STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/27/2011

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/25/11 and completed on 07/27/11, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, staff failed to follow policies regarding accident/injury reports for 1 of 1 sampled resident (Resident #13) who experienced a near fall from a stand lift. Failure to complete an incident report inhibited staff's ability to investigate the incident and implement preventive measures, and could result in Resident #13 experiencing an additional fall. Findings include: Review of the facility "Policy on Accident/Injury Report" occurred on 07/27/11. The undated policy stated, "The accident/injury report attached is completed for . . . all accidents or incidents where there is injury or the potential to result in injury . . . Licensed personnel are responsible for the initiation and completion of the accident/injury report. An incident is defined as any happening, not consistent with the routine operation of the	F 281	1. Policy and Procedure updated and reviewed for incident/accident reports. This information was reviewed at the nurses meeting scheduled for August 8, 2011. See F281A-1 F281A-2 F281A-3 F281A-4 2. Completion of the investigation for the near miss on Resident #13 was completed 7/27/2011. See F281B 3. Monitoring of Resident #13 for possible incidents by reviewing nurses notes will be done by DON or designee weekly x 4 then monthly thereafter. See F281C.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Owen — TITLE: Adm. — (X6) DATE: 8/16/11

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 281	Continued From page 1 long-term care facility, that does not result in bodily injury or property damage . . . All resident [sic] who fall or are found on the floor must have their vital signs taken as soon as possible . . . If a resident is seen falling or is found on the floor and presumed to have fallen, an initial assessment that includes the following will be done: a. Range of Motion (ROM) b. Full body search. c. Vital signs . . . Fully complete the accident/ incident report legibly and place it in the chart for 72 hrs [hours] so follow-up can be charted . . . Observe resident closely for any change from normal habits that could be an indication that there is an injury not noticed or diagnosed during the initial assessment. . . ." The attached "Resident Incident Report" included a section for documenting the 24, 48, and 72 hour assessments. Review of the facility policy "EZ Stand [brand name of stand lift]" occurred on 07/27/11. The policy, dated August 2010, stated, "An EZ stand lift is used appropriately to facilitate transfers of residents . . . 2. Position the top of the harness around the upper body of the patient. 3. Secure plastic buckle and pull the loose strap to tighten . . . 6. Have the patient place feet on footplate and position their shins into the shin pad. (if needed secure shin straps around the residents [sic] legs to keep feet on foot plate) . . ." Review of Resident #13's medical record occurred on July 26-27, 2011. The record identified diagnoses including multiple sclerosis (MS), paretic paraparesis (partial paralysis of the lower limbs) secondary to MS, and osteoporosis. A quarterly Minimum Data Set, dated 07/12/11, identified Resident #13 required extensive	F 281	This monitoring will also include a random sample of residents. Review of findings will be completed at the monthly disciplinary meetings.	8/11/2011

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F 281	Continued From page 2 assistance of two or more persons for transfers and had no falls since the prior assessment. The current care plan identified Resident #13 at high risk for falls. Approaches included "transfers assist of two and E-Z Stand. Hoyer [full body lift] PRN [as needed]." A nurse's note, dated 07/24/11 at 7 a.m., stated, "Res [resident] slid thru [through] sling of EZ Stand - was eased to floor - [no] injury received." The record lacked evidence staff completed an incident report, obtained vital signs or performed an assessment, including ROM and 24, 48, and 72 hour post fall assessments per facility policy. During an interview on the morning of 07/27/11, an administrative nurse (#2) stated she was not aware of Resident #13's fall on 07/24/11 and had not received an incident report. During an interview, on 07/27/11 at 1:20 p.m., an administrative nurse (#2) confirmed staff did not complete an incident report for the fall on 07/24/11. The nurse stated she interviewed staff on duty when the incident occurred and stated staff informed her Resident #13 did not slide out of the lift, but her feet came off the foot plate during the transfer, which conflicts with the nurse's note, dated 07/24/11 which identified the resident "eased to the floor." Failure to complete an incident report and to perform an initial and follow-up assessments following the incident inhibited the facility's ability to investigate the incident and implement preventive measures to prevent future incidents involving the stand lift. This failure placed Resident #13 at risk for injury during lift transfers.	F 281		

