.m. and 9:15 to 9:50 a.m. showed Resident #2 awake in her room. Observation on 03/09/16 at 11:28 a.m. showed a nurse (#38) exiting Resident #2's room. The nurse stated she had just given Resident #2 her morning medications (scheduled for 7:00 a.m., 8:00 a.m., and 9:00 a.m.) When asked why they were administered late, the nurse (#38) stated the resident had been sleeping all morning. Review of Resident #2's medication	F 333	documentation. Medication documentation will be reviewed for timely administration and sign off, along with any documented variances. QI will be done weekly X4, monthly X3, and quarterly until compliant. Education to be completed by April 21, 2016. This is the responsibility of the DON.	

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F 333	Continued From page 45 administration record (MAR), dated 03/09/16, identified the following medications administered at approximately 11:28 a.m.: * 7:00 a.m. medications: Levothyroxine and Omeprazole * 8:00 a.m. medications: Brimonidine Tartrate, Benazepril, Cetirizine, Fenofibrate, Glimepride, Lasix, Lexapro, Potassium Chloride, Vitamin D3, Gabapentin, Risperdal, Calcium, Metformin, Ativan, Divalproex Sodium * 9:00 a.m. medication: Colestipol Further review of the MAR showed Resident #2's did not receive the scheduled Ativan at 8:00 a.m., received Gabapentin bid instead of tid, Risperdal bid instead of tid, and Tylenol once instead of tid. Review of Resident #2's medical record showed the nurse (#38) failed to document the reason the medications were administered late.	F 333		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		4/14/16

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F 441	Continued From page 46 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow infection control practices for 12 of 27 sampled residents (Resident #2, #6, #10, #12, #15, #16, #18, #19, #20, #23, #25, and #27). Failure to follow infection control practices related to enteric (intestinal) precautions (Resident #2), droplet precautions (Resident #18), dressing changes (Resident #10 and #6), and hand hygiene/perineal cares (Resident #6, #12, #15, #16, #19, #20, #23, #25, and #27) has the potential to spread infection to other residents, staff, and visitors.	F 441	All residents including those identified will receive appropriate care to prevent spread of infections to staff or other residents. Resident #2 Enteric precautions are provided, Resident # 18 Droplet Precautions are provided. Resident # 6 and #10-dressing changes are done following correct IC practices-nurses reeducated at April 13th Nurse Meeting. Resident #6, #12, #15, #16, #19,#20,#23,#25 #27-All cares provided using proper IC practices and staff were reeducated on Infection control procedures at C.N.A. meeting April 6 &	

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F 441	Continued From page 47 Findings included: ENTERIC PRECAUTIONS Review of the facility policy titled "Isolation Precautions" occurred on 03/10/16. This policy, revised January 2016, stated, ". . . Enteric Contact Precautions - Clostridium diffcile [C.diff]: . . . *Visitors to a room with a resident with active C difficile diarrhea must wear both the gown and gloves. *Soap and water is required for hand hygiene for C difficile diarrhea because alcohol does not kill spores. Remove alcohol waterless antiseptic from these rooms during contact precautions." - Review of Resident #2's medical record occurred on all days of survey and identified the infection (C. diff). A sign affixed to the resident's door stated "Enteric Precautions." Observation on 03/08/16 at 9:55 a.m. showed one nurse (#42) and one certified medication aide (CMA) (#43) donned gloves and entered Resident #2's room. The staff member (#43) gave the resident her morning medication as the other staff member (#42) visited with the resident. The staff member (#42) washed her hands before exiting the room, however, the other staff member (#43) used hand sanitizer. Observation showed the hand sanitizer dispenser located on the wall next to the bathroom. Observation on 03/08/16 at 10:25 a.m. showed the certified nursing assistant (CNA) (#44) donned gloves and a gown, entered Resident #2's room, and provided perineal cares after a bowel movement. Observation showed stool on	F 441	7th and Nurse Meeting April 13th. Infection control practices are being followed appropriately. All residents have the potential of being affected if appropriate infection control practices are not followed. A mandatory inservice for staff was provided for staff by our Infection Control Nurse and Staff Educator the week of March28-April 4th with attendance of over 200 staff. Staff observed for proper use of PPE, hand hygiene, peri care, and DRO precautions. Review of Infection Control at the C.N.A. meetings, Nurse meetings and Charge Nurse Meetings. Emphasis placed on need for soap and water to be used with all residents diagnosed with C-Diff. Wound Care nurse instructed and observed on proper technique. Observation of cares by Infection Control nurse and charge nurse will be done: Peri cares, hand hygiene, enteric precautions, droplet precautions and dressing changes-2 staff observations weekly on each unit. QI will be done weekly X4, monthly X3, and then quarterly until compliant. All education to be completed by April 21st, and Qi's starting April 7th. This is the responsibility of the DON.	

