| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355094 | A. BUILDING _____ B. WING _____ | 05/26/2011 |

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| GOOD SAMARITAN SOCIETY - MOHALL | 602 E MAIN ST MOHALL, ND 58761 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on May 23, 2011 and completed on May 26, 2011 the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey. | F 000 | F0160<br>1. All Resident Fund Account (RFA) balances will be paid within 30 days of death to their representative.<br><br>2. All residents who have a RFA have the potential to be affected by this practice. | |
| F 160 SS=B | 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH<br><br>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed within 30 days of death for 2 of 3 supplemental residents (Resident #15 and #16). This has the potential to affect all residents with funds in a resident account.<br><br>Findings include:<br><br>Review of a random accounting of conveyance of funds following death occurred on the afternoon of 05/25/11 with an administrative staff member (#7). Review of resident trust account information identified the following:<br>* Resident #15 expired on 11/02/10. The facility issued a check for the remaining $40.00 on | F 160 | 3. At least 2 x's monthly a resident fund balance report will be run, dated and signed by business office personnel to check for any refunds to be paid.<br><br>4. The Quality Assurance Coordinator will audit monthly X 3 months and then quarterly X 3months then as needed.<br><br>5. Date of correction will be | 06/22/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly L. Uhlig — TITLE: Administrator — (X6) DATE: 6-24-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 160 | Continued From page 1<br>01/19/11, 78 days later.<br>* Resident #16 expired on 02/10/11. The facility issued a check for the remaining $50.17 on 03/23/11, 41 days later.<br><br>During an interview on 05/25/11 at 1:45 p.m., an administrative staff member (#7) confirmed the facility failed to convey the residents' funds and a final accounting of the funds to the individual or probate jurisdiction administering the residents' estates, as required. The staff member (#7) stated they "were missed." | F 160 | F0221<br>1. For Resident #9 a physical restraint assessment will be reassessed using GSS #248 and the Physical Restraint procedure will be implemented on 06/09/2011. A physician order will be obtained for the appropriate restraint. The Interdisciplinary team will assess and complete their portion on the GSS #248 on 06/09/2011. Physical Therapy will re-evaluate the next day they are in the facility. | |
| F 221 SS=D | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents remained free from physical restraints for 1 of 1 sampled resident (Resident #9) using physical restraints. Failure to accurately identify physical restraints, perform an initial and ongoing assessments, obtain a physician's order, and care plan, limited the residents' ability to attain and maintain their highest practicable level of well-being.<br><br>Findings include:<br><br>Review of the facility procedure titled "Physical Restraints" occurred on 05/26/11. This policy, | F 221 | 2. All residents who have a device, material, or equipment attached or placed adjacent to their body have the potential to be affected by this practice.<br><br>3. The current procedure is being reviewed with all Charge Nurses and the MDS Coordinator on or before 06/23/2011. A Physical Restraint checklist will be implemented 06/09/2011 for staff to use.<br><br>4. A. The QA Coordinator or designee will audit to assure the GSS #248 is implemented and the care plan updated by 06/13/2011, re-audit will be the week of 06/20/2011, then monthly X 3, and then as needed. If concerns are identified, the DON or designee will be notified and immediate corrective action will be implemented. A report will be submitted to the QA committee at each scheduled meeting.<br>5. Date of correction is | 06/27/2011 |

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| F 221 | Continued From page 2<br>revised August 2008, stated, "PURPOSE: To ensure appropriate use of restraints . . .<br>DEFINITIONS . . .<br>Physical Restraints - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body.<br>Physical Restraints may include, but are not limited to . . . lap trays . . . that the resident cannot remove. Also included as restraints are center practices that meet the definition of a restraint, such as . . .<br>* Using devices in conjunction with a chair such as trays, tables, belts, that prevent a resident from rising.<br>* Placing a resident in a chair that prevents rising, i.e., geri-chair may be a restraint . . .<br>Remove easily - the manual method, device, material, or equipment that can be removed intentionally by the resident in the same manner as it was applied by the staff . . . considering the resident's physical condition and ability to accomplish objective (e.g. transfer to a chair, get to the bathroom on time) . . .<br>PROCEDURE . . . Non-Emergency Restraint Use<br>1. Prior to the application of a non-emergency physical restraint, the following must be completed:<br>a. There must be documentation in the Interdisciplinary Progress Notes . . . of the observations that suggest a physical restraint is indicated and response to previous interventions attempted.<br>b. Each center will need to designate a committee that reviews restraint use. In most | F 221 | B. The Care Plan Coordinator will audit to assure that the Interdisciplinary team completes the designated portion of the GSS #248 within one (1) week of assessment, with quarterly MDS's X 2, and random audits as needed. A report will be submitted to the QA committee at each scheduled meeting.<br><br>C. The Falling Leaf Interdisciplinary committee will monitor/review at least every month and document in the IDP notes. | 6/27/2011 |

