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 _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	**305 8TH AVE NE MINOT, ND 58703**

(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 The standard Medicare/Medicaid and complaint survey started on 04/02/18 and concluded on 04/05/18. Portions of the complaint were substantiated.	F 000		
F 550	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		4/26/18

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

Electronically Signed | 04/26/2018

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/22/17. Based on observation, review of Resident's Council Minutes, and resident interview, the facility failed to provide care for 1 of 17 sampled residents interviewed (Resident A) and one of one supplemental resident (Resident #39) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure by staff to knock on doors, announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the Resident's Council minutes occurred on 04/04/18. The minutes, dated March 19, 2018, stated, ". . . One resident shared that staff were not waiting for him to respond after they knock on his door. . . ." During an interview on 04/02/18 at 4:01 p.m., Resident A stated, "The staff do not respect my	F 550	Discussion held with Resident A and Resident #39 to immediately report to charge nurse or nurse manager if staff are not knocking on door and waiting for resident to acknowledge or give permission to enter room. Immediate discussion held with Housekeeping Director and education provided to staff. All residents have the potential to be affected and have their personal dignity and individuality violated if staff do not knock on doors, announce themselves, and wait for permission prior to entering residents' rooms. All Trinity Homes staff received education regarding knocking on resident's door, introducing themselves, and requesting permission before entering. Staff knocking on doors, announcing themselves and waiting for permission prior to entering resident rooms preserves the residents' personal dignity and enhances their quality of life and avoids the risk of embarrassment and/or emotional harm. This will be part of the	

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F 550	Continued From page 2 privacy, they do not always knock and introduce themselves before entering my room or they knock as they enter my room. I have spoken with the staff about this and remind them to knock. I have reported this at a Resident Council meeting." Observation on all days of survey showed Resident A had a sign "knock before entering" taped to his/her door. - Observation on 04/03/18 at 10:52 a.m. showed a housekeeper knocked twice, opened Resident #39's room door, and stated, "housekeeping" while entering the room. The housekeeper failed to wait for Resident #39 to acknowledge or give permission to enter his room.	F 550	agenda monthly for the Resident Council. Mandatory staff meetings held on April 24 & 25, 2018 for all staff to address the deficiencies, including this deficiency. Copies of the education for the Plan of Correction (POC) of the deficiencies were placed in all appropriate departments as an in-service and staff has been educated through the read and sign process. These deficiencies have a specific quality assurance audits: Audit staff to assure all staff members knock on doors and wait for the resident to acknowledge or give permission (if resident is able to do so) and all staff will announce themselves to the residents. QA audits started on April 23rd and will be done weekly on each unit 5 times/weekly for four weeks, then 10 times monthly for 4 weeks, and then 10 times quarterly until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 657	Severity/Scope = 2/1 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		4/26/18

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F 657	Continued From page 3 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/22/2017. Based on observation, record review, facility policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 3 of 35 sampled residents (Resident #37, #40, and #294). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident.	F 657	The care plan was revised for resident #40 by removing the nursing interventions for diagnosis regarding anticoagulants as the medication was discontinued. The care plan for resident #37 was revised to reflect the use of bilateral assist bars. A bed rail assessment was also completed, consent signed, and provider order received. The care plan was revised for resident #294 to include the use of a Foley catheter.	

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F 657	Continued From page 4 Findings include: Review of the facility policy/procedure titled "Care Planning," occurred on 04/05/18. This policy, dated, January 2015, stated, ". . . Each nursing unit is responsible for the reviewing and updating of the resident care plans. . . . Objectives: A. To develop a concise, easily understood plan of care for each resident which meets State and Federal requirements for resident care planning. . . . E. To assure optimum levels of care for each resident are being provided. . . . Care plans are to be revised according to the resident's condition. Each discipline is responsible for the approaches listed on the care plan and will be identified on the appropriative section. . . . Care Plan Review: On each shift the CNA's (Certified Nurse Assistants) and Nurse review care plans and care guides so that each resident's care plan is reviewed by the three shifts monthly adding or deleting problems, goals, and approaches as appropriate." - Review of Resident #40's medical record occurred on all days of survey. Diagnoses included hemiplegia (loss of movement on one side of the body) following cerebral infarction (stroke) affecting right side, depression, aphasia (loss of ability to understand or express speech), and gastrostomy (feeding tube). The facility received a physician order to discontinue Lovenox (a blood thinner) on 02/19/18. Resident #40's care plan stated, ". . . [Name] is at risk for bleeding r/t [related to] anticoagulant. . . Administer anticoagulant as ordered. Monitor sings/symptoms of bleeding . . ." Staff failed to review and revise the care plan after the order to	F 657	All residents have the potential to be affected if the care plan is not revised by an interdisciplinary team in a timely manner. Failure to update the care plan in a timely manner limits the ability of staff to communicate care needs and does not ensure continuity of care for each residents. All care plans will be revised/updated in a timely manner for any changes in condition or changes in care. All Trinity Homes nursing staff received education to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his/her care. Staff meetings held April 24 & 25, 2018 for all staff to address the deficiencies, including this deficiency. Copies of the education for the POC of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through the read and sign process. These deficiencies have a specific quality assurance audits: Care plans will be reviewed weekly to assure that all care plans are	

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F 657	Continued From page 5 discontinue the anticoagulant. Observation on all days of survey showed Resident #40 with a push button call light in the resident's room. Resident #40's care plan stated, ". . . at risk for falls r/t right sided weakness due to stroke and history of falls. . . . Soft touch call light. Keep within easy reach. . . ." Staff failed to review and revise the care plan to reflect the resident's current call light device. During an interview on 04/05/18 at 11:45 a.m., an administrative nurse (#3) confirmed staff failed to update Resident #40's care plan. - Review of Resident #37's medical record occurred on all days of survey. Diagnoses included cerebral palsy and weakness. The current care plan stated, ". . . [Name] is not able to do her own activities of daily living r/t cerebral palsy and weakness. . . . upper half side-rails to enable repositioning. . . ." Observation on all days of survey showed Resident #37's bed with bilateral assist bars attached to the bed. The care plan failed to identify the assist bars. - Review of Resident #294's record occurred on all days of survey. Diagnoses included dementia and anxiety. The current physician's orders, dated 03/27/18, identified a Foley catheter. Observations on all days of survey showed Resident #294 with a Foley catheter. The care plan failed to identify the Foley catheter. During an interview on 04/04/18 at 11:00 a.m., a	F 657	revised/updated with resident conditions and changes in care. QA audits started on April 23rd and in addition to the care plans scheduled for the monthly care plan session, three care plans from each unit will be reviewed weekly for four weeks, then 2 care plans monthly for 4 weeks until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The DON is responsible to assure that the POC is followed.	