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F 323 SS=G	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: Based on observation, record review, review of professional reference, facility policy, family interview, and staff interview, the facility failed to implement interventions to prevent accidents for 2 of 10 sampled residents (Resident #4 and #5) identified by the facility as experiencing falls. This failure resulted in Resident #4 and #5 experiencing injuries related to falls. Findings include: The Food and Drug Administration (FDA) Center for Devices and Radiological Health publication titled, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" issued on 03/10/06, stated, ". . . FDA has received reports in which . . . patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term 'entrapment' describes an event in which a patient is caught, trapped or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in death and serious injuries . . . The current International	F 323	1. Review of updated ½ side rail policy was completed at the nurses meeting held on August 8, 2011 and with the Certified Nurse Assistants (CNA) at the CNA meeting held on August 9, 2011. See F323A 2. Resident #4's use of ½ side rail was reviewed and discontinued as of 8/1/11. See F323B. All other residents with orders for ½ side rail will be reviewed and care plan will be updated by 8/23/11. Initial nurse assessment for possible use or need of ½ rail will be completed on admission. Education to families and residents will be an ongoing process to ensure residents safety. Restraint reduction will be done quarterly with MDS. If no reduction is indicated documentation will address benefits vs. risks 3. The monitoring of ½ side rail use and/or discontinuation will be completed by DON or designee weekly x 4 then monthly thereafter. These findings will be reviewed at the	

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F 323	Continued From page 4 Electrotechnical Commission (IEC) standard recognizes that the bed frame, deck, and rails are the major elements involved in entrapment . . ." Safety Alert: Entrapment Hazards with Hospital Bed Side Rails, August 23, 1995, and Joint Commission on Accreditation of Healthcare Organization: Sentinel Event Alert, Issue 27, September 6, 2002, have identified bed rail-related entrapment deaths and injuries can occur in the elderly population, who are often at risk due to limited mobility, psychoactive or sedative medications, confusion, sedation, restlessness, lack of muscle control, size and physical deformities. Death by asphyxiation or injuries to the resident's extremities can occur when the resident becomes caught between the mattress and the bed rail; the headboard and the bed rail; or getting his or her head/extremity stuck in the bed rail. Both split and full rails have the potential to cause fall-related injuries as well as entrapment. Additionally fall-related injuries or injuries to extremities can occur when confused/ disoriented residents climb over the top of side rails or get an arm or leg entrapped. Review of the facility "Policy for the use of side rails" occurred on 07/27/11. The policy, dated 05/17/06, stated, "Purpose: 1. If the resident has difficulty turning themselves in bed, the side rails may be used to enable him/her to do this on their own or to assist aides in this procedure. 2. Resident is restless in his/her sleep and has a tendency to roll out of bed. 3. Resident lies very close to the edge of the bed and will roll out easily. 4. Side rails will be used per family and/or resident request. Procedure: . . . 3. Resident should be checked at least every two to three	F 323	monthly interdisciplinary meetings. See F323C 4. All nurses and CNA's were in-serviced on chair alarm policy regarding bathroom use. This in-service was held on August 8, 2011 and August 9, 2011. See Agenda F323D-1 F323D-2 F323D-3 5. Resident #5's care plan has been updated to state "resident should not be left unattended in bathroom" see F323E. 6. Random monitoring of the residents with chair alarms will be done by DON or designee weekly x 4 then monthly thereafter. See F323F. These findings will be reviewed at monthly interdisciplinary meetings.	8/23/2011

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F 323	Continued From page 5	F 323		

hours and prn [as needed] to assure he/she is not attempting to crawl through or over the rails. . . ."

