STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	For the standard Medicare/Medicaid recertification survey started on 05/12/14 and completed on 05/15/14, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew Lidge — TITLE: Administrator — (X6) DATE: 6/25/14

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 05/12/14 and completed on 05/15/14, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000	Preparation and submission of this plan does not constitute an admission or agreement by the Rolette Community Care Center of the truth of the facts alleged and shall not be construed in any administrative or judicial form for the purpose of establishing liability of our facility, its Board of Directors, Administration, Employees or Representatives. This plan is our allegation of substantial compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	1.Resident # 5 fracture is healed and he has resumed previous level of movement in right arm. 2.All residents have the potential for requiring physician intervention if they should experience an injury. 3.Nursing staff reviewed the policy and procedure for Accident/Incident Report at the Nurses meeting on June 24, 2014 4.The Director of Nursing or her designee will review all falls/incidents resulting in injury requiring physician involvement until ten (10) uninterrupted observations meet 100% compliance. Falls committee will continue weekly thereafter. 5.The Director of Nursing or her designee will be responsible for reviewing Quality Improvement studies and revising policy and procedure and providing staff education as needed to meet and maintain compliance.	July 15 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and review of facility policy, the facility failed to promptly notify a resident's physician of a change in condition for 1 of 1 sampled resident (Resident #5) who experienced a "near fall" with fracture. Failure to notify Resident #5's physician of the incident and injury resulted in pain and delayed treatment.

Findings include:

Review of the facility policy titled "Acute Condition Changes - Clinical Protocol" occurred on 05/14/14. This policy, revised February 2013, stated, ". . . 5. Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the Physician . . . 6. The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response. . . ."

Review of the facility policy titled "Pain Assessment and Management" occurred on 05/14/14. This policy, revised October 2010, stated, ". . . Reporting, Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain . . . 3. Prolonged, unrelieved pain despite care plan interventions."

Review of the facility policy tilted "Assessing Falls

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and Their Causes" occurred on 05/14/14. This policy, revised October 2010, stated, ". . . After a Fall . . . Nursing staff will notify the resident's Attending Physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax or by phone the next office day). . . ."

Review of Resident #5's medical record occurred on all days of survey and diagnoses included cerebral palsy, aphasia, and osteoporosis. The quarterly Minimum Data Set (MDS), dated 03/08/14, identified the resident required total assistance of two or more staff members for transfers. The current care plan stated, ". . . [Resident #5] has DJD [degenerative joint disease], has chronic left hip pain and left knee discomfort . . . [Resident #5] will sign that he has pain by pointing to body area and frowning to indicate pain or discomfort . . . [Resident #5] is extensive to dependent [with] all ADL's [activities of daily living], He has cerebral palsy, has generalized spasticity and contractures of hands and feet, is tall and leans backwards when transferred . . . Hoyer lift only (revised after incident on 10/17/13). . . ."

Review of Resident #5's Progress Notes identified the following:
*10/18/13 at 1:09 p.m. - "Resident appeared to be very agitated early in this shift, his skin was cold and clammy and he seemed as though he was having some trouble breathing. He was grimacing and gesturing towards his right leg. O2 [oxygen] was 91% on RA [room air]. Resident was given

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PRN [as needed] Ativan and PRN ES [extra strength] tylenol of 1000 mg [milligrams] for suspected pain. Resident lyed [sic] down at 11:00 a.m. VS [vital signs] WNL [within normal limits] and resident appears to be in a better mood and appears to be feeling better."
*10/19/13 at 8:53 a.m. - "Noted redness on medial side of right forearm. Does not look bruised, but red and skin hardened. When touched [Resident #5] flinches. He has a tendency to let his right arm down to the inside of the w/c [wheelchair] next to his leg. Ice pack applied. [Resident #5] smiled and was happy about the ice bag."
*10/20/13 at 9:09 a.m. - "Resident RT [right] outer forearm continues to be red and hard, area does not seem to have grown in size since yesterday. This morning however, RT forearm has a purple bruise noted over the top of the reddened area. Resident is able to move arm with regular strength. Ice pack applied to site, resident seems to be content with ice pack."
*10/20/13 at 9:48 p.m. - "resident right forearm tender when touched - did get relief with scheduled pain medication - area bruised and red with raised area at wrist - resident pleasant and cooperative - will continue to monitor."
*10/21/13 at 9:09 a.m. - "Redness noted on right medial forearm, cool to touch on 10/19/13 . . . Today floor nurse notified myself that [Resident #5's] right forearm was bruised from elbow to distal fingers. No deformities noted, no crepitus. Facial expression indicated flinching et [and] painful expression. [Resident #5] indicated . . . through nonverbal communication his discomfort through restlessness and anxiety and being diaphoretic. [Name of Doctor] notified and orders to obtain X-rays obtained."
*10/21/14 at 6:38 p.m. - "Res [resident] had an

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apt. [appointment] in [name or town], for x-ray. Res has a broken (RT) lower arm. Res returned at 5:00 p.m. with driver from facility. (RT) arm in a sock, casting and also splint stabilizer. Res. perspiring, skin cool and clammy. Oxycodone given for pain at 5:00 p.m., and also Ativan given per families [sic] request. Res assisted to bed per lift and assit [sic] of four. 6:30 p.m. Res resting quietly."

