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	355110	A. BUILDING _____ B. WING _____	07/09/2014

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F 000	INITIAL COMMENTS For the standard medicare/Medicaid recertification survey started on July 7, 2014 and completed on July 9, 2014, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	1. Review of the Abuse Policy and Investigation Report was completed at the CNA in-service on 8/5/14 and the Nurse In-service on 8/7/14. The policy will be again reviewed at the All Staff In-service on September 2, 2014. An employee investigation interview form has been implemented in addition to completing the incident report of unknown origin. This report will be completed by the DON, Administrator or Designee. The interview form was used to complete investigation of incidents of unknown origin for resident #2 and #7. See Agendas F225 A and B 2. Any resident with an unknown origin injury and is not able to verbalize possible cause due to cognitive deficits will have an incident report completed including the additional	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8-7-14

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 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate allegations of abuse/neglect for 2 of 2 sampled residents (Resident #2 and #7) with bruises of unknown origin. Failure to complete thorough investigations placed all residents at risk for abuse/neglect. Findings include: Review of the facility policy titled "Elm Crest Manor Abuse Policy" occurred on 07/09/14. This undated policy stated, ". . . Investigation of Abuse Allegations: 1. All allegations must be thoroughly investigated by a team of two (2) Department Manager and Administration, who are under general direction of the Administrator or designee. This may include but not be limited to interviewing all person [sic] associated with the situation, medical record review, and physical assessment of alleged victim. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and depression. The current Minimum Data Set (MDS), dated 06/05/14, identified severe cognitive impairment.	F 225	employee investigation interview report. See form F225 C 3. Monitoring of the investigation reports for injury of unknown origin will be completed by DON or designee. The QA monitor will be to review documentation on those reports to ensure the employee investigation interview form was also completed appropriately. The QA monitor will be completed weekly x4 weeks and then monthly thereafter. Findings will be discussed at the monthly QA interdisciplinary meetings. See QA monitor form F225 D	8/7/14

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F 225	Continued From page 2	F 225		

Resident #2's nurses' notes stated the following:
*05/04/14 at 8:00 p.m.: ". . . Staff reported new bruising- has 3 cm [centimeter] bruise to L) [left] inner thigh - 2 cm bruise to R) [right] buttock et [and] 1 cm to L) buttock - also has sl. [slight] bruising around rectal area - Res. [resident] denies discomfort to areas - has fragile skin et [and] bruises easily - Also is on Coumadin [an anticoagulant] . . ."
*05/05/14 at 6:00 a.m.: ". . . Cont. [continue] 3 cm hard raised hematoma to L) inner thigh - [no] change to other various bruised areas . . ."

An incident report regarding the bruising stated the following: ". . . Comments: Resident's INR [international normalized ratio] had been elevated - did ask her if she knew what happened [and] she was not sure 'I don't know' asked if she felt rushed [with] cares or if anyone had been rough [and] she denied - the area on inner thigh does appear to be a possible finger print or maybe pinch during cares - rectal bruise maybe due to supp [suppository] given 5-3-14 - nurse ordered to [check] orders for INR. . . ."

The facilty failed to complete follow up interviews with staff who cared for the resident or who administered the suppository in an effort to determine causative factors for the resident's bruising.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and depression. The current MDS, dated 06/29/14, identified severe cognitive impairment.