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| F 221 | Continued From page 3<br>centers this will either be the interdisciplinary care team or the reduction committee.<br>c. The interdisciplinary care team or reduction committee will be notified of the proposed need for a physical restraint. The team will then evaluate the environmental, physical, and psychosocial causes.<br>d. The interdisciplinary care team or reduction committee will review the attempted alternatives and explore further alternatives and intervention to be implemented prior to restraint application. The team may wish to involve physical and/or occupational therapy in this process. The care plan will be updated with these new interventions.<br>e. There will be documentation in the medical record of the resident's response to these new interventions. This documentation may be in the Interdisciplinary Progress Notes . . . or the Interdisciplinary Assessment and Summary Review . . .<br>2. If the interventions are deemed unsuccessful and a restraint may be needed, the following must be completed:<br>a. The registered nurse will complete the designated portions of the Physical Restraint Assessment . . .<br>b. The RN [registered nurse] will give the [form number] to the interdisciplinary care team or the reduction committee.<br>c. The interdisciplinary care team or the reduction committee will complete the designated portion of the [form number]. The team may want to involve physical and/or occupational therapy in this process.<br>d. Contact the physician and describe the rationale, alternatives tried and recommendations.<br>e. Obtain the physician order for the | F 221 | | |

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| F 221 | Continued From page 4 | F 221 | | |

appropriate restraint, times to be used and the medical symptom for use.

f. Obtain informed consent using the Permission for Use of Physical Restraints . . . If the resident is unable to provide consent, documentation must be completed stating the reason. Permission will be obtained from a person authorized to sign for the resident.

g. Update the resident care plan to include the reason for the restraint, the required monitoring and a measurable goal relating to the rationale for its use.

h. Any change in the type of the physical restraint used requires that the resident, physician and family be notified and a new Permission for Use of Physical Restraints . . . be completed . . .

3. Throughout utilization of the restraint, the following must be completed:

a. Restraints must be released at least every two hours. Check for areas of irritation, reposition the resident and allow the resident to exercise or an opportunity to move.

b. Observe restrained residents. Frequency of this observation is determined by the care plan team.

c. The interdisciplinary team or reduction committee must continually monitor and evaluate the utilization of the restraint and pursue the least restrictive device with a goal to utilize alternatives whenever possible . . .

d. The interdisciplinary team or reduction committee will complete the Physical Restraint Review [form number] quarterly . . ."

- Observations on the morning of 05/26/11 showed Resident #9 sitting in a multi-positional wheelchair with a tray table across the full length

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| F 221 | Continued From page 5<br>of the chair. On 05/26/11 at 11:45 a.m., observation showed Resident #9 stood and ambulated to the bathroom with the assistance of two staff members and a gait belt. After the resident walked back to his multi-positional wheelchair with staff assistance and staff secured the lap tray in place, the surveyor asked Resident #9 to remove his lap tray. The resident stated, "It is pretty" and made no attempt to remove the tray on his wheelchair.<br><br>Review of Resident #9's medical record occurred on May 26, 2011. Diagnoses included Parkinson's Disease, end stage dementia, and depression. A quarterly Minimum Data Set (MDS), dated 03/29/11, identified the resident with long and short-term memory problems, moderately impaired difficulty with daily decision making, and difficulty focusing attention (easily distracted, out of touch or difficulty following what was said, etc.). The MDS showed Resident #9 required extensive assistance of two or more staff members for transferring, walking in his room and the corridor, locomotion on the unit, and for toileting. The MDS showed the resident was totally dependent on one staff member for locomotion off the unit and used a wheelchair for mobility. The MDS failed to identify Resident #9's physical restraint in his chair preventing him from rising. All of the MDSs completed since the initiation of the restraint on 07/26/10 failed to identify the multi-positional geri chair and tray table.<br><br>Resident #9's current care plan identified the problem "potential for injury R/T [related to] impaired cognition, impaired mobility, Parkinson's," and listed the following goals: "will | F 221 | | |