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F 657	Continued From page 6 licensed nurse (#21) confirmed staff failed to update Resident #294's care plan to include the Foley catheter. Severity/Scope = 2/1	F 657		
F 658	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's guidelines, and staff interview, the facility failed to follow professional standards of practice to prime an insulin pen for 2 of 2 supplemental residents (Resident #52 and #166) observed receiving insulin. Failure to follow the manufacturer's recommendation for priming an insulin pen has the potential for residents to receive an inaccurate dose of insulin. Findings include: Review of the Humalog Kwikpen manufacturer's instructions occurred on 04/05/18. The instructions stated, " . . . Pull off the Outer Needle Shield. . . . Hold your Pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. . . . Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. . . . A stream of insulin should be seen from the needle. . . ." Observation on 04/04/18 at 8:05 a.m. showed a	F 658	Immediate action was taken to educate the nurse who was identified with this deficiency. The nurse was educated with the instructions for use for the Humalog Kwikpen guide and gave a return demonstration. All residents who receive insulin have the potential to be affected if the insulin pen is not primed correctly and has the potential for residents to receive an inaccurate dose of insulin. All staff that administer insulin via pen were given an in-service on the proper way to prime an insulin pen. The staff then completed an insulin priming demonstration to ensure their competency of meeting the professional standard. The Instructions for use Humalog Kwikpen guide is the resource that is on each nursing unit. These instructions were discussed at the all staff education	4/26/18

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F 658	Continued From page 7 licensed nurse (#2) prepared Resident #52's insulin pen for injection. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield and hold the pen vertically while priming the insulin pen. With the shield still in place, the nurse was unable to visualize a stream of insulin from the needle. Observation on 04/04/18 at 8:18 a.m. showed a licensed nurse (#2) prepared Resident #166's insulin pen for injection. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield and hold the pen vertically while priming the insulin pen. With the shield still in place, the nurse was unable to visualize a stream of insulin from the needle. During an interview on 04/05/18 at 11:30 a.m. an administrative nurse (#3) stated she expected staff to hold an insulin pen with the needle pointing up and the outer needle shield should be off when priming.	F 658	and nurses meeting on April 24 & 25, 2018. Instructions are also located in the nurse educator's office. Staff meetings were held on April 24 & 25, 2018, as well as a nurse meeting on April 4th for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign process. These deficiencies have a specific quality assurance audits: QA audits started on April 23rd. Four audits will be done weekly for 8 weeks, and then four audits monthly until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 677	Severity/Scope = 2/1 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		4/26/18

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F 677	Continued From page 8 by: Based on information provided by the complainant, observation, and record review, the facility failed to provide assistance with activities of daily living (ADLs) on 3 of 4 days of survey (April 2-4, 2018). Failure to assist a resident who cannot perform the task independently may result in decreased self-esteem and poor grooming. Findings include: Information provided by the complainant indicated staff had not provided adequate hair care to a resident. Review of Resident #132's medical record occurred on all days of survey. Diagnoses included Alzheimer's, dementia, and weakness. The resident's current quarterly Minimum Data Set (MDS), dated 03/02/18, identified extensive assistance from one person for personal hygiene. The current care plan stated, " . . . Grooming/hygiene self care deficit R/T [related to] weakness, dementia . . . staff to comb/brush hair . . . every morning. Random observations on April 2- 4, 2018 showed Resident #132's hair looked disheveled and unkempt with large clumps of hair sticking straight out.	F 677	Immediate action was taken to educate staff who cared for resident #132. Resident had her hair care done again. The care plan for resident #132 was revised to reflect the behavior of the resident following grooming. All residents who are dependent on staff for cares have the potential to be affected if not provided with necessary services to maintain grooming. All staff received education regarding residents who are unable to carry out activities of daily living and must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Staff meetings were held on April 24 & 25, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign process. These deficiencies have a specific quality assurance audits: QA audits started on April 23rd. Four audits, looking at resident appearance, will be done weekly on each unit for four weeks, then two audits on each unit for 4 weeks, or until compliance is sustained. QA audits will be done by designated staff and monitored weekly by ADON and	

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F 677	Continued From page 9	F 677	DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 684	Severity/Scope = 2/1 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/22/17. Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, the facility failed to ensure 3 of 15 sampled residents (Resident #128, #190, and #191) requiring assistance with fluids received the necessary care and services to ensure his/her safety. Failure to properly position Resident #128, #190, and #191 in bed when assisted with fluid intake has the potential to negatively affect the overall swallow safety and placed the residents at risk of aspiration. Findings include:	F 684	Immediate action was taken to educate staff for proper positioning of residents #128, #190, and #191 at a 90 degree sitting position when assisted with fluids. All residents have the potential to be affected if not properly positioned to receive fluids. All staff received education regarding residents who receive assistance with fluids. Providing care in accordance with professional standards of practice allows safety for the resident when receiving fluids and decreases the risk of aspiration. Resident's should be at a 90	4/26/18

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F 684	Continued From page 10 Review of the facility policy titled "Guidelines for Residents dining in their room" occurred on 04/05/18. This policy, updated February 2018, stated, ". . . Positioning the resident comfortably . . . 45 to 90 degrees sitting is preferred . . ." Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . ." - Review of Resident #128's medical record occurred on all days of survey. Diagnoses included dementia and COPD (chronic obstructive pulmonary disease). The quarterly Minimum Data Set (MDS), dated 03/01/18, identified long and short term memory loss and eats independently after set up assistance. Observation on 04/03/18 at 5:00 p.m. showed two CNAs (certified nursing assistants) (#16 and #17) completed cares for Resident #128 and provided the resident a drink of water with the head of the bed at an approximate 30 degree angle. - Review of Resident #190's medical record occurred on all days of survey. Diagnoses included COPD and reflux disease. The quarterly MDS, dated 02/27/18, identified severely impaired cognition and requires supervision with eating.	F 684	degree angle when fluids are being given. Staff meetings were held on April 24 & 25, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign process. These deficiencies have a specific quality assurance audits: Audit staff to assure all residents are in the proper sitting position of 90 degrees when fluids are being offered. QA audits started on April 23rd and will be done weekly on each unit 5 times/weekly for four weeks, then 10 times monthly for 4 weeks, and then 10 times quarterly until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	