Resident #7's nurses' notes identified the following:

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F 225	Continued From page 3 * 04/28/14 at 6:00 a.m. : "During bath noted 3 cm x 3 cm hematoma to L)FA [left forearm] - also 1 cm x 1 cm bruise to L)FA - Res unaware of origin - denies discomf [discomfort] is on Coumadin therapy . . ." * 07/03/14 at 10:26 a.m.: "Skin Problems: Has abrasion/bruise . . . *NEW AREA** Description: purple Location: left posterior thigh . . . Length (cm): 6 width (cm) 3 . . ." Incident reports regarding the above hematoma/bruising identified the following: * 04/29/14: ". . . Comments: interviewed resident - she denies knowing what happened. When asked if someone was rough with her she stated 'No' - area is dark purple in color. No specific shape noted appears as though she may have bumped it on a doorway when walking through. . . ." * 07/03/14: ". . . Comments: Assessed area - resident unable to verbalize what happened - did ask if anyone was rough with cares [and] resident stated no - resident is self-ambulatory . . . on coumadin . . . area did not appear to have finger print type bruising - does occas [occasionally walk [without] walker - it could have been caused by sitting hard." The incident reports lacked follow up interviews with staff who cared for the resident in an effort to determine causative factors for the resident's bruising. During an interview on the morning of 07/09/14, an administrative nurse (#6) stated she interviewed staff regarding the bruises for Resident #2 and #7 but failed to document the interviews.	F 225		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=D	Continued From page 4 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and policy and procedure review, the facility failed to provide the necessary treatment and services to promote the healing of pressure ulcers for 1 of 2 sampled residents (Resident #4) identified with current pressure ulcers. Failure to implement established treatment interventions may contribute to a delay in the healing of Resident #4's pressure ulcers. Findings include: Review of the facility policy titled "POLICY AND PROCEDURE FOR PRESSURE ULCERS" occurred on 07/09/14. This policy, dated 2012, stated, ". . . GENERAL SKIN CARE GUIDELINES: . . . 9. Avoid positioning resident on an existing pressure ulcer. . . . PRESSURE REDRISTRIBUTION [sic]: . . . 6. When a resident is up in a chair: . . . c. Use pressure-reducing cushion on the seat of the chair. . . ." Review of Resident #4's medical record occurred on July 07-09, 2014. Current diagnoses included colon cancer, chronic renal impairment, and	F 314	1. Review of facility policy on Pressure Ulcer was completed at the CNA meeting on 8/5/14 and the Nurses meeting on 8/7/14. See agenda F314 A and B 2. Resident #4 received a 2nd pressure relief cushion on 7/9/2014 – one for recliner and one for WC. Nursing staff received re-education on proper placement of heel boots for resident #4 to maintain compliance with the care plan on 7/9/2014 and 7/10/2014 by the DON. At the Nurses meeting on 8/7/14 current lists were comprised for those residents needing pressure relieving devices. See Form F314D. We will revise the lists as changes occur and use this list to pick the random selection monitoring. 3. Monitoring of pressure relief devices will be done for resident #4 and a random selection of a minimum of 5 residents 5x per week for 2 weeks, then 5 residents 3x per week for 2 weeks, 5 residents weekly for 2 weeks and then monthly thereafter by the DON or designee. The findings will be	

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F 314	Continued From page 5 mixed incontinence. An admission Minimum Data Set (MDS), dated 06/11/14, identified the resident required extensive assistance of two or more staff for bed mobility and transfers; at risk for the development of pressure ulcers; one Stage I pressure ulcer present upon admission; and the utilization of pressure reducing devices in the chair and bed. Record review showed a pressure ulcer on Resident #4's right heel. A progress note dated 07/07/14 stated, "PRESSURE ULCER: Has partial thickness loss of skin layers that presents as an abrasion or blister (Pressure Stg. 2) [stage]. SKIN PROBLEMS: open area **NEW AREA**, LOCATION: coccyx, ONSET/DISCOVERY DATE: 07/07/2014 . . . INTERVENTION: Has pressure reducing device for chair. Has pressure reducing device for bed. Receives [sic] turning/repositioning program. . . ." Record review showed a pressure ulcer on Resident #4's coccyx. Resident #4's current care plan, stated, "PROBLEM: ALTERATION IN SKIN INTEGRITY R/T [related to] R) [right] heel . . . APPROACHES: . . . 2. OBSERVE FOR S & S [signs and symptoms] OF INFECTION/HEALING. DOCUMENT CHANGES WEEKLY IN NURSE'S NOTES. . . . TURN AND REPOSITION EVERY TWO HOURS AND PRN [as needed]. . . ." A physician's order dated 06/19/14 stated, "Bilateral foot/ankle heel lift suspension boots when in recliner and/or bed". The care plan failed to identify the use of bilateral foot/ankle boots and the resident's Stage II pressure ulcer on the coccyx. Review of Resident #4's progress notes from	F 314	discussed at the monthly QA interdisciplinary meetings. See QA monitor form F314 C	8/7/14