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| F 221 | Continued From page 6<br>be free of injury from falls" and "will transfer and ambulate safely." The plans and approaches identified included: ". . . Use geri chair with tray when up. Reposition every 2 hours if he is not shifting his own weight. Be alert for self transfers, [Resident #9] does not remember that he needs staff assist for all transfers/ambulation . . ."<br><br>On 07/26/10 a nurse completed a "Physical Restraint Assessment" for the "geri chair [with] tray." The facility staff member answered "Yes" to the question "Would the recommended device for this resident be a restraint?" The initial "Physical Restraint Assessment" stated, ". . . Why is a physical restraint being considered? Resident is not suppose to be up [without] maximum assistance . . . What is the probable cause(s) for this? . . . Cognitive loss/dementia . . . healing [right] fracture acetabulum [sic] . . . Can this be eliminated or lessened? . . . Has been going to PT [physical therapy] for gait training [and] strengthening . . . What is/are the specific medical symptom(s) that require(s) the use of restraints? Forgetting he needs help to stand up (has dementia) . . . Explain how the restraint will allow the resident to reach his/her highest level of independence. Be [sic] allowing him not to fall [and] acquire any fractures . . . Explain what alternative(s) to a physical restraint have been tried and the date(s) of the trial. Chair check, lap buddy, seat belt in [wheelchair] [and] recliner, bed check (no trial dates were listed) . . . Based upon review of the medical record, what is the interdisciplinary team's recommendation for restraint use for this resident? Up in Geri Chair with tray when not in recliner or bed . . . Why is this the most appropriate restraint? Least restrictive and allows him to shift around in chair | F 221 | | |

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| F 221 | Continued From page 7<br>safely . . ." Review of the "Physical Restraint Review" forms, completed on 10/14/10, and the most recent on 12/29/10, identified no recommended changes to Resident #9's restraint use.<br><br>Review of the most recent "Interdisciplinary Assessments and Summary Reviews" entry, dated 04/07/11, stated, ". . . Resident has had no falls this quarter . . . Geri-chair [with] chair [sic] [tray] for position. Repositioning [every] 2 [hours] . . ." The facility failed to complete thorough and ongoing interdisciplinary assessments of Resident #9's physical restraint.<br><br>During an interview on 05/26/11 at 11:00 a.m., an administrative nurse (#3) stated the facility discussed Resident #9's geri chair with tray table at care plan meetings and they feel it is not a restraint as he is able to remove it if he wants to. The staff member lacked awareness of the initial physical restraint assessment, completed on 07/26/10, identifying the geri chair with the tray table as a restraint. The staff member (#3) stated the facility did not obtain a physician's order for the restraint and did not complete ongoing interdisciplinary assessments and care planning on the restraint.<br><br>The facility failed to obtain a physician's order prior to initiating Resident #9's physical restraint (geri chair with tray); failed to develop a comprehensive care plan addressing the restraint; and failed to assess, monitor, and evaluate the utilization of the geri chair and lap tray table as a physical restraint on an ongoing basis. | F 221 | | |
| F 278 | 483.20(g) - (j) ASSESSMENT | F 278 | | |

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| F 278 SS=B | Continued From page 8<br>ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 5 of 12 sampled residents (Resident #2, #4, #8, #9, and #12). | F 278 | F0278<br>1. A. For resident #2 a modification to admission MDS dated 02/28/2011 was completed to reflect the resident's documented aggressive behaviors, non-compliance with treatment and refusal of cares.<br>B. For Resident #4, a modification to admission MDS dated 03/01/2011 was completed to code a fall that occurred on 02/26/2011. Additionally, the fall CAA was also completed.<br>C. For Resident #8 a modification to quarterly MDS dated 05/04/2011 was completed to identify a fall that occurred on 04/22/2011<br>D. For Resident #9 modifications were completed to a quarterly MDS dated 09/29/2011, an Annual MDS dated 12/29/2010, and a quarterly MDS dated 03/29/2011. Corrections were made to reflect a restraint that was initiated on 07/26/2010.<br>E. For Resident #12 a modification was completed to admission MDS dated 04/20/2011 to code behavior that occurred during the assessment period, including non-compliance and rejection of cares.<br><br>2. All Residents who have MDS's completed have the potential to be affected.<br><br>3. The current procedure for chart review and the MDS completion process will be reviewed by each individual who | |