- Resident #4's medical record, reviewed on all days of survey, identified diagnoses including schizophrenia, borderline intellectual functioning, chronic anxiety, and tardive dyskinesia (TD). Resident #4's medication regimen included Remeron (an antidepressant with sedative effects) 45 milligrams (mg) daily at bedtime, Buspar (an antianxiety) 10 mg twice a day, Zyprexa (an antipsychotic) 15 mg daily and 45 mg at bedtime, and lorazepam 0.5 (an antianxiety) mg four times a day.

The record identified Resident #4 experienced a fracture of the right femur on 01/17/11 without surgical repair. Minimum Data Sets (MDSs), dated 01/31/11 and 04/24/11, identified the resident required extensive assistance with bed mobility, had frequent urinary incontinence, not on a toileting program, experienced falls since the prior assessment, and used a bed rail daily. A physician's order, dated 02/01/11, stated, "Foam padded 1/2 siderail used for positioning and safety."

Resident #4's care plan, dated 12/29/09, identified a problem, "Alteration in ADLs [Activities of Daily Living] R/T [related to] unstable moods . . . Tardive Dyskinesia . . . hospitalized 1/11 for R) [right] femoral neck fx [fracture] . . . Returned without surgical repair. Fall Assessment high risk . . ." Approaches to the problem included, "Transfer with extensive assist of one or two 4/28/11 . . . 2-1-11 Foam padded 1/2 siderail for repositioning et [and] safety. Bed alarm on bed . . ."

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F 323	Continued From page 6	F 323		

Review of "Care Plan Update" notes identified the following:
* 04/26/11: "4-19-11 p [after] x-ray of (R) hip showed it was healed. Res [resident] continues to require extensive assist [with] ADLs due to weakness. Res able to sit on edge of bed per self at times. Res bed in lowest position. Has half siderails [with] padding due to attempts to get up per self. Also has fall mat beside bed. . . ."
* 07/27/11: "Res needs assist . . . in & [and] out of bed, is at times able to sit up in bed per self . . . Res transfers [with] assist of 1 or 2 . . . is walking in room [with] assist of 2 at this time. . . ."

Review of nurse's notes identified the following:
* 03/20/11 at 1 p.m.: "Has sm [small] open areas on knees - does become restless & rubs knees on bed rails or walls."
* 03/22/11 at 6:50 p.m.: "Staff found Res sitting on floor mate [sic] beside her bed. Denies any injuries. Has a skin abrasion [with] faint puffness [sic] . . . Ice pack applied to R) FA [forearm].
* 03/22/11 at 10 a.m. "R) forarm [sic] with increased discoloration & puffyness [sic]."
* 03/23/11 at 6 a.m."Ace Wrap rewrapped - cont [continues] to have 4 cm [centimeter] long abrasion [with] hematoma."
* 04/02/11 at 12 noon: "Bruise (R) arm yellow et [and] fading."
* 04/05/11 at 1:55 a.m.: "Res had been very anxious & restless for the past 1/2 hr [hour]. Res sitting up & trying to crawl out of bed 4 to 5 times in past 1/2 hour . . ."
* 04/09/11: 6:30 a.m.: "Bed Alarm Sounding - found Res laying on R) side beside bed . . ."
* 04/15/11 at 3:45 a.m.: "Nurse found res laying on her bedroom floor on her (L) [left] side next to