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the linen under the resident. The CNA removed her gown and gloves and exited the room to obtain clean linen. The CNA (#44) failed to wash her hands before exiting the room. The CNA (#44) donned a new gown and gloves, re-entered the room with clean linen, removed the soiled linen and, with the same gloves, put the clean linen on the bed.

Observation on 03/08/16 at 10:55 p.m. showed two CNAs (#44 and #45) donned gloves and a gown, entered Resident #2's room, and boosted her up in bed. Both CNAs removed their gloves and gown and washed their hands. The resident asked for a fresh glass of water and the CNA (#44), with her bare hand, obtained the empty glass from Resident #2's bedside and exited the room. The CNA (#44) failed to obtain the glass with gloved hands.

Observation on 03/08/16 at 4:20 p.m. showed two CNAs (#46 and #47) donned gloves and a gown, entered Resident #2's room, and provided perineal cares after a bowel movement. After completion, both CNAs removed their gown and gloves and exited the room without washing their hands.

DROPLET PRECAUTIONS

Review of the facility policy titled "Isolation Precautions" occurred on 03/10/16. This policy, revised January 2016, stated, ". . . Gloves . . . Decontaminate hands immediately after gloves are removed . . . Gown . . . Remove a soiled gown as promptly as possible and perform hand hygiene to avoid transfer of microorganisms to other residents or environments. . . . Resident

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F 441	Continued From page 49 transport . . . Limit the movement and transport of the resident from the room . . . Droplet Precautions . . .When a private room is not available and cohorting is not achievable, maintain spatial separation of at least six (6) feet between the infected resident and other residents and visitors. . . . " Review of the facility policy titled "Infection Control Barriers (gloves, gown, mask)" occurred on 03/10/16. This policy, revised February 2012, stated, ". . . Procedure for Removing Barriers and Leaving an Isolation Room 1) Bag all linen and equipment to be removed from the room into the yellow linen bags . . . 5) Remove the gloves. 6) Wash your hands. 7) Remove your mask, remembering to touch only the ties. 8) Untie your gown remove it and discard in the appropriate receptacle. 9) Take the linen and garbage bags to the carts. Avoid having the bags touch your clothing. 10) Wash your hands or use waterless hand antiseptic. Take care not to touch environmental surfaces on the way out of the patient/resident room. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice" 10th Edition, Pearson Education Inc., Upper Saddle River New Jersey, 2016, Page 619, stated, ". . . Droplet Precautions. . . Limit movement of client outside the room to essential purposes. Place a surgical mask on the client while outside the room. . . ." - Observation on 03/07/16 at 10:55 showed Resident #18 seated in a recliner at the nurses station visiting with a nurse (#34). The nurse (#34) identified Resident #18 on droplet precautions. Neither the nurse (#34) or Resident	F 441		

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F 441	Continued From page 50 #18 wore a mask. Observation on 03/08/16 at 8:45 a.m. showed a CMA (#1) donned a gown, gloves, and mask and entered Resident #18's room to obtain vital signs. The CMA (#1) attempted and failed to get a blood pressure reading, then attempted to assist Resident #18 with eating; however, the resident refused. The CMA picked up the resident's bedside tray, exited the room, and returned the food tray to the nurses station counter. The CMA then returned to the room, entered the resident's bathroom, removed her gown, and disposed of the gloves. The CMA (#1) exited the resident's room with the gown rolled up under her arm and disposed of it in the shower room down the hall in a yellow receptacle, then continued to the nurses station to wash her hands. Observation on 03/08/16 at 9:45 a.m. showed two CNAs (#3 and #37) donned a gown, gloves, and masks to enter Resident #18's room to provide cares. The two CNA's changed Resident #18's brief, wet with urine, and provided perineal cares. After completed, one of the CNAs (#37) removed her gown and disposed of gloves in the bathroom. The CNA (#3) reminded the other CNA (#37) to wash her hands before she left the room. The CNA (#37) balled up the gown under her arm, sanitized her hands, exited the room with the gown, and disposed of it in the utility room down the hall. After CNA (#3) completed cares she removed her gown, disposed of her gloves, exited the room with the gown balled up in her hands, and disposed of it in the utility room down the hall, then returned to the nurse's station to wash her hands.	F 441		

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Observation on 03/08/16 at 12:05 p.m. showed a CNA (#3) donned a gown, gloves, and mask and entered Resident #18's room with her tray for lunch. The CNA assisted the resident with tray set up and a few bites of food before the resident began to spit out the food and refused to eat anymore. A nurse (#39) entered Resident #18's room, without donning a gown, gloves, and a mask, to talk to the CNA (#3) and stood within three feet of the resident. The CNA (#3) removed her gown, disposed of her gloves, sanitized her hands, exited the room with the gown under her arm, and disposed of it in the utility room down the hall, then washed her hands at the nurses station.