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F 314	Continued From page 6 June 2014 to July 2014 identified the following: * 06/10/14 at 11:21 a.m. - "FOOT PROBLEM/CARE: R) [right] heel darkened areas nonopen . . . length (cm) [centimeters]: 0.5, width (cm): 0.5 . . ." * 06/14/14 at 11:19 a.m. - ". . . LOCATION: right heel . . . HEALING PROGRESS: no change . . ." * 06/21/14 at 11:11 a.m. - "SKIN PROBLEMS: right heel . . . HEALING PROGRESS: no change . . ." * 06/25/14 at 10:58 a.m. - "FOOT PROBLEM/CARE: right heel . . . HEALING PROGRESS: no change . . ." * 06/28/14 at 11:02 a.m. - ". . . LOCATION: . . . right heel . . . length (cm): .5, width (cm): 1.0 . . ." * 07/07/14 at 1:23 p.m. - ". . . LOCATION: right heel . . . HEALING PROGRESS: improving . . ." Record review identified several different nurses observed the pressure ulcer and no measurements obtained. Observations on 07/07/14 at 9:15 a.m. and 1:45 p.m. showed Resident #4 sitting in her recliner and her heels directly resting on the foot rest. The resident's foot/ankle boots sat on the floor. Observation on 07/08/14 at 8:25 a.m. showed Resident #4 sitting in her recliner and her heels directly resting on the foot rest. Observation on 07/08/14 at 8:55 a.m. showed Resident #4 sitting in her recliner with her heels floated on a pillow. At 9:05 a.m. two Certified Nursing Assistants (CNAs) (#7 and #8) entered the resident's room to provide personal cares. Upon completion of the personal cares Resident #4's heels rested directly on the foot rest. Observation on 07/08/14 at 10:40 a.m. showed	F 314		

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F 314	Continued From page 7 Resident #4 sitting in her recliner and her heels directly resting on the foot rest. Two CNAs (#7 and #8) transferred Resident #4 from her recliner to her electric wheelchair and failed to move the resident's pressure-reducing cushion to the wheelchair. Observation on 07/08/14 at 12:25 p.m. showed two CNAs (#7 and #8) transfer Resident #4 from her wheelchair to her recliner. A CNA (#7) floated the resident's heels on a pillow. Observation on 07/08/14 at 2:00 p.m. showed Resident #4 sitting in her recliner and her heels floated with a pillow. Failure to off-load Resident #4's heel by use of the foot/ankle boots and utilize a pressure-reducing cushion for the coccyx, and measure Resident #4's right heel pressure ulcer weekly may prolong the healing of the pressure ulcers.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, policy	F 323	Part 1: 1.On July 10, 2014 visited with therapy as they had been working with Resident #4 regarding appropriateness of transferring her with pivot with extensive assist of 2 or EZ stand PRN. After reviewing resident #4 care plan, correction was made to transfer extensive 2 assist or EZ stand PRN. Review of facility policy on Transfers was completed at the	