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F 323	Continued From page 7 her fall mat . . . Observed 3.4 cm wide x 3.6 cm long light purple bruise to (R) knee. . . ." * 04/29/11 at 9:15 a.m.: "Res rose from bed unassisted. Found on floor off floor mat - stated she hit the back of her head during the fall on the floor . . ." * 05/08/11 at 10:22 p.m.: "CNAs [certified nursing assistants] report res had had [increased] restlessness . . . has attempted to climb out of bed x 5 in the last 10 minutes . . ." * 05/26/11 at 11:30 p.m.: "[increased] restlessness climing [sic] out of bed . . . 0500 [5 a.m.] Cont [continues] to try to climb out of bed per self . . ." * 07/13/11 at 2 a.m.: Awake [with] legs over side rail. Did return to bed [after] being told the time of day." * 07/17/11 at 12 a.m.: "CNA Reports old bruising to L) outer knee area also questioned possible swelling. Assessment shows old bruise. Resident is Restless @ [at] times and does bump knees on side rails. No swelling felt to area." Observation during the initial tour of the facility, on 07/25/11 at approximately 9:30 a.m., identified Resident #4 resting in a low bed with one side of the bed next to the wall and a 1/2 padded side rail elevated on the exit side of the bed. On 07/26/11 at 9:05 a.m. observation showed two CNAs (#6 and #7) assisted Resident #4 into bed. The CNAs lowered the bed and elevated the siderail on the exit side of the bed. A CNA (#7) placed the padding on the outside of the side rail, not between the resident and the siderail. Observations on 07/27/11 at 9:35 a.m. and 2:25 p.m. showed Resident #4 in bed with one side of	F 323		

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F 323	Continued From page 8	F 323		

the bed next to the wall and a padded 1/2 rail elevated on the exit side of the bed.

Review of Resident #4's Restraint Consent, Side Rail Assessments, Physical Restraint Elimination Assessments, and Resident Incident Reports (from the falls on 03/22/11, 04/15/11 and 04/29/11) lacked evidence the facility reconsidered continued use of the side rail when the resident experienced injuries when crawling out of bed with the 1/2 rail elevated. All three incident reports identified "Rising unassisted" as a contributor to the falls.

During an interview on 07/27/11 at 11:30 a.m. administrative nurses (#2, #3, and #4) stated they expect staff to place the padding between the resident and the side rail. When asked about the Resident #4's side rail, the nurses stated staff elevate the side rail to prevent Resident #4 from getting out of bed without assistance.

The facility failed to consider alternatives to the side rail when Resident #4 repeatedly attempted to get out of bed with the rail elevated. The resident developed open areas related to the side rail, hit her head, and experienced an abrasion and bruises when she exited the bed with the side rail elevated. Failure to attempt alternatives to the 1/2 side rail resulted in Resident #4 experiencing the above injuries and placed the resident at risk for further injuries related to use of the side rail.

- Review of the facility "Chair Alarm Policy" occurred on 07/27/11. The policy, dated October 2001, stated, "Purpose: To assure the safety of a resident with confusion or dementia and/or with a fall alert. Procedure: 1. Place wheelchair alarm on

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F 323	Continued From page 9	F 323		

chair to alert staff if resident attempts to get out of wheelchair without assist. . . ."

Resident #5's medical record, reviewed on all days of survey, identified diagnoses including dementia, anxiety, osteoarthritis, and legal blindness. A quarterly MDS, dated 06/03/11, identified the resident with moderate cognitive impairment, and required extensive assistance of one person with transfers and walking in the room. A nurse's note, dated 12/04/10 at 4:15 p.m., identified staff responded to the chair alarm and found Resident #5 on the floor in her room. The facility transferred Resident #5 to the hospital where she was was diagnosed with a left hip fracture.

Resident #5's care plan, dated 12/16/10, identified a problem, "Alteration in ADLs . . . Fall Assessment: High Risk. . . ." Approaches to the problem included, "Transfer with ext [extensive] assist of one or two 2/10/11 . . . Chair alarm on chair . . ."

A nurse's note, dated 07/06/11 at 9 p.m., stated, "Res fell off toilet - scraping right knee - Res did not pull call light . . ." A right rib X-ray report, dated 07/07/11, identified "Minimally displaced fractures of the anterior ribs of the eighth, ninth, and tenth ribs. Decreased lung volumes are noted on the right."