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F 684	Continued From page 11 Observation on 04/03/18 at 10:00 a.m. showed a CNA (#18) completed cares for Resident #190 and provided the resident a drink of water with the head of the bed at an approximate 20 degree angle. - Review of Resident #191's medical record occurred on all days of survey. Diagnoses included recent surgery on digestive system and osteoarthritis. The admission MDS, dated 03/13/18, identified the resident as cognitively intact, requires extensive assistance of two staff members for bed mobility and eats independently after set up assistance. Observation on 04/02/18 at 4:15 p.m. showed a CNA (#16) and an unidentified CNA completed cares for Resident #191 and provided the resident a drink of water with the head of the bed flat. During an interview on 04/05/18 at 11:30 a.m., an administrative nurse (#3) stated she expected staff to raise the resident's head of bed to a 90 degree angle when providing fluids. Severity/Scope = 2/1	F 684		
F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		4/26/18

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F 689	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of operating instructions, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 3 sampled residents (Resident #191) observed during transfers utilizing a sit to stand lift. Failure to transfer Resident #191 safely placed the resident at risk of an accident and/or injury. Findings include: Review of the facility's "Operator's Instructions" for the EZ Way Smart Stand Lift occurred on 04/05/18. The instructions, dated 12/21/10, stated, ". . . Have patient place feet (help patient if needed) on foot plate and position their shins into the shin pad. . . ." Review of Resident #191's record occurred on all days of survey. Diagnoses included recent surgery on the digestive track, diabetic neuropathy, and macular degeneration. The current care plan stated, ". . . Resident is dependant for transfers - pal lift [sit to stand lift] . . . wears glasses r/t [related to] macular degeneration. . . ." Observation on 04/03/18 at 9:46 a.m. showed two certified nursing assistants (CNAs) (#19 and #20) transferred Resident #191 from the wheelchair to the bed. The CNA (#20) instructed the resident to place her feet on the foot plate. The resident stated "I'm legally blind, I can not see it." The CNA (#20) failed to assist the resident with placing her feet on the foot plate,	F 689	Immediate action was taken to educate staff on proper use of assistive devices and positioning of resident□s feet for resident #191. All staff educated on assisting residents with placing of feet on the foot plate. All residents have the potential to be affected if not properly supervised when using assistive devices. All staff received education regarding proper use of assistive devices and adequate supervision during this process to prevent accidents. Staff must ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Staff meetings were held on April 24 &25, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign process. These deficiencies have a specific quality assurance audits: Observe staff while using Stand Lift to assure that residents feet are positioned correctly, flat on the foot plate. QA audits started on April 23rd, observations of	

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F 689	Continued From page 13 and the resident's left foot rested on the raised edge of the foot plate during the entire transfer. During an interview on 04/05/18 at 11:40 a.m., an administrative nurse (#3) stated she expected staff to assist residents with placement of their feet on the foot platform when using the sit to stand lift.	F 689	resident's who use the lift to transfer. Observations will be done on 3 residents weekly per unit for 4 weeks, then 2 residents per unit for 8 weeks or until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 700	Severity/Scope = 2/1 Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		4/26/18

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F 700	Continued From page 14 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to try alternatives to bed rails, assess resident safety with the use of bed rails, and obtain informed consent prior to installation for 16 of 34 sampled residents (Resident #6, #29, #51, #58, #59, #68, #108, #126, #128, #148, #159, #174, #180, #185, #191, and #294) with quarter length or half length bed rails. Failure to implement and/or assess the effectiveness of alternatives attempted prior to instituting bed rails and how those alternatives failed to meet the residents' needs, failure to assess residents for the risk of entrapment or injury, and failure to explain the possible risks/benefits of utilizing bed rails did not allow the resident/representative to make an informed decision and may have contributed to injuries from the bed rails. Findings include: - Review of Resident #59's medical record occurred on all days of survey. The care plan, dated 03/26/18 , stated, ". . . not able to do her own activities of daily living (ADL's) due to weakness. . . . Bed Mobility: Independent in bed mobility. Uses 1/2 siderails to aid in positioning. . . ." A nurse's note, dated 02/19/18 at 7:18 a.m. stated, "While resident was attempting to hang up her phone, she scraped her left arm on side rail on bed and has a skin tear to left upper arm. . . ." On 04/02/18 at 11:30 a.m., observation showed	F 700	The facility failed to document proper alternatives prior to installing bed rails. Assessments and consents being completed on Residents #6, #29, #51, #58, #59, #68, #108, #126, #128, #148, #159, #174, #180, #185, #191, and #294; as well as all residents in the facility. All residents have the potential to be affected by not assessing the effectiveness of alternatives attempted prior to instituting bed rails and how those alternatives failed to meet the residents needs, failure to assess residents for the risk of entrapment or injury, and failure to explain the possible risks/benefits of utilizing bed rails does not allow the resident/representative to make an informed decision and may contribute to injuries from the bed rails. All staff received education regarding the newly implemented bed rail assessment form. Nursing, social work, and therapies are assisting with the resident bed rail assessment process. These assessments are being done will all current residents and on all new residents who come to our facility. The education includes appropriate alternatives prior to installing a bed rail. The facility must ensure correct installation, use, and maintenance of bed rails. Staff is currently completing a bed	