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F 323	Continued From page 8 and procedure review, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 5 of 8 sampled residents (Resident #1, #2, #4, #6, and #8) observed during transfers. Failure to use gait belts, or use them properly during transfers (Resident #1, #2, and #6); failure to lock wheelchair brakes (Resident #8); and failure to use a mechanical lift as indicated (Resident #4) placed the residents at risk of accidents and injury. Findings include: Review of the facility policy titled "Gait Belts for Transfer" occurred on 07/09/14. This policy, dated July 2012, stated, ". . . POLICY . . . Gait belts are used on those residents needing assist with transfers and ambulation. . . . Ensure belt is snug but allow enough room for your hand to comfortably grasp it. . . ." - Review of Resident #4's medical record occurred on July 07-09, 2014. Diagnoses included osteoarthritis and backache. The resident's current care plan stated, ". . . TRANSFERRING: Extensive assist, 2 or more assist EZ - Stand . . ." Observation on 07/08/14 at 8:55 a.m. identified two Certified Nursing Assistants (CNAs) (#7 and #8) providing personal cares while Resident #4 sat in a recliner. To complete perineal cares the staff members used a gait belt to stand the resident. Resident #4 became weak and her feet slid forward. The resident sat down five times to rest during this observation of care. Observation on 07/08/14 at 10:40 a.m. identified	F 323	CNA meeting on 8/5/14 and the nurses meeting on 8/7/14. A Physical therapist and Occupational therapist did present to CNA's and Nurses the proper transfer with a gait belt. See forms F323-A and F323-B. The PT, OT, DON or designee will complete a CNA skills monitor for transfer with gait belt. This will include assessing each CNA transferring a resident using a gait belt and re-education if necessary. See form F323 C. This will be completed by 8/15/14. 2. QA monitor for proper transfers with a gait belt for resident #1, #8 and #6 along with a random selection will be completed on a weekly basis for 4 weeks than monthly thereafter. This QA will be completed by OT, PT, DON, or designee. QA Monitoring will be reviewed monthly QA team at the interdisciplinary meeting. See Form F323 D. PT/OT have comprised a list of all current residents that use the EZ-stand. Form F323-E. Therapy has been assessing monthly the appropriateness of the EZ-stand for these residents. Refer to form F323 F.	

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F 323	Continued From page 9 two CNAs (#7 and #8) used a gait belt to transfer Resident #4 from her recliner to her wheelchair. Observation on 07/08/14 at 12:25 p.m. identified two CNAs (#7 and #8) used a gait belt to transfer Resident #4 from her wheelchair to her recliner. Facility staff failed to safely transfer Resident #4 by not following the plan of care of using a mechanical lift for transfers. - Review of Resident #6's medical record occurred on July 07-09, 2014. Diagnoses included Alzheimer's disease and dementia. Observation on 07/08/14 at 8:40 a.m. identified one CNA (#7) assisted Resident #6 to the bathroom. The staff member lifted under the resident's right arm to assist the resident from a sitting to a standing position. The staff member failed to utilize a gait belt to assist Resident #6. - Observation on 07/08/14 at 9:10 a.m. showed two CNAs (#9 and #10) assisted Resident #1 to transfer from his bed to the wheelchair. The staff members applied a gait belt and assisted him to a standing position and to pivot transfer to the wheelchair. One CNA (#10) lifted under Resident #1's arm during the transfer and failed to utilize the gait belt. - Observation on 07/08/14 at 12:30 p.m. showed two CNAs (#4 and #5) assisted Resident #8 to sit in his wheelchair from a standing position. The CNAs stood on each side of Resident #8 and placed the wheelchair behind him. The CNAs did not apply the wheelchair brakes and as Resident #8 began to sit down, the wheelchair started to roll back. As the resident fell backward, the CNAs	F 323	Therapy will continue to monitor these residents on a monthly basis as well as review the care plans to make sure the care plan coincides with the appropriate method of transfer. If there are any changes therapy will notify the MDS Nurses right away for the correction to be made. This monitoring will also be reviewed monthly at the QA Interdisciplinary meeting. Part 2: 1. All chemicals stored in the Oak and Willow soiled utility rooms were placed behind a locked cupboard. Review of facility policy on Chemical Storage was completed at the CNA meeting on 8/5/2014 and the Nurse meeting on 8/7/2014. See Attached F323 E and F323 F. Information was conveyed to all staff on July 20, 2014 in the ECHO. The policy will also be reviewed again at the Mandatory All Staff In-service on 9/2/2014. 2. There will be a QA monitoring to ensure that all chemicals are in a locked cupboard in all of the soiled utility rooms. This QA monitoring will	8/15/14