An incident report, dated 07/06/11 at 9 p.m., stated, "Res was sitting on toilet - turned to get something and fell off, bruise and 2 cm [centimeter] scrape to right knee." The incident identified "Contributors to Incident" as "Confusion, Forgets to use call light, and Rising unassisted."

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F 323	Continued From page 10	F 323		

The incident report failed to identify interventions to prevent falls in the bathroom.

Observation, on 07/25/11 at 3:10 p.m. identified a CNA (#5) entered Resident #5's room in response to the call light. The CNA (#5) stated the resident's husband (who shares her room) usually puts on the call light. The CNA assisted Resident #5 out of bed. During the transfer, the resident stated, "Every time I move yesterday and today I get dizzy." The CNA assisted Resident #5 to walk to the bathroom. After assisting the resident to sit on the toilet, the CNA (#5) closed the bathroom door and left the room. At 3:22 p.m. observation identified Resident #5's husband activated the call light and at 3:24 p.m. the CNA (#5) arrived to assist Resident #5 out of the bathroom. Observation showed the CNA left the resident unattended in the bathroom for approximately 12 minutes.

An interview with Resident #5's family member (#1) occurred on 07/25/11 at 3:12 p.m. The family member stated, when Resident #5 fell on 07/06/11, staff had assisted her to the bathroom and left the room. The family member (#1) stated the resident "hollered for help" and he (the family member) activated the call light. He stated staff returned to the room and found Resident #5 had fallen in the bathroom.

Resident #5 experienced fractured ribs when she fell from the toilet while unattended on 07/06/11. The resident complained of feeling dizzy during her transfer to the bathroom on 07/25/11 at 3:30 p.m. The facility failed to ensure Resident #5's safety when staff left her alone in the bathroom. This failure placed Resident #5 at risk of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 11 experiencing another fall and/or injury.	F 323		
F 373 SS=C	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid	F 373	1. Care-planning team will assess all residents during quarterly assessment process or more often with significant changes noted, to determine if there is a change in residents ability to chew or swallow. 2. A written update will be placed in the care-plan update sheet to indicate the assessment results. 3. Review of Feeding Assistant Policy will be completed at in-service on August 17, 2011. See F373A-1 F373A-2 4. All residents will be monitored for written update by MDS Coordinator or designee on a weekly basis x 4 then monthly thereafter. These findings will be reviewed by interdisciplinary team monthly. See F373B	8/22/2011

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	355110	A. BUILDING _____ B. WING _____	07/27/2011

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 373	Continued From page 12 feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and staff interview, the facility failed to ensure the charge nurse assessed residents' ability to be fed by a paid feeding assistant (PFA) for 6 of 6 sampled residents (Resident #2, #4, #5, #8, #9, and #11) and 2 of 2 supplemental residents (Resident #16 and #17) identified by facility staff as fed by PFAs. Failure to ensure a PFA feeds only residents without complicated feeding problems placed residents at risk for choking and aspiration. Findings include:	F 373		

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F 373	Continued From page 13	F 373		

Review of the facility's policy titled "Feeding Assistant Policy" occurred 07/27/11. The undated policy stated, ". . . 5. Feeding Assistants may only feed residents that do not have complicated feeding problems. 6. Residents will be assessed by the care planning team via the MDS [Minimum Data Set] and other assessments to determine if there are complicated feeding problems that inhibit feeding assistants to feed them. 7. If a resident cannot be fed by a feeding [sic], it will be denoted on the care plan and the feeding assistants will be made aware of these residents. On each resident's care plan it will be denoted if a resident can or cannot by [sic] fed by a feeding assistant. . . . 9. Staff will be made aware of those residents that cannot be fed by feeding assistants."