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F 700	Continued From page 15 Resident #59's bed with two elevated half bed rails at the head of the bed (HOB), with foam padding taped over the top of each rail. During an interview on 04/03/18 at 3:37 p.m., Resident #59 stated staff padded the rails after she hit the rail with her arm when she answered her phone, which caused the skin tear. Resident #59's record lacked evidence of alternatives tried, an assessment, a reassessment for safety issues related to the use of bed rails after her injury, and an informed consent for the use of bed rails. - On all days of survey, observation showed residents' beds with the following types of bed or side rails elevated and attached to one or both sides of the HOB: *Quarter length rails: Resident #6, #29, #68, #108, #126, #128, #174. #180, #185, #191, and #294 *Half length rails: Resident #51, #58, #148, and #159 Review of the above listed residents' records failed to show evidence staff attempted alternatives to bed rails, completed an assessment for safety and appropriate use of bed rails, explained the risks/benefits of bed rails, including a risk of entrapment or obtained consent from the resident/resident representative for the use of the bed rails. During an interview on 04/05/18 at 10:35 a.m., two administrative nurses (#3 and #15) stated staff did not complete bed rail assessments or obtain consents for the bed rails.	F 700	rail assessment for safety and appropriate use of bed rails, explaining the risks/benefits of bed rails (including a risk for entrapment), and if alternatives fail to meet the resident□ needs, a consent is being obtained from the resident/resident representative for the use of bed rails. Staff meetings were held on April 24 & 25, 2018 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for the plan of correction (POC) of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign process. These deficiencies have a specific quality assurance audits: Assessments of all residents are being done on each unit. QA audits started on April 23rd and will be done weekly on specific units for completion of assessment, alternatives, and consent completion if residents are utilizing assist bars or side rails. QA audits will be done weekly until all residents have been assessed and side rails/turn bars are removed from bed unless resident/POA request they remain on the bed, and they have been given the risks/benefits and made an informed decision and signed the consent. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee.	

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F 700	Continued From page 16	F 700	The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 725	Severity/Scope = 2/2 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, review of facility policy, resident,	F 725	Staffing has been reviewed on all units and one week prior to survey additional	4/26/18

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F 725	Continued From page 17 family, group, and staff interviews, the facility failed to assure sufficient nursing staff and related services available at all times to meet the residents' needs for 7 anonymous residents (Resident A, C, G, H, J, K, L) and 3 of 7 residents attending the group interview (Resident D, E, F). Failure to provide sufficient staffing to answer call lights in a timely manner does not promote each resident's rights and physical, mental, and psychosocial well-being. Failure to promptly respond to resident calls for assistance may result in residents experiencing falls and/or incontinence. Findings include: Review of the facility policy titled "Answering Patient Call Lights" occurred on 04/05/18. This policy, dated August 2016, stated, "Trinity Hospitals recognizes that prompt answering of patient call lights is essential for the following reasons: 1. It provides the patient with a means of summoning nursing personnel in order to communicate needs to them. 2. It ensures patient safety. 3. It promotes good rapport with patient and family. 4. It promotes fall prevention. . . . All call lights are to be answered promptly. . . ." - During an interview on 04/02/18 at 11:10 a.m., Resident C stated, "Staff are busy and short, I can wait 30 to 60 minutes for assistance, especially during supper when staff are feeding people." - During an interview on 04/02/18 at 03:16 p.m.,	F 725	staff was added to one unit to insure that the needs of all residents are being met and that call lights are answered timely. Due to anonymity of resident interviews, staff has educated residents on addressing concerns about call lights being on for extended times with charge nurse/supervisor. All residents have the potential to be affected by insufficient nursing staff to promptly answer call lights. It is the responsibility of all staff within the building to attempt to answer call lights promptly. Review of staffing and staffing patterns show that there is sufficient staff to meet resident needs. We will be changing processes/assignments to assure residents do not have to wait extended periods of time for their call lights to be answered. Nursing will assign one staff member to specifically answer lights during the busier times on the units; e.g. breakfast and supper. All Trinity Homes staff received education regarding answering call lights. It is everyone in the buildings responsibility to answer the call light, and then when necessary seek out appropriately trained staff person when called for. The education was completed on April 24 & 25, 2018 with all facility staff to address deficiencies, including this one. Copies of the education and plan of correction were placed on the nursing units as in-services,	

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F 725	Continued From page 18 Resident G stated, "It can take a long time [for staff] to answer the call light, up to an hour, so now I avoid calling at 5:30 as they are so busy with supper. I wet myself once waiting at that time, so now I call before suppertime starts." - During an interview on 04/02/18 at 3:42 p.m., Resident A stated he/she has to wait for long periods of time for staff to answer the call light, an average wait time is 30-40 minutes. - During interviews on 04/02/18 at 4:08 p.m., Resident J stated early this morning she requested assistance. A staff member responded and stated she had someone else on the toilet and would come back. Resident C stated the staff member never came back. Resident C added, "When I put the call light on, sometimes it takes a long time [for staff to answer], most of time it is not too bad." Another resident, Resident K, stated the staff "don't answer call lights like they are supposed to," and stated Resident J put the call light on this morning and staff didn't answer until an hour later. - During an interview on 04/03/18 at 3:01 p.m., Resident L stated, "Sometimes it takes a long time [for staff to respond to the call light], about 15 minutes, which is more typical than a faster response. I know they are short of help." - During an interview on 04/03/18 at 4:55 p.m., a family representative for Resident H reported having to wait long periods of time for staff to answer the call light. He/She will leave the resident room to look for staff and will need to ask up to 4 different staff before he/she is assisted.	F 725	and staff has been educated through the read and sign process. These deficiencies have a specific quality assurance audits: 5 resident interviews will be completed weekly on each unit to ask about the timeliness of the resident's call light being answered. These audits will be done weekly times 4 weeks, monthly times 2 months, and then quarterly until compliance is achieved. These audits were started April 23, 2018. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. Call lights will also be on the agenda for resident council monthly, and that report will be shared monthly with the Quality Assurance committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	