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| F 278 | Continued From page 9<br>Failure to accurately complete portions of the MDS for sampled residents does not allow each resident's comprehensive assessment to reflect care provided consistent with their individual needs and problems.<br><br>Findings include:<br><br>- Review of Resident #4's medical record occurred on May 23-25, 2011. Medical diagnoses included macular degeneration, dementia, and degenerative joint disease. Review of Resident #4's interdisciplinary notes showed the resident fell on 02/26/11 while self-transferring from the toilet to her wheelchair.<br><br>Review of Resident #4's admission MDS, dated 03/01/11, identified no falls occurred since admission. Review of the triggered "Falls Care Area Assessment" from admission, dated 03/01/11, stated, "Note that [Resident #4] does need staff assistance for transfers. She does voice a fear of falling and has at times appeared somewhat unsteady during transition during transfer. She does complain of general arthritic pain or pain to her feet at times which could impact her risk of falling. She does use a Fentanyl patch [used for pain] 20 mcg [micrograms] and this has potential for side effects that may increase risk of falling such as sedation or dizziness. Note that [Resident #4] does continue to take diuretic medication which may cause urinary frequency or urgency. This could impact her risk of falling if she were to attempt to use the bathroom without assistance. She does also take . . . antipsychotic med [medication], Seroquel 25 mg [milligrams] qd [every day], and antidepressant meds, Remeron | F 278 | completes a portion of the assessment by 06/23/2011.<br><br>4. The MDS Coordinator will audit for coding accuracy of falls and behaviors on the MDS assessments every week X 2, then monthly X 2, then quarterly X 2, following with random audits as needed. If concerns are identified, immediate corrective action and re-education will be implemented. The MDS coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.<br><br>5. Date of Correction | 06/23/11 |

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| F 278 | Continued From page 10<br>45 mg hs [hour of sleep] and Celexa 20 mg qd. These medications may impact her risk of falling with possible side effects such as orthostatic hypotension, dizziness, aching, tremors, or drowsiness." The "Falls Care Area Assessment" identified Resident #4 at risk of falling, but failed to reflect the resident's actual fall on 02/26/11.<br><br>During an interview on 05/25/11 at 4:00 p.m., an administrative nurse (#8) agreed Resident #4's fall on 02/26/11 should have been coded on the admission MDS.<br><br>- Observations on the morning of 05/26/11 showed Resident #9 sitting in a multi-positional wheelchair with a tray table across the full length of the chair. On 05/26/11 at approximately 11:45 a.m., the surveyor asked Resident #9 to remove his lap tray. The resident stated, "It is pretty" and made no attempt to remove the tray on his wheelchair.<br><br>Review of Resident #9's medical record occurred on May 26, 2011. Diagnoses included Parkinson's Disease, end stage dementia, and depression.<br><br>On 07/26/10 a nurse completed a "Physical Restraint Assessment" for the "geri chair [with] tray." The facility staff member answered "Yes" to the question "Would the recommended device for this resident be a restraint?"<br><br>Review of the "Physical Restraint Review" forms, completed on 10/14/10, and the most recent on 12/29/10, identified no recommended changes to Resident #9's restraint use. | F 278 | | |

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Review of Resident #9's MDSs completed since the initiation of his physical restraint on 07/26/10, included the following: a quarterly MDS, dated 09/29/10; annual MDS, dated 12/29/10; and quarterly MDS, dated 03/29/11. All three MDSs failed to identify Resident #9's multi-positional geri chair with tray table preventing him from rising.

- Review of the medical record for Resident #2 occurred May 23-26, 2011. The record showed the facility admitted the resident in February 2011. The admission MDS, dated 02/28/11, identified the resident exhibited no behaviors. The Resident Care Area Assessments (CAAs) completed with this MDS did not include the Behavioral Symptom CAA.

The CAAs completed with the MDS dated 02/28/11 identified the following behaviors:
* Delirium CAA, 03/09/11, ". . . from IDP [interdisciplinary progress] notes and staff interview, it is noted that she has been frequently uncooperative with cares, at times attempting to hit, spit, or bite at staff. . . ." Documentation identified the staff interview occurred on 02/28/11.
* Cognitive Loss/Dementia CAA, ". . . She does have a hearing aid but refuses to wear it. She has had some impulsiveness and agitation at times, especially when staff attempts to assist in providing cares for her. She has had behaviors such as attempting to bite, hit, or spits at staff. . . ." Documentation showed this information in the IDP notes and a staff interview conducted on 02/28/11.
* Communication CAA, ". . . She does refuse care and did refuse to let Charge nurse examine ears for cereumen [sic] impaction. . . ." Documentation