On the morning of 07/27/11, facility staff provided a list of residents who may be fed by PFAs. Review of Resident #2, #4, #5, #8, #9, #16, and #17's medical records occurred on 07/27/11. Resident #2, #4, #5, #8, #9, #11, #16, and #17's records lacked an assessment by a licensed nurse to determine whether the residents could be fed by a PFA.

During an interview on 07/27/11 at 2:05 p.m., four administrative staff members (#3, #4, #9, and #10) confirmed the lack of assessments for the above residents.

Resident #16's current plan of care identified the intervention, ". . . May be assisted by feeding assistant if needed." An evaluation, completed by the speech therapist on 01/12/11, identified the following, ". . . to [decrease] pocketing [and] help trigger the swallow, offer a suck/cold bolus (ex:

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F 373	Continued From page 14 lemon ice) small bite before meal. Massage cheek, chin to [decrease] pocketing. During feeding, gently apply pressure to middle of tongue to help [with] swallow ability. . ." During an interview on the afternoon of 07/27/11, an administrative nursing staff member (#4) identified the care plan for Resident #16 as incorrect and indicated, based on the evaluation by the speech therapist, Resident #16 no longer met the requirements to be fed by a PFA.	F 373		
F 441 SS=B	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	F 441	1. All nurses and CNA's were in-serviced on tub cleaning policy at meetings scheduled for August 8, 2011 and August 9, 2011. F441A-1 F441A-2 2. All bathing equipment including tubs, tub chair, and shower chair will be disinfected with proper cleaner and will be left on per manufacturer's recommendations. No cleaning supplies, example scrub brush, will be on the floor. 3. All bathing areas were provided a timer to allow staff monitoring of time cleaner is placed on equipment. 4. Random monitoring will be completed by DON or designee weekly x 4 then monthly thereafter. These findings will	

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F 441	Continued From page 15 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interview, the facility failed to ensure the proper cleaning/sanitation of 1 of 2 tubs (tub on Oak/Willow wing) used to bathe residents. Failure to provide a sanitary environment may cause the transmission of disease and infection. Findings include: Review of the facility "Policy for Disinfecting the Tub Oak/Willow" occurred on 07/27/11. The policy, dated March 2011, stated, "Purpose: Tubs will be thoroughly disinfected on a regular schedule and as necessary. Procedure: . . . 2. Remove the 'Disinfecting wand' from the cabinet. 3. Turn the 'Disinfecting valve' to 'Disinfect.' 4. Spray the interior of the tub. You may use a brush or sponge to clean the walls of the tub . . . 6. Let the disinfecting solution [brand name] remain on the surface of the tub for the recommended bacteria killing time (10 minutes) given by the manufacture [sic] of the disinfecting solution you are using. . . . "	F 441	be reviewed at the monthly interdisciplinary team meetings. F441B	8/17/2011

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F 441	Continued From page 16	F 441		

- On 07/26/11 at 10:40 a.m., a certified nursing assistant (CNA) (#8) demonstrated cleaning of the Arjo tub in the Oak/Willow wing following the bathing of a resident. The CNA (#8) used a wand to spray what she described as "disinfectant" over the tub, grabbed a brush which rested with the base on the floor and the handle against the wall, and scrubbed the entire inside surface of the tub with the brush. The CNA (#8), when asked, stated there was no specific amount of time required to leave the sanitizer on the tub to complete the cleaning process. The CNA failed to ensure the disinfectant remained on the tub the required amount of time. Upon completion, the CNA placed the brush, base side down, back onto the floor, which was located near the drain for the tub.

A tour of the environment occurred on 07/27/11 at 9:30 a.m. with a supervisory environmental staff member (#1). During the tour, observation in the Oak/Willow tub room showed the tub brush on the floor near the drain.

During an interview on the morning of 07/27/11 at 11:30 a.m., an administrative staff nurse (#2) stated the brush utilized in cleaning the Arjo tub should not be placed on the floor, and stated the sanitizing of the tub should occur for 10 minutes between bathing of residents to ensure proper sanitation.