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F 725	Continued From page 19 During an interview on 04/05/18 at 1:45 p.m., an administrative staff member (#28) stated they are aware of the problem of short staffing, and are working on solutions. - During a group interview on 04/04/18 at 10:05 a.m., three of seven residents present stated they often have to wait long periods of time for help. Resident D stated they often wait for long periods of time for staff to answer their call light. Resident E stated they have to wait as long as an hour sometimes. Resident F stated sometimes staff leaves them on the toilet for up to 25 minutes. All residents present at the group meeting said there should be more staff at meal times, at bedtime, and in the morning. Severity/Scope = 2/2	F 725		
F 770	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to properly store laboratory supplies in 1 of 13 storage areas (3 South). Failure to discard expired vacutainers (blood specimen collection tubes) and a culture swab increases the risk of staff utilizing outdated laboratory	F 770	The expired supplies were on the 3 South unit and was immediately thrown away. Nurse #21 educated on routinely looking at supplies kept in the supply area and discard all outdated supplies.	4/26/18

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F 770	Continued From page 20 supplies and may skew the test results. Findings include: Observation of the 3 South medication and nursing supplies area occurred on 04/04/18 at 2:00 p.m. with a licensed nurse (#21). Observation identified the following expired supplies: * Four light green top vacutainers (contained Lithium/Heparin) expired January 2017 * Three purple top vacutainers expired April 2017 * Two purple top vacutainers expired February 2016 * Two red top vacutainers expired January 2017 * Two blue top vacutainers expired July 2016 * One yellow top vacutainer expired July 2016 * One culture swab expired July 2013 During the observation, the licensed staff member (#21) agreed staff should discard the above items.	F 770	All residents have the potential to be affected by expired laboratory equipment. Expired laboratory equipment can lead the residents to have to be re-drawn, increasing their risk of site infection, and other risks associated with a lab draw. All staff received education on checking for expired lab equipment and all lab equipment is to be stored in the locked D room on the first floor on the shelves and the lab draw cart. Laboratory staff will check for expired supplies that are in the locked D room on the first floor and on their blood draw cart. The education for Trinity Homes staff was completed on April 24 & 25, 2018 with all facility staff to address deficiencies, including this one. Copies of the education and plan of correction were placed on the nursing units as in-services, and staff has been educated through the read and sign process. These deficiencies have a specific quality assurance audits: Supply areas on each unit will be checked weekly for outdated supplies and all lab supplies will be stored in the D room on the shelves and in the lab carts. Lab staff will check the D room and carts weekly, nursing will check the units weekly for outdated supplies. These QAs will be done weekly for 4 weeks, then every 2 weeks for four weeks, and then monthly until compliance is achieved. QA audits started on April 23rd. QA audits will be	

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F 770	Continued From page 21	F 770	done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	
F 812	Severity/Scope = 2/1 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: ROOM TRAYS 1. Based on information provided by the complainant, observation, review of policy and	F 812	Staff on unit where #39 resides instructed on assistance with meals needed, checking with resident during	4/26/18

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F 812	Continued From page 22 procedure, and staff interview, the facility failed to provide timely removal of uneaten food for 2 of 2 supplemental residents (Resident #39 and #69) who dine in their rooms. Failure to remove room trays containing uneaten food in a timely manner has the potential for a food safety hazard. Findings include: Information provided by the complainant indicated meal trays containing uneaten food staff leave in resident rooms for long periods of time. Review of the facility policy/procedure titled "Guideline for Residents dining in their room" occurred on 04/05/18. This policy, dated July 2011, stated, ". . . PROCEDURE: . . . E. Prepare the tray by: 1. Insuring that the food is properly arranged. 2. Assist the resident for meal and tray set up. H. Record fluids and meal intake in the EHR (electronic health record). I. Return the tray to the tray cart. . . ." Review of the facility policy titled "Meal Service Policy" occurred on 04/05/18. This policy, dated February 2017, stated, ". . . Breakfast . . . 4East/4Central - 8:00 a.m. . . . Lunch . . . 4East/4Central - 12:00 p.m. . . ." Observation on all days of survey revealed the following: *04/02/18 at 11:37 a.m., Resident #39's breakfast tray located on the overbed table in the resident room, contained a portion of ground meat, a fried egg, a piece of toast, and appeared untouched. *04/02/18 at 3:14 p.m., Resident #39's lunch tray located on the overbed table in the resident	F 812	meals and removing tray from room in a timely manner. All nutrition services staff has received education on how to properly hold and serve plate, bowl and glasses for serving food and beverages during meal services. All residents who get a tray delivered to their room have the potential to be affected by trays not being picked up or offered help with nutrition. All residents have the potential of being effected by dishware contamination. All staff was educated in a meeting on April 24th and 25th regarding deficiencies, including this one. All trays will be delivered to the rooms upon the tray cart arriving. Trays are expected to be removed from the resident□s room by 0930, 1330, and 1930. All staff is expected to report to the nurse if a resident has appeared to not have touched their tray. Definitive times for room tray removal were created to prevent potential food safety hazards. Copies of the education for the POC of the deficiencies were placed on all the nursing units as in-services, and staff has been educated through read and sign. All nutritional service staff have been educated and attended an in-service on the facilities procedures for maintaining a sanitary tray line on April 26th. In-service training included observation of each employee performing the procedure to properly	

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F 812	Continued From page 23 room, contained a serving of spaghetti and a bread stick, which appeared untouched. *04/03/18 at 8:27 a.m., an unidentified CNA (certified nurse assistant) delivered the breakfast tray to Resident #39. At 9:23 a.m. a CMA (certified medication assistant) took a medication cup into Resident #39's room. At 10:52 a.m., an unidentified housekeeper entered and exited Resident #39's room. Neither staff removed the meal tray. At 11:27 a.m., Resident #39's breakfast tray remained on the overbed table in the resident room. *04/03/18 at 12:32 p.m., an unidentified CNA delivered the lunch tray to Resident #69's room. At 3:54 p.m., the lunch tray remained on the overbed table in the resident room. *04/03/18 at 12:39 p.m., an unidentified CNA delivered the lunch tray to Resident #39's room. At 3:54 p.m., observation showed the lunch tray located on the floor, in the corner of Resident #39's doorway, with most of the food still on the plate. *04/04/18 at 10:54 a.m., observation showed Resident #39's breakfast tray located on the overbed table in the resident room, with the plate and cups still full. At 10:58 a.m., a CNA(#10) delivered a mighty shake (protein supplement) to Resident #39 and upon leaving the room, failed to remove the breakfast tray. During an interview on 04/05/18 at 11:45 a.m., an administrative nurse (#3) stated she expects staff to check back with the residents in a timely manner and document meal intake when staff remove the room tray. She confirmed staff had not removed the room trays from the rooms timely.	F 812	serve a plate, bowl, and drinking glasses and to maintain a sanitary tray line by wearing gloves while serving. A validation checklist will be completed for each nutrition service employee to determine if the employee is performing the procedure correctly. Findings will be reviewed with each employee. These deficiencies have a specific quality assurance audits: Staff will be monitored for appropriate tray delivery, assistance and tray pickup in a timely manner and maintaining a sanitary tray line by wearing gloves while serving. QA audits started April 23rd and will be done weekly on each unit 5 times/weekly for four weeks, then twice weekly for 4 weeks, and then monthly until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nutrition Services is responsible to make sure the POC is followed.	