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| F 278 | Continued From page 12<br>showed this information came in the an ID [interdisciplinary data] tool, dated 02/24/11, and other sources.<br>* Urinary Incontinence and Indwelling Catheter CAA, "[Resident #2] does need staff assistance for transferring into the bathroom. . . . Staff reports that she is not always cooperate [sic] with their efforts to assist her with toileting and she has been physically aggressive at times. . . ." Documentation showed this information in the IDP notes and a staff interview conducted 02/28/11.<br>* Mood CAA, "Noting that [Resident #2] is taking an antidepressant for the management of her depression. She also does have dementia with behavioral disturbances. She has presented with periods of agitation and frequently has not been cooperative with cares. She has been aggressive at times when staff has attempted to assist her, reacting by attempting to bite, spit or strike out. . . ."<br><br>- Review of the medical record for Resident #12 occurred May 25-26, 2011. The record showed the facility admitted the resident in April 2011. Diagnosis included uncontrolled diabetes mellitus type II, and left below the knee amputation. The admission MDS, dated 04/20/11, identified the resident exhibited no behaviors. CAAs triggered for this MDS were falls, nutritional status, dehydration-fluid maintenance, and pain.<br><br>The following IDP notes during the assessment period demonstrate Resident #12's behaviors:<br>* 04/18/11, 9:30 p.m., " . . . states didn't always take insulin as Dr [doctor] ordered cause it was too much so he just wasted it and [sic] not tell the nurses, explained need to know accurate | F 278 | | |

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| F 278 | Continued From page 13<br>amounts to be able to adjust it correctly - He said the Dr wouldn't listen to him [and] refused evening scheduled Levemir [a long acting insulin]. . . ."<br>* 04/20/11, 11:00 p.m., "[Resident #12] refused HS [hour of sleep] Levemir insulin stating he was not going to take it with BS [blood sugar] 136. 'I don't know why they wont let me do what I need and do it my self, I know what I need.' Informed him we need to follow Dr. orders. Stated understanding but cont [continued] to Ref [refuse] insulin. . . ."<br>* 04/21/11, 1:20 a.m., ". . . also requesting BS [check]. Reading 238, states 'guess I ate too much candy but I'll be good. I don't need anything.' and went back to his room to bed."<br>* 04/21/11, 5:00 p.m., ". . . Non compliant BSL [blood sugar level] QID [four times a day] [with] insulin given as ordered. Requested Blood sugar [check] this afternoon - felt low - was 79. Enc [encouraged] to have juice or milk - declined [and] said 'I'll find candy - it works for me [and] tastes better.' Told him he would to [up] quickly, but BSL would also [drop] quickly - that milk had protein [and] fat [and] would help stabilize BS spikes [and] drops. He was not interested [and] wheeled [wheel chair] away while nurse speaking. . . ."<br><br>A physician progress note, dated 04/20/11, identified the following regarding Resident #12: ". . .Per the nursing staff, the patient has not been compliant with his diet and seems to want to order from outside. He insists on wanting to control his own insulin, stating this is how it has worked best for him in the past. . . . Given the fact he has poorly controlled diabetes leading to partial foot amputation of the right leg and now | F 278 | | |

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| F 278 | Continued From page 14<br>the recent amputation of the left leg, the patient needs more aggressive diabetic management. However, he believes that the reason the blood sugars are high is because we are not doing it appropriately. Patient insists this will not work for him as he is not willing to comply with diabetic diet and wants to eat what he wants to eat and states this is not going to change. . . ."<br><br>Interview with an administrative staff member (#5) on 05/26/11 at 1:15 p.m., agreed she failed to code Residents #2 and #12's behaviors.<br><br>Failure to code Resident #2 and #12 behavior of rejecting care resulted in the assessment not triggering the Behavioral Symptoms CAA.<br><br>- Review of the medical record for Resident #8 occurred May 23-26, 2011. A quarterly MDS, dated 05/04/11, identified the resident experienced no falls since admission or prior assessment. The CAAs triggered for Resident #8 did not include falls.<br><br>The medical record showed Resident #8 experienced a fall in his room on 04/22/11.<br><br>Interview with an administrative staff member (#8) on 05/25/11 at 5:20 p.m., agreed she failed to code Resident #8's falls on the quarterly MDS, dated 05/04/11.<br><br>Failure to code Resident #8 accurately for falls resulted in the assessment not triggering the Fall CAA. Failure to complete the CAA does not direct staff to consider complicating factors, risks, and any referral for this resident for this care area. | F 278 | | |
| F 281 | 483.20(k)(3)(i) SERVICES PROVIDED MEET | F 281 | | |