Review of a physician progress note, dated 10/21/13, stated, ". . . scheduled today after injuring his upper extremities some time over this past weekend. Reportedly he was either being transferred or using a standing type of device and his arms were in the device and his legs gave out. He slid to the floor causing some pulling type injury to both upper extremities, nursing contacted me today stating he was having a lot of swelling to the right upper extremity and bruising, some on the left, appeared to have some significant pain to the right upper extremity . . . He has cerebral palsy and communicates by gesturing and some hand signals . . . On the right upper extremity he has a large area of ecchymosis [bruising] from below his elbow to his left hand and thumb . . . x-ray shows a displaced, spiral fracture of the right, mid to distal ulna . . . He is placed in a soft roll wrap and then a forearm splint. Will contact orthopedics regarding further management . . . He has Tylenol and Tramadol for pain already and Rx [prescription] for Oxycodone 5 mg . . . provided."

An investigation completed by the facility on 10/25/13, stated, ". . . During the course of the investigation all staff that had been on duty 1 day prior to the bruise being noted were interviewed. It was during these interviews that we learned of

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a near fall from the sit/stand lift on October 17th 2013 . . . The two aides caring for him on 10/17/13 demonstrated what happened when resident's leg buckled and caused him to almost fall . . . The staff were able to lift him from the strapped position and get him into a chair where they then called for the nurse . . . The aides demonstrated and described how he 'hung on' on the lift while they transferred him. . . ."

Staff interviews completed during the above investigation of Resident #5's injury identified the following:
*". . . the day of Oct. 17, 2013 when we were hoyering him into bed . . . was favoring that arm (Rt) and we had to assist him more to turn him. . . ."
*". . . Friday the 18th . . . he seemed agitated and would hollar out. . . ."
*". . . Friday 18th crying . . . not acting himself. . . ."
*". . . Friday pm he used his Rt hand to tap his knee. This is what he does to tell us his knee hurts. . . ."
*". . . On Friday Oct. [October] 18th . . . noticed a bruise on his right arm. It was not very big . . . On Saturday Oct 19th . . . his whole right arm was bruised. He seemed like he was in pain and when we moved him onto his right side . . . we could hear him cry (scream) so we went back . . . we kept on his left side the rest of the night. . . ."
*". . . On Sat (Saturday - 10/19/13) - he was very agitated . . . kept right arm close to side. . . ."
*". . . 10-21-13 - [Right] arm swollen bruised - left under arm bruised. . . ."

Resident #5's medical record lacked evidence the facility notified the resident's physician of the resident's change in condition until 10/21/13 (four

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F 157	Continued From page 6 days after the "near fall" on 10/17/13).	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure resident access to the most recent Health and Life Safety Code surveys, including plans of correction on 3 of 3 days of survey (May 12-14, 2014). Failure to make the results of the surveys readily accessible to residents is an infringement of their rights. Findings include: On 05/12/14 at 1:15 p.m., observation showed the surveyor unable to locate the most recent Health and Life Safety survey results. A medication aide (CMA) (#1) stated the binder is in a drawer at the nurses' station and directed the surveyor to a drawer inside the nurses' station. Review of the binder identified the most recent Health survey, but failed to include the most recent Life Safety Code survey conducted on	F 167	F 167 1.The most recent Health Department Survey has been placed in the survey binder at the desk with the resident's telephone near the nurse's station. The most recent Life Safety Code Survey has also been placed in the survey binder at the desk with the resident's telephone near the nurse's station. 2.This deficiency has the potential to affect all residents that would like to view the prior survey results. 3.After every survey, a copy of the survey and our response will be placed in the survey binder at the desk with the resident's telephone near the nurse's station to be made available for residents, family, visitors and staff. Signs will be placed prominently within the facility indicating where the most recent surveys are located. 4.The night shift charge nurse will audit that the most recent surveys are located in the survey binder that is placed at the desk with the resident's telephone by the nurse's station in conjunction with her other checks nightly. 5.The Director of Nursing or her designee will complete weekly checks for 3 months and will be reported to the QI committee meetings for review. This will be then done monthly thereafter.	07-15-2014