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F 323	Continued From page 10 (#4 and #5) quickly held onto the resident, moved the chair closer, and applied the brakes, averting a fall. The resident stated "I should have locked the brakes, the . . . thing was running away on me." During an interview on 07/09/14 at 2:00 p.m., an administrative nursing staff member (#6) confirmed staff should apply the wheelchair brakes prior to a resident sitting in a wheelchair. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included arthritis. The resident's current care plan identified extensive assistance from staff for transfers. Observation on 07/08/14 at 10:05 a.m. identified two CNAs (#4 and #5) assisted Resident #2 from her recliner to her wheelchair and into the bathroom. The staff members used a gait belt, which they initially applied around the waist. The gait belt fit loosely and slid up to the resident's chest area and then under her arms. The gait belt remained loose under the resident's arms as the CNAs transferred the resident from her wheelchair to the toilet and from the toilet to the wheelchair. The CNAs failed to readjust and tighten the gait belt at any time. Observation on 07/08/14 at 2:57 p.m. identified two CNAs (#1 and #2) assisted Resident #2 from her recliner to her wheelchair and into the bathroom. The staff members used a gait belt, which was loose and slid up across the resident's chest and under her arms. The gait belt remained loose as the CNAs transferred the resident from her wheelchair to the toilet, and from the toilet to the wheelchair. The CNAs failed to readjust and	F 323	be completed by housekeeping or designee on a weekly basis for 4 weeks then monthly thereafter. This QA monitor will then be reviewed by the QA interdisciplinary team at the monthly meeting. See form F323 G	7/20/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	100 ELM AVE NEW SALEM, ND 58563

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F 323	Continued From page 11 tighten the gait belt at any time. HAZARDOUS CHEMICALS 2. Based on observation, review of facility policy, review of the Material Safety Data Sheets (MSDS), and staff interview, the facility failed to maintain an environment free of accessible hazardous chemicals in the soiled utility rooms of Oak and Willow on 1 of 3 days of survey. Accessible hazardous chemicals placed cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility policy titled "Chemical Storage" occurred on 07/08/14. This policy dated February 2013, stated, "There is an active, facility-wide chemical storage control program with effective measures to identify, control, and prevent chemicals from being exposed to residents and always placing chemicals in locked storage for all departments. . ." On 07/07/14 at 3:55 p.m., observation of the environment revealed an unlocked cupboard located in the unlocked soiled utility room on the Oak hallway containing the following chemicals: * 3 Clorox Urine Remover Bottles * 2 VSS Enzolve Enzyme Laundry Pre-Treatment Bottles On 07/07/14 at 4:15 p.m., observation of the environment revealed an unlocked cupboard located in the unlocked soiled utility room on the Willow hallway containing the following chemicals:	F 323		

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F 323	Continued From page 12 * 1 Clorox Urine Remover Bottle * 1 VSS Enzolve Enzyme Laundry Pre-Treatment Bottle The MSDS's stated the following: * Clorox Urine Remover: "Eye irritant: This product contains hydrogen peroxide which may cause temporary skin irritation or skin whitening after prolonged contact with concentrated product. . ." * VSS Enzolve: ". . . Eyes: May cause irritation on contact. Skin: May cause irritation on prolonged or repeated contact. Ingestion: May be harmful if swallowed. . ." During an interview on 07/07/14 at 4:30 p.m., when asked about the storage of cleaning chemicals, the maintenance supervisor (#14) did not have an explanation for the storage of chemicals in an unlocked cabinet. During an interview on 07/07/14 at 5:00 p.m., a nursing staff member (#6) agreed residents should not have access to chemicals and cleaning supplies.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. On 7/10/ 2014 the temperature of the wash cycle of the dishwasher machine was adjusted to 160 degrees per the manufacturer's guidelines. On July 20, 2014 the Dietary staff were informed of this information in the ECHO. This information will be reviewed again on September 11, 2014 at the next Dietary meeting.	