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| F 281 SS=B | Continued From page 15<br>PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, professional reference, and staff interview, the facility failed to follow nursing standards of practice regarding the documentation of medication administration of coumadin (medication to thin the blood) for 2 of 4 residents (Residents #3 and #7) with orders for Coumadin. Failure to follow professionally accepted standards of practice regarding medication administration has the potential for residents to experience adverse consequences related to the medication.<br><br>Findings include:<br><br>Taylor, Lillis, and LeMore, "Fundamentals of Nursing, The Art and Science of Nursing Care", 4th ed., J.B. Lippincott Company, Pennsylvania, page 627 stated, "The medication record is a legal document. Recording each dose of medication as soon as possible after it is given provides a documented record about whether the patient received the medication."<br><br>- Review of Resident #3's medical record occurred on all days of survey. Medical diagnosis included atrial fibrillation/flutter.<br><br>Review of Resident #3's physician's order, dated 04/15/11, included Coumadin 5 milligrams (mg) daily six days per week (not Friday). Review of | F 281 | F0281<br>1. Charge Nurses will document all medications given by signing with initials on the Medication Administration Record.<br>2. All Residents who are administered medications have the potential to be affected by this practice.<br>3. The Medication Administration Record will be reviewed by all Charge Nurses by 06/23/2011.<br>4. Charge Nurses will audit Medication Administration Records for signatures every shift x 2 weeks, then once a week x 2 weeks, then monthly x 2, then quarterly x 2 and random as needed. If concerns are identified, they will be reported to the Director of Nursing or designee. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.<br>5. Date of correction will be | 06/27/2011 |

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| F 281 | Continued From page 16<br>the medication administration record (MAR) revealed on Monday, 05/09/11 and Thursday, 05/12/11, the MAR lacked documentation by staff indicating administration of the coumadin or an explanation as to why it was not given.<br><br>During an interview on 05/24/11 at 9:50 a.m., a staff nurse (#4) stated, "if the medication had been ordered to be held it would be initialed and circled."<br><br>- Review of the medical record for Resident #7 occurred May 23-26, 2011. Diagnoses included aortic stenosis and history of deep vein thrombosis.<br><br>Review of the MAR for March 2011 showed Resident #7 had a physician order for Coumadin 1 mg on Sunday, Monday, Wednesday, Friday and took a different dose on Tuesday, Thursday and Saturday. The MAR lacked documentation of Coumadin administration on 03/09/11. Nursing staff failed to identify the medication as given, or to provide an explanation why staff did not administer the medication.<br><br>Interview with an administrative nursing staff member (#3) on the afternoon of 05/26/11, stated staff failed to initial the MAR to indicate the medication was given. | F 281 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. | F 441 | | |

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| F 441 | Continued From page 17<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy and procedure, and staff interview, the facility failed to follow acceptable infection control standards for 4 of 9 sampled residents (Resident | F 441 | F0441<br>1.A. the facility will require that nursing staff wash their hands after each direct Resident contact.<br>B. Staff will be required to cue cognitive impaired Residents to wash their hands after self toileting.<br>C. Nursing staff will be required to follow proper procedure for disposal of linen and incontinence pads.<br>2. A. All Residents with cognitive impairment who self toilet have the potential to be affected by this practice.<br><br>B. All Residents that receive direct care have the potential to be affected by this practice.<br><br>3. A. Certified Nursing Assistants will be inservice regarding hand hygiene, proper handling of linen, disposal of incontinent pads through mini-inservices held during the weeks of June 8th through June 22nd.<br>B. Dietary, Activity Assistants, and Certified Nursing Assistants will be in-serviced regarding replacing food and drink if contaminated by other residents and/or staff. | |