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F 167	Continued From page 7 03/19/14. During the group interview, conducted at 2:00 p.m. on 05/12/14, only 1 of 5 residents in attendance knew the survey results were "at the nurses station." During an interview on 05/14/14 at 1:55 p.m., an administrative nursing staff member (#2) agreed the location of the survey binder, in a drawer at the nurses' station, was not readily accessible to residents.	F 167		
F 225 SS=E	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	F 225		

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violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported 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 perform an investigation for 4 of 4 sampled residents (Resident #4, #5, #6, and #7) with unexplained injuries. Failure to report and investigate these injuries placed these sampled residents and other residents at risk for mistreatment and/or neglect, and did not allow the facility to determine causative factors for the injury and implement corrective action.

Findings include:

Review of the facility policy titled "Accidents and Incidents - Investigating and Reporting" occurred on 05/14/14. This policy, revised December 2011, stated, ". . . All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator . . .
1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of

1.Resident #4 toenail is healed and has no lasting effects. Nurses notes reviewed and possible cause from resident sliding out of chair on 01-08-2014. Investigation completed, abuse not suspected.

Resident #6 abrasions have healed and there is no lasting effects. Resident was being transferred from shower room to resident room by CNA. Top of both feet obtained abrasions from improper positioning of resident in shower chair. CNA was immediately educated by nurse on duty. 7-15-2014

Resident #7 ankle bruise has resolved. Investigated and this was found not to be an incident of abuse or neglect.

The resident #5 incident was investigated, state reportable and determined that it was not an incident of abuse or neglect. The fracture is also healed and movement of arm has been restored. The blood clot has also resolved.

2. All residents have the potential to be affected by this practice.

3.The Director of Nursing or her designee will provide an in service to all staff by July 15, on the policy/procedure for investigation/reporting of allegations of abuse, neglect, mistreatment and misappropriation of property.

4.Audit of all incidences of injuries, neglect, mistreatment, or abuse are completed on time and all are reported to the Director of Nursing or her designee and Administrator in the appropriate time frame of 24 hours. This will be done weekly by the Director of Nursing or designee until there is 100% compliance. Follow up will be done for nursing staff for three months on the reporting and investigations of incidences.

5.The audits will be reported to the Quality Improvement monthly.

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the accident or incident . . .
5. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. . . ."

- Review of Resident #5's medical record occurred on all days of survey and diagnoses included aphasia, cerebral palsy, congenital deafness, and history of deep vein thromboses. Current medications included Coumadin [blood thinner] daily. The current care plan stated, ". . . [Resident #5] is extensive to dependent [with] all ADL's [activities of daily living], He has cerebral palsy, has generalized spasticity and contractures of hands and feet, is tall and leans backwards when transferred . . . Hoyer lift only (revised after incident on 10/17/13) . . . high back w/c [wheelchair], can propel self most times with right leg. . . ."

Review of Resident #5's August 2013 nurse's notes identified the following:
*08/12/13 at 1:44 p.m. - "LT [left] inner calf has reddened appearing abrasion. Warm soaks applied; Area is 5 cm [centimeters] X 1.5 cm wide. Will cont. [continue] to monitor."
*08/14/13 at 9:21 p.m. - "Left calf continues to be red, it is warm to touch. No drainage noted. Edema noted at +2."
*08/18/13 at 6:48 p.m. - "Lt calf continues to be red but is now the same temp [temperature] as the rest of his skin. . . ."

Resident #5's medical record lacked evidence of an investigation as to possible causes of the injury, as well as reporting and additional follow-up/monitoring of the left calf.

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Review of October 2013 nurse's notes identified the following:
*10/18/13 at 1:09 p.m. - "Resident appeared to be very agitated early in this shift, his skin was cold and clammy and he seemed as though he was having some trouble breathing. He was grimacing and gesturing towards his right leg. . . ."
*10/19/13 at 8:53 a.m. - "Noted redness on medial side of right forearm. Does not look bruised, but red and skin hardened. When touched [Resident #5] flinches. He has a tendency to let his right arm down to the inside of the w/c next to his leg. . . ."
*10/20/13 at 9:09 a.m. - "Resident RT [right] outer forearm continues to be red and hard, area does not seem to have grown in size since yesterday. This morning however, RT forearm has a purple bruise noted over the top of the reddened area. Resident is able to move arm with regular strength. . . ."
*10/20/13 at 9:48 a.m. - "resident right forearm tender when touched - did get relief with scheduled pain medication - area bruised and red with raised area at wrist - resident pleasant and cooperative - will continue to monitor."
*10/21/13 at 9:09 a.m. - "Redness noted on right medial forearm, cool to touch on 10/19/13. See previous notes. Today floor nurse notified myself that [Resident #5's] right forearm was bruised from elbow to distal fingers. No deformities noted, no crepitus. Facial expression indicated flinching et [and] painful expression. [Resident #5] indicated . . . through nonverbal communication his discomfort through restlessness and anxiety and being diaphoretic. [Name of Doctor] notified and orders to obtain X-rays obtained."
*10/21/13 at 6:38 p.m. - "Res had an apt [appointment] . . . for x-ray. Res has a broke

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[right] lower arm . . . arm in a sock, casting and also splint stabalizer [sic]. Res perspiring, skin cool and clammy. . . ."