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F 812	Continued From page 24 DISHWARE CONTAMINATION 2. Based on observation and staff interview, the facility failed to ensure staff served food was served under sanitary conditions during 2 of 3 meals observed (breakfast and lunch). Failure to properly handle dishware when serving meals to residents places residents at risk for illness due to contamination of dishware. Findings include: Observation in the kitchenette on 04/03/18 at 8:19 a.m. showed a dietary staff member (#1) touched the inside of the bowls with her bare fingers. Observation on 04/04/18 at 12:08 p.m. showed a dietary staff member (#1) leaned on plates, with her bare forearm, and used those same plates to serve food to residents. With her bare hands, the dietary staff member handled glasses and cups, by the rims, used to serve drinks/food to residents. During an interview on 04/05/18 at 10:35 a.m. two administrative nurses (#3, and #15) stated the dietary staff member failed to follow facility practice. Severity/Scope = 2/2	F 812		
F 880	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/26/18

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F 880	Continued From page 25 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 26 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/22/17. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standard infection control practices for 14 of 34 sampled residents (Resident #1, #37, #51, #93, #113, #126, #132, #150, #158, #183, #187, #190, #191, and #294) observed during cares. Failure to follow standard infection control practices may result in the spread of infections within the facility. Findings include:	F 880	Staff immediately educated on the use of dignity bags on all catheter bags for resident #190 and resident #294. Staff was educated on the proper cleaning of equipment after each resident use and after using lift with resident #183, #113, and #187. Staff was educated on handwashing-hand hygiene at proper times and changing of gloves at appropriate times with resident #183, #132, #113, #93, #126, #37, #1, #158, and #191. Staff was educated on proper procedure for contact precautions with resident #113. Staff was educated on	

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F 880	Continued From page 27 HAND HYGIENE/DISINFECTION OF EQUIPMENT Review of the facility policy titled "Handwashing-Hand Hygiene" occurred on 04/05/18. This policy, dated February 2018, stated,". . . Handwashing has long been considered the most important measure to prevent the transmission of disease causing microorganisms . . . when is hand hygiene necessary . . . before and after having direct contact with a resident . . . before and after entering isolation precautions . . . handling catheters . . . before and after changing a dressing . . . after handling soiled equipment . . . after performing personal hygiene actions . . . after removing gloves or gowns. . . ." Review of the facility policy titled "Cleaning, Disinfection and Sterilization" occurred on 04/05/18. This policy, dated February 2018, stated, ". . . Any multi-use medical equipment needs to be cleaned if visibly soiled and disinfected after every resident use . . . Such equipment as hoyers, commodes and shower chairs are disinfected between each resident . . . Gloves are to be worn for handling soiled equipment and for use of chemicals . . ." - Observation on 04/02/18 at 2:50 p.m., showed two unidentified CNAs checked and changed Resident #183's brief using a sit-to-stand lift. One of the CNAs removed the lift from the resident's room, parked it in the hallway, and then walked away. The CNA failed to disinfect the lift after use. * 04/03/18 at 09:18 a.m., two CNAs (#29 and #	F 880	proper procedure for enteric precautions and utilizing soap and water with resident #51. All residents have the potential to be affected by improper infection control practices and can result in increased risk of infections for residents and staff. Staff meetings were held on April 24th and 25th to educate staff on deficiencies, including this one. Copies of the education for the plan of correction for deficiencies were posted on the nursing units as in-services, and staff has been educated through the read and sign process. Staff education included hand sanitizers, washing hands between glove changes and before exiting resident rooms. Staff educated on removing soiled gloves/or gowns before exiting resident rooms. Staff educated that the floor is considered “dirty” and to either replace or sanitize items that fall on the floor; dependent on item/situation. Education also provided on disinfection of equipment between resident use as well as deep cleaning. These deficiencies have a specific quality assurance audits: Staff will be monitored for appropriate hand hygiene and application and removal of gloves from dirty to clean areas, and standard infection control practices. Equipment will be disinfected between each resident use and a deep cleaning schedule was created for the	

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F 880	Continued From page 28 30) donned gloves and transferred Resident #183 from his Broda chair to the commode using a sit-to-stand lift. One CNA (#30) performed peri cares, removed her gloves, pulled the resident's pants up, and with the other CNA's (#29) assistance transferred Resident #183 back to his chair. The CNA (#30) removed the lift from the resident's room and parked it in the hallway before transporting the resident to the activity room. Both CNAs (#29 and #30) failed to perform hand hygiene prior to leaving the resident's room and one of the CNAs (#30) failed to disinfect the lift after use. - Observation on 04/02/18 at 3:38 p.m., showed a CNA (#16) donned gloves and provided Resident #132 incontinence (BM) cares. Without removing her gloves, the CNA (#16) applied a clean brief, applied protective ointment to the resident's buttocks, and pulled up the resident's pants. The CNA (#16) removed her gloves, adjusted Resident #132's blanket, and gave her the call light. The CNA (#16) failed to remove her gloves and perform hand hygiene after providing perineal cares. During an interview on 04/05/18 at 11:30 a.m., an administrative nurse (#3) stated she expects staff to perform hand hygiene after removing their gloves. - Review of Resident #113 medical record occurred on all days of survey and identified isolation precautions. Diagnoses included Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant Enterococci (VRE), and Carbapenum-resistant organism (CRO).	F 880	Hoyer lift and pads and PAL lifts and slings. Monitoring will be completed to ensure dignity bags are covering the catheter, catheters are not being placed on the floor or dragging on the floor, and equipment will be cleaned between resident use. QA audits started April 23rd and will be done weekly on each unit 5 times/weekly for four weeks, then twice weekly for 4 weeks, and then monthly until compliance is achieved. QA audits will be done by designated staff and monitored weekly by ADON and DON. Reporting of all QA audits will be done monthly at the Quality Assurance Committee. The Director of Nursing (DON) is responsible to assure that the POC is followed.	