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| F 441 | Continued From page 18<br>#1, #4, #6, and #7) observed receiving personal cares. Failure to perform hand hygiene after completing pericares, properly handle soiled linens has the potential to spread infections throughout the facility.<br><br>Findings include:<br><br>Review of the facility procedure titled "Perineal Care" occurred on 05/26/11. This policy, revised November 2009, stated, ". . . 2. Wash hands and put on gloves. (If additional supplies are needed during perineal care, remember to remove soiled gloves, wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care.) . . . 5. Wash perineal area from front to back with mild cleansing solution, wipes or no-rinse perineal cleanser . . . 7. . . . After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing. 8. Remove and discard gloves and wash hands . . . 10. Remove and dispose of linen and bed protectors appropriately. Clean and dispose of or store equipment . . ."<br><br>Review of the facility laundry procedure titled "Infection/Exposure Control" occurred on 05/26/11. This policy, revised November 2006, stated, "Personnel will handle, store, process and transport linens so as to prevent the spread of infection . . . Laundry will be handled as little as possible . . . It should be bagged or placed in container at the location where it is used . . ."<br><br>Review of the facility procedure titled "Standard Precautions" occurred on 05/26/11. This policy, revised January 2009, stated, ". . . Used linen | F 441 | 4. A. Nursing staff will audit proper hand washing, proper handling of linen and incontinent pads weekly x 2, then in 2 weeks, and then monthly x 2 (July & Aug) and then random audits as needed.<br>B. Dietary Manager or designee will audit dining room for proper infection control regarding food and fluid items weekly x 2,<br><br>5. Completion date will be | 06/27/2011 |

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| F 441 | Continued From page 19<br>soiled with blood, body fluids, secretions and excretions will be handled, transported and processed in a manner to prevent skin and mucous membrane exposures, contamination of clothing, and to avoid transfer of microorganisms to other residents and environments . . ."<br><br>- Observation on 05/23/11 at 4:10 p.m. showed two certified nursing assistants (#9 and #10) transferred Resident #4 to the toilet. After completing pericares, the CNA (#9) failed to perform hand hygiene, proceeded to take the resident's soiled clothing to the soiled utility room, removed her gloves, and without performing hand hygiene, went to assist another resident.<br><br>- During an observation of personal cares on 05/24/11 at 8:45 a.m., a CNA (#6) assisted Resident #6 to the bathroom. The CNA (#6) guided Resident #6 to the toilet and instructed the resident to pull down his pants and sit on the toilet. The CNA then left the bathroom and shut the door. When the CNA opened the door to the bathroom, Resident #6 had pulled up his pants and flushed the toilet. The resident walked out of the room and was taken to therapy. The CNA (#6) failed to cue/offer Resident #6 to wash his hands after using the bathroom.<br><br>- On 05/24/11 at 10:10 a.m., two CNAs (#11 and #12) assisted Resident #1 out of bed and performed morning cares. The staff members (#11 and #12) placed the resident's nightgown and bedding protector, soiled with urine, directly onto a chair in the resident's room rather than bagging the soiled linen. Staff failed to cleanse Resident #1's chair after removing the soiled linen. | F 441 | | |

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| F 441 | Continued From page 20<br><br>- During an observation on 05/24/11 at 2:05 p.m., two CNAs (#13 and #14) performed incontinence cares on Resident #1 with the resident standing from her wheelchair. They removed her incontinence pad soiled with urine, placed the soiled pad directly onto the resident's carpeted floor, performed pericares, and placed the soiled wipes used during pericares directly onto the floor. Observation showed Resident #1's garbage receptacle across the room by the window.<br><br>- Observation on 05/24/11 at 3:10 p.m. showed a CNA (#1) assisting Resident #7 with incontinence cares. The CNA (#1) placed the resident's clothes, soiled with stool, on a soaker pad, also soiled with stool, in the resident's wheelchair seat, as the resident toileted. The CNA (#1) left the room to obtain a clean cover for Resident #7's wheelchair cushion as it was soiled with stool. The CNA (#1) placed the soiled clothes and soaker pad on the bathroom floor. The CNA (#1) took the wheelchair cushion from the wheelchair, removed the soiled cover and laid the cover on the floor with the other soiled items. After putting a clean cover on the wheelchair cushion, the CNA (#1) obtained a plastic bag, picked up the soiled clothing/linens from the floor and bagged them.<br><br>During an interview on 05/26/11 at 1:40 p.m., an administrative nurse (#3) stated she expected staff to perform hand hygiene immediately after completing pericares, once the resident is in a safe position. The staff member (#3) stated she expected staff to bag soiled incontinence products and either bag or place soiled linen in a hamper rather then setting them directly on the | F 441 | | |

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| F 441 | Continued From page 21<br>floor. | F 441 | | |