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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of dish machine temperature logs, and staff interview, the facility failed to follow the manufacturer's recommendations for the correct water temperature during the wash cycle of the dish machine in 1 of 1 kitchen. Failure to ensure the proper wash temperature of dishes in the dish machine may result unclean dishes. Findings include: Review of the manufacturer's recommendations for the dish machine occurred on 07/09/14. This information, dated October 2002, stated, ". . .Water Temperature, Wash 160 degrees F. . ." During the kitchen tour on 07/09/14 at 9:25 a.m., review of dish machine temperature logs showed staff recorded wash cycle temperature readings from the dish machine gauge after each meal and consistently recorded 140 degrees F. At 9:28 a.m., the dish machine wash temperature gauge read 136 degrees F. The dietary manager (#11) instructed a dietary staff member (#12) to stop using the dish machine and stated she will call the service person. The dietary manager stated the dish machine wash cycle is set to run at 140 degrees F. During an interview on 07/09/14 at 1:00 p.m., a service technician (#13) stated the manufacturer's recommendation for the water temperature in the facility's dish machine is 160 degrees F. He stated an adjustment will be made to the wash temperature at the time of the service	F 371	2. This is the only dishwasher in the facility, so will be the only one monitored. 3. The temperature of the dishwasher will be monitored 3 times a day by the Dietary staff. They will check the temperature at Breakfast, Dinner and Supper times. The Dietary Manager will oversee the temperature checks weekly. This monitoring report will be reviewed with the QA/Interdisciplinary team monthly. See form F371 A	7/20/14

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F 371	Continued From page 14 call. During an interview with the dietary manager (#11) on 07/09/14 at 1:20 p.m., she agreed the wash water temperature needs adjustment to 160 degrees F.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Nurse #3 was re-educated on 7/7/14 by DON regarding using germicidal wipes for glucometer cleaning. 2. Review of Fingerstick for Glucose Policy was reviewed and signed off by all nurses by 7/23/14. See form F441 A. The policy was reviewed again at the Nurse meeting on 8/7/14. See form F441 B 3. A QA monitor to assess proper cleaning of the glucometers will be completed by DON or designee on a weekly basis for 4 weeks then monthly thereafter. These findings will be discussed at the monthly QA interdisciplinary meetings. See Form F441 C	8/7/14

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F 441	Continued From page 15 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 3 supplemental residents (#16) observed receiving a blood glucose check. Failure to disinfect the glucometer after each resident use has the potential to spread infection to residents and staff. Findings include: Review of the facility policy, "Fingerstick for Glucose," dated June 2012, stated, ". . . Procedures: . . . 12. Cleanse glucometer with germicidal wipes after each use." Observation of medication administration occurred on 07/07/14 at 4:45 p.m. After the nurse (#3) finished checking a resident's blood glucose level, she placed the glucometer on top of the medication cart and continued to administer medications to residents, without disinfecting the glucometer with a germicidal wipe. At 5:00 p.m., the nurse (#3) prepared insulin at the medication cart for another resident and cleansed the glucometer with an alcohol wipe prior to taking it to check Resident #16's blood glucose level. During an interview on 07/07/14 at 5:10 p.m., an	F 441		

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F 441	Continued From page 16 administrative nursing staff member (#6) stated staff should use "PDI wipes" (germicidal wipes) on the glucometer machines and not alcohol wipes.	F 441		