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F 880	Continued From page 29 Observation showed the following on 04/02/18 at 3:50 p.m., Resident #113 attempted to get out of bed. Two certified nursing assistants (CNAs) (#13 and #14) entered the room and touched the resident's hands and clothing before applying gloves and a gown. The CNA (#14) provided (bowel movement) (BM) incontinence cares while the other CNA (#13) assisted with rolling the resident side to side. After completing the cares, one CNA (#14) removed her gown, exited the room, and re-entered with a sit-to-stand lift. The CNA (#14) then removed her soiled gloves and applied clean gloves and a new gown. Both CNAs (#13 and #14) transferred Resident #113 to her wheelchair (WC) using the sit-to-stand lift. The CNA (#14) removed her gown (not her gloves), exited the room with the lift and disinfected the handle bars, but not the harness on the lift. Both CNAs (#13 and #14) failed to perform hand hygiene after touching Resident #113's hands and clothing and before applying gloves and a gown. The CNA (#14) failed to remove her soiled gloves before exiting Resident #113's room on two occasions and failed to perform hand hygiene after removing her soiled gloves and before applying new gloves. Observation on 04/02/18 at 4:59 p.m., showed a nurse (#11) and a CNA (#12) entered Resident #113's room and touched the resident's hands, body, table and chair. The nurse and CNA failed to apply gloves and gowns before entering Resident #113's room. The nurse (#11) and the CNA (#12) then went to the door and applied gloves and gowns. The nurse (#11) and the CNA (#12) provide incontinence cares and with the same gloves, utilized the sit-to-stand lift and	F 880		

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F 880	Continued From page 30	F 880		

transferred the resident to her wheelchair. The nurse (#11) failed to remove her gloves and exited to room with the lift. Both the nurse and the CNA failed to perform hand hygiene before exiting Resident #113's room and failed to disinfect the sit-to-stand lift.

- Observation on 04/03/18 at 10:10 a.m., showed two CNAs (#4 and #5) donned gloves before transferring Resident #93 from her bed to the shower chair using a gait belt. The CNAs failed to perform hand hygiene after transferring the resident and prior to exiting the room.

- Review of Resident #187's medical record occurred on all days of survey and identified contact isolation precautions. Diagnoses included Carbapenem-resistant organisms (CRO).

Observations on 04/03/18 at 11:14 a.m., showed three CNAs (#5, #6, and #7) transferred Resident #187 using a full body mechanical lift. The CNAs failed to disinfect the lift after use.

- Observation on 04/03/18 at 02:35 p.m., showed two CNAs (#31 and #33) provided cares to Resident #126. One CNA (#33) donned gloves, removed the resident's wet sheet, t-shirt, and brief, removed her gloves, donned clean gloves, and applied cream to Resident #126's groin area. The CNA (#33) then removed her gloves, donned clean gloves, placed the wet linen into a bag, removed her gloves and donned new gloves. Both CNAs (#31 and #33) dressed the resident and applied clean linen to his bed. One CNA (#33) repeatedly failed to perform hand hygiene after removing her gloves and before applying new ones.

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F 880	Continued From page 31 During an interview on 4/5/18 at 8:15 a.m., a unit manager nurse (#32) stated she expected staff to perform hand hygiene in between glove changes. - Observation on 04/03/18 at 5:15 p.m., showed a CNA (#16) provided Resident #37 incontinence BM cares while another CNA (#23) assisted in rolling the resident side to side. The CNA (#16) removed her gloves and without performing hand hygiene, donned clean gloves and assisted with applying a clean brief, pulled the resident's pants up, and transferred Resident #37 into her wheelchair. The CNA (#16) failed to perform hand hygiene after removing her gloves and prior to applying new ones. - Observation on 04/04/18 at 11:54 a.m., showed two CNAs (#6 and #8) toileted Resident #1. The CNA (#6) failed to perform hand hygiene before and after providing perineal cares, and before leaving the room. The CNA (#6) then transported the resident to the dining room, prepared a cup of hot chocolate for Resident #1, and assisted another resident to the dining room. - Observation on 04/04/18 at 02:01 p.m., showed two CNA's (#6 and #8) donned gloves and provided Resident #158's toileting cares. The CNA (#6) cleansed the same area of Resident #158's perineum without folding the perineal wipe. The CNA (#6) then disposed of the soiled brief, applied a clean brief, removed her gloves, donned new gloves, and dressed the resident. Both CNAs (#6 and #8) placed the mechanical lift sling under Resident #158. One CNA (#6), left the resident's room without removing her gloves and returned with the resident's wheelchair. Both	F 880		

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F 880	Continued From page 32 CNAs (#6 and #8) then transferred Resident #158 into the wheelchair before exiting the room. The CNAs (#6 and #8) failed to perform hand hygiene after removing their gloves and before exiting the room. CONTACT PRECAUTIONS Review of the facility policy titled "Isolation Precautions" occurred on 04/05/18. This policy, dated February 2018, stated, ". . . Enteric Contact Precautions - Clostridium difficile [C. diff] . . . Because C diff is a spore former it lives in the environment for prolonged times. Bleach is the most effective disinfectant. . . . 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 facility policy titled "Isolation Precautions" occurred on 04/05/18. This policy, dated February 2018, stated, ". . . for specified resident known . . . to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident . . . contact precautions are to be used in the resident's room to decrease staff colonization risk and risk of cross-contamination . . . decontaminate hands after contact with a residents' intact skin . . . and contact with inanimate objects in the immediate vicinity of the resident . . . decontaminate hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents of environments . . . decontaminate hands between tasks and procedures on the same resident to	F 880		