During a staff interview on 03/10/16 at 2:10 p.m., an infection control nurse (#35) stated a resident on droplet precautions should not leave their room.

The staff failed to routinely mask when within six feet of Resident #18 and failed to properly dispose of and remove infection control barriers when leaving the isolation room.

HAND HYGIENE/PERINEAL CARE

Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 03/10/16. This policy, dated December 2015, stated, ". . . When is Hand Hygiene (Alcohol Hand Sanitizers) necessary? . . . Before and After entering isolation precautions, [including methicillin resistant Staphylococcus aureus (MRSA)]. Before and After assisting a resident with personal care . . . After contact with resident's mucous membranes and body fluids,

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or excretions . . . After removing gloves or gowns. . . . When is Handwashing (Soap and Water) necessary? . . . Before and After assisting a resident with toileting, . . ."

Review of the facility policy "Peri Care - Female" occurred on 03/10/16. This policy, dated January 2016, stated, ". . . PROCEDURE . . . 5. Perform hand hygiene with soap and water. . . . Resident is to be on back. . . 8. Put on gloves. . . . 4. Wet a washcloth . . .5. Clean the supra pubic area first then use one gloved hand to stabilize and separate the vulva. With the other gloved hand, proceed as follows. Bring soaped washcloth in one downward stroke, being sure not to bring the washcloth back upwards on the skin . . . 6. Turn resident away from you. . . . 8. Expose anal area. Wash area, stoking from perineum to coccyx. . . . 11. Return resident to back. 12. Remove gloves and discard. If the resident wears briefs, apply clean brief after removing the disposable gloves. . . . 21. Perform hand hygiene with soap and water. . . ."

- Review of Resident #16's medical record occurred on all days of survey and identified Contact Precautions related to MRSA.

Observation on 03/09/16 at 9:30 a.m. showed a CNA (#10) donned a gown and gloves and provided perineal cares for Resident #16. With the same gloves, the CNA dressed the resident, utilized a full body mechanical lift (Hoyer), and with the assistance of another CNA (#51), transferred the resident into a wheelchair. The CNA (#10) then changed her gloves. The CNA (#10) failed to change gloves after providing perineal cares and before continuing with other

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cares.

- Review of Resident #20's medical record occurred on March 09-10, 2016 and identified Contact Precautions related to MRSA.

Observation on 03/09/16 at 4:20 p.m. showed the CNA (#8), donned a gown and gloves and provided perineal cares for Resident #20 after a bowel movement. Without changing gloves, the CNA placed the call light within reach for the resident, operated the bed control, and handed the resident a glass of water. The CNA (#8) then applied a barrier cream to Resident #20's front peri-area, removed his/her gloves, applied clean gloves, and positioned the sling used for a Hoyer transfer under the resident. Another CNA (#50), donned a gown and gloves, entered the room and assisted the CNA (#8) to transfer Resident #20 from bed to a wheelchair. Both CNAs removed their gowns and gloves and exited the room without washing or sanitizing their hands.

During an interview on the afternoon of 03/10/16, the unit manager (#13) stated she expected staff members to sanitize their hands before exiting Resident #20's room.

- Review of Resident #19's medical record occurred on March 09-10 and identified a urinary tract infection (UTI) on 02/04/16.

Observation on 03/09/16 at 5:28 p.m. showed a CNA (#27) provided Resident #19 with personal cares. The CNA (#27) donned gloves, removed the resident's brief wet with urine, used a washcloth to wipe the resident's perineal area front to back then back to front, applied protective

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ointment to Resident #19's perineal area, and then removed her gloves. The CNA failed to wipe the perineal area according to policy and failed to remove gloves before applying the protective ointment.

During an interview on 03/10/16 at 10:30 a.m., an administrative nurse (#13) stated she expected staff to wipe the perineal area from the front perineal area towards the back perineal area.

- Review of Resident #27's medical record occurred on March 09-10, 2016 and identified a UTI on 01/27/16.

Observation on 03/10/16 at 8:50 a.m. showed two CNAs (#10 and #31) donned gloves and provided perineal cares for Resident #27 after an incontinent bowel movement. The CNAs provided back (rectal) perineal cares, but failed to provide frontal perineal cares.

During an interview at 03/10/16 at 9:35 a.m., a unit manager (#33) stated he expected staff to perform complete perineal cares for Resident #27.

- Observation on 03/08/16 at 11:40 a.m. showed two CNAs (#16 and #17) assisted Resident #15 onto the toilet. One CNA (#16) completed perineal care, and after removing their gloves, both CNAs (#16 and #17) ambulated Resident #15 to the dining room. Both CNAs failed to perform hand hygiene before leaving the resident's room.