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F 880	Continued From page 33 prevent cross contamination of different body sites . . . use antimicrobial soap . . . for routine handwashing . . . when possible, dedicate the use of non-critical patient care equipment to a single resident to avoid sharing between residents . . . If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another resident . . . " - Review of Resident #51's medical record occurred on all days of survey. Medical diagnoses included upper respiratory infection, C.diff, colitis (inflammation of the colon), and MRSA (Methicillin-resistant Staphylococcus aureus (a bacterium that causes infections in different parts of the body). The current care plan stated, ". . . Resident #51 has a Drug Resistant Organism: MRSA and C. Diff. that could cause further infectious problems. Contact precautions. Use good hand washing (principles of infection control). Nightly disinfecting and cleaning of wheelchair. . . ." Observation on all days of survey showed a sign on Resident #51's door stating, "Enteric Contact Precautions." Observation on 04/03/18 at 11:48 a.m. showed a CNA (#25) and a nurse (#24) transferred Resident #51 from the bathroom to the recliner using a mechanical lift. With ungloved hands, the nurse (#25) touched the handle of the lift to guide the resident, removed the lift sling, and adjusted Resident #51's clothing. The nurse (#24) used hand sanitizer upon exiting Resident #51's room and failed to complete handwashing with soap and water as stated in the facility's policy.	F 880		

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 _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 34 During an interview on 04/05/18 at 10:37 a.m., an infection control nurse (#27) stated she expects staff to complete hand washing with soap and water after contact with a resident on Enteric Contact Precautions. - Review of Resident #191's medical record occurred on all days of survey. Diagnoses included recent surgery on the digestive track and a pressure ulcer. The current care plan stated, ". . . has a drug Resistant Organism and VRE [vancomyacin resistant organism] that could cause further infections. . . . Contact precautions. . . ." Observation on 04/02/18 at 4:14 p.m. showed two CNAs (#16 and an unidentified CNA) assisted Resident #191 with incontinence cares. Before leaving the room one CNA (#16) attempted to use the hand sanitizer located on the wall. She stated, "It's empty." The hand sanitizer remained empty until 04/03/18 at 9:40 a.m. when an unidentified CNA requested a housekeeping staff member to replace it. DRESSING CHANGE Review of the facility policy titled "Dressing Change Guideline" occurred on 04/05/18. This policy, dated March 2015, stated, ". . . Using gloved hands, remove soiled dressings. Place soiled dressings in plastic bag. Remove gloves and perform hand hygiene. . . . for any cleansing or irrigation of wounds. Put on new gloves. . . ." - Review of Resident #150's medical record occurred on all days of survey. Medical	F 880		

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F 880	Continued From page 35 diagnoses included quadriplegia (loss of movement of all four limbs), chronic pain, and a pressure ulcer. A treatment order, dated 03/12/18, stated, . . . "to ulcer . . . cleanse with normal saline, apply Mupirocin ointment to open area, cover with one layer of drain sponge, secure with Mefix (self-adhesive fabric tape). . . ." Observation on 04/04/18 at 10:29 a.m., showed a nurse (#26) gathered supplies (tube of normal saline, 4x4 gauze, mupirocin ointment, drain sponge, and a strip of Mefix) for the pressure ulcer treatment. While walking down the hall, holding the supplies in her hands, the nurse (#26) dropped the tube of normal saline on the floor. The nurse picked the tube of saline off the floor and proceeded to Resident #150's resident room. The nurse failed to clean or obtain a different tube of saline, therefore contaminating the supplies. The nurse completed the wound care and dressing change without cleaning or replacing the tube of saline. During an interview on 04/05/18 at 11:45 a.m., an administrative nurse (#3) confirmed the nurse had contaminated the dressings and should have replaced them prior to completing the dressing change. - Review of Resident #191's medical record occurred on all days of survey. Diagnoses included a pressure ulcer present on admission. The admission MDS, dated 03/13/18, identified one unstageable pressure ulcer. A physician's order dated 03/23/18, stated, ". . . normal saline wet to dry dressing, cover with	F 880		

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F 880	Continued From page 36 whole ABD pad (abdominal pad). . . ." Observation of a dressing change on 04/02/18 at 4:20 p.m., showed a licensed nurse (#22) donned gloves and removed a soiled dressing from Resident #191's coccyx area. Without changing gloves or performing hand hygiene, the nurse cleansed the wound with normal saline. The nurse (#22) then removed her gloves, and without performing hand hygiene, donned clean gloves and applied a wet to dry dressing to the pressure ulcer. During an interview on 04/05/18 at 11:30 a.m., an administrative nurse (#3) stated she expects staff to change gloves and perform hand hygiene after removing a dressing. URINARY CATHETER CARE - Review of Resident #190's medical record occurred on all days of survey. Diagnoses included right femur fracture and retention of urine. The current physician's orders, dated 03/08/18, identified a Foley Catheter. Observation showed the following: * 04/02/18 at 4:15 p.m., Resident #190 in bed with a Foley catheter urine bag lying on the floor without a dignity cover. * 04/03/18 at 10:00 a.m., showed a CNA (#18) transferred Resident #190 from the wheelchair to the bed. During the transfer the cloth cover fell off of the urine bag and the bag rested directly on the floor. The CNA (#18) picked up the cloth cover, folded it, and placed it on the resident's bedside table. The CNA (#18) failed to ensure the bag did not rest directly on the floor and failed	F 880		

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F 880	Continued From page 37 to cover Resident #190's urine bag before exiting the room. - Review of Resident #294's record occurred on all days of survey. Diagnoses included dementia and anxiety. The current physician's orders dated 03/27/18, also identified a Foley catheter. Observations showed the following: * 04/02/18 at 3:58 p.m., showed Resident #294 in bed with a cloth dignity cover on her urine catheter bag. The urine catheter bag rested on the floor. * 04/03/18 at 8:25 p.m., Resident #294 sat in a wheelchair with a cloth covered urine bag touching the floor. At 9:02 a.m., an unidentified staff member transported Resident #294 to the physical therapy room with the urine bag dragging on the floor during the transport. During an interview on 04/05/18 at 11:30 a.m., an administrative nurse (#3) stated she expects staff to position foley catheter urine bags so they do not touch or drag on the floor. Severity/Scope = 2/2	F 880		