- Observation on 03/09/15 at 5:15 p.m. showed two CNAs (#14 and #15) changed Resident

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#23's wet and soiled brief. Observation showed visible stool on the wet wipe. After completing perineal care and before removing gloves, the CNA (#15) opened the cabinet door, obtained a tube of perineal ointment, handed the ointment to the other CNA (#16), and removed his gloves. After donning new gloves, the CNA (#15) assisted Resident #23 into the wheelchair, collected the garbage, removed the bed linens, removed his gloves, and left the room. The CNA (#15) failed to perform hand hygiene after perineal care, prior to completing other tasks, and before exiting the resident's room.

- Observation on 03/08/16 at 9:55 a.m. showed a CNA (#24) performed perineal care for Resident #6 who was incontinent of bowel and then removed her gloves. Without performing hand hygiene, the CNA (#24) donned gloves, applied Resident #6's brief, covered the resident with a sheet, positioned a pillow on the resident's right side and under her legs, and adjusted Resident #6's pillow under her head. The CNA (#24) washed her hands and exited the room. The CNA (#24) failed to perform hand hygiene after providing perineal care and before completing other tasks.

Observation on 03/08/16 at 4:20 p.m. showed a CNA (#25) performed perineal care for Resident #6 who was incontinent of bowel, and then removed her gloves. Without performing hand hygiene the CNA donned gloves, applied skin protectant cream to Resident #6's buttocks, and removed her gloves. The CNA donned gloves, applied a brief, and removed her gloves. The CNA (#25) adjusted Resident #6's pillow under her head, placed pillows under the resident's

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legs, covered the resident with a sheet, gave Resident #6 her call light, adjusted the bed with the bed controls, and then performed hand hygiene. The CNA (#25) failed to perform hand hygiene after providing perineal care and before completing other tasks.

- Observation on 03/08/16 at 3:30 p.m. showed a CNA (#8) donned gloves, positioned the full body lift sling under Resident #12, emptied a urinal into the toilet, opened the resident's door to retrieve the full body mechanical lift, hooked the sling to the lift, and transferred Resident #12 from his recliner to the commode. The CNA (#8) then unhooked the sling from the lift, put the call light near Resident #12, removed his gloves, and performed hand hygiene. With no gloves on, the CNA removed the chair protector soiled with bowel and carried it into the hallway unbagged. Resident #12 activated his call light, and the CNA (#8) donned gloves and emptied the urinal into the toilet. Without removing his gloves, the CNA positioned the cushion in the recliner, applied a new chair protector, hooked the sling to the mechanical lift, performed perineal cares with bowel present, applied skin protectant to Resident #12's buttocks, removed his gloves, and performed hand hygiene. The CNA (#8) failed to remove his gloves after emptying the urinal, failed to apply gloves while handling soiled items, and failed to dispose of soiled items properly.

- Review of Resident #25's medical record occurred on March 09-10, 2016. The current care guide stated, ". . . Safety . . . contact precautions . . ." The current care plan stated, ". . . Problem: Infection Precaution - VRE

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F 441	Continued From page 57 [Vancomycin-Resistant Enterococci] positive on admission representing colonization . . ." Observation on 03/10/16 at 10:28 a.m. showed two CNAs (#6 and #7) donned gown and gloves, and toileted Resident #25. The CNAs removed their gowns and gloves and exited the room. The CNAs (#6 and #7) failed to perform hand hygiene before exiting the room. DRESSING CHANGE - Observation on 03/09/16 at approximately 9:15 a.m. showed a wound nurse (#26) donned gloves, removed Resident #6's wound dressings, measured the wounds, performed perianal care for Resident #6's bowel incontinence, and removed her gloves. Without performing hand hygiene the nurse donned gloves, cleansed the wounds, and removed her gloves. The nurse (#26) donned gloves, placed the new dressing, removed her gloves, and washed her hands. The nurse (#26) failed to perform hand hygiene after providing perianal care and before completing a dressing change. - Observation on 03/08/16 at 10:10 a.m. showed a licensed nurse (#23) removed a wound dressing containing light brown drainage from Resident #10's right foot. Without changing gloves, the nurse obtained scissors from a tray, removed the dressing from the left foot, removed her gloves, and performed hand hygiene. The nurse (#23) failed to change gloves and perform hand hygiene after removing the dressing from the right foot. During an interview on 03/10/16 at 8:10 a.m., an	F 441		

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F 441	Continued From page 58 administrative nurse (#35) stated she provides infection control education to new CNAs and new facility employees during the CNA training program and upon hire. All staff members are re-educated during a yearly skills fair.	F 441		