An investigation completed by the facility on 10/25/13, stated, ". . . During the course of the investigation all staff that had been on duty 1 day prior to the bruise being noted were interviewed. It was during these interviews that we learned of a near fall from the sit/stand lift on October 17th 2013 . . . The two aides caring for him on 10/17/13 demonstrated what happened when resident's leg buckled and caused him to almost fall . . . The staff were able to lift him from the strapped position and get him into a chair where they then called for the nurse . . . The aides demonstrated and described how he 'hung on' on the lift while they transferred him. . . ."

During an interview on the afternoon of 05/13/14, an administrative nurse (#2) stated the only incident report staff completed in regards to Resident #5's right arm fracture occurred on 10/21/13. This report identified a large bruise found on the resident's right forearm. The nurse (#2) stated staff failed to report the near fall from the sit/stand lift on 10/17/13.

Staff failed to report and document Resident #5's incident of "near miss" on 10/17/13. This failure resulted in a delayed investigation related to Resident #5's right arm fracture.

A nurse's note, dated 01/02/14, stated, "Res [Resident] noted to have a purple bruise on [right] inner forearm. (1 inch X [by] 1 inch around.) Res unable to tell nursing staff how he received bruise. No open areas."

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Resident #5's medical record lacked evidence of an investigation as to possible causes of the bruising, as well as reporting and follow-up/monitoring of the bruise.

- Review of Resident #4's medical record occurred on all days of survey and diagnoses included dementia. The current care plan stated, ". . . Bilateral upper and lower extremity weakness. [Resident #4] is unable to stand per self. Needs staff extensive assist . . . Uses W/C as a main mode of transportation . . . may walk with extensive assist of two with gait belt and wheelchair nearby, but has been refusing to walk most days . . . uses the EZ stand [mechanical lift] to transfer. . . ."

A nurse's note, dated 01/09/14, stated, "Res complaining of his toe being 'broke.' Writer examined left foot. Red drainage noted on sock. Great toenail is attached only on left inner side, writer removed toe nail and cleansed area with saline and Telfa bandage applied. Res tolerated well."

Resident #4's medical record lacked evidence of an investigation as to possible causes of the injury, as well as reporting and follow-up/monitoring of the injured toe.

- Review of Resident #6's medical record occurred on all days of survey and diagnoses included paraplegia. The current care plan stated ". . . Resident is unable to walk (paraplegia) . . . Transfer with assistance of two using the Hoyer device or EZ Stand. . . ."

A physician's progress note, dated 03/04/14, stated, ". . . He [Resident #6] is seen for rounds .

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. . He thinks he injured his left foot when he was in the shower chair. His foot dropped on the floor, he has had some bloody drainage at the end of his right great toenail as well . . . Skin/Extremities: His right great toenail needs trimming and there are some dry bloody drainage along the edge of the mail. Dorsum of the toes of the left foot with some healing abrasions and bruising . . . A/P [assessment/plan] . . . Recent foot injury and need for foot care . . .Continue his current care . . . monitor his feet and try to avoid any re-injury."

A nurse's note, dated 03/04/14, stated, "Res seen on rounds today. . . ."

Resident #6's medical record lacked evidence of an investigation as to possible causes of the injury, as well as reporting and follow-up/monitoring of the injured toe.

During an interview on the morning of 05/14/14, an administrative nurse (#2) stated she expected staff to report, document, and follow-up/investigate all resident incidents. The nurse (#2) stated the facility "is lacking in this area."

- Review of Resident #7's medical record occurred on May 14-15, 2014. Diagnoses included dementia and Alzheimer's disease. The quarterly MDS, dated 03/01/14, identified the resident required total assistance of one or two staff members for ADL.

Review of Resident #7's progress notes identified the following related to a left ankle bruise: *12/30/13 at 5:42 a.m. - "Resident has been awake some tonight . . . Lt outer ankle appears bruised. Resident moans out when leg moved. Lt

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foot is puffy and warm to touch."
*12/30/13 at 1:53 p.m. - "Resident has been crying, coughing and moaning through out the day . . ."
*12/31/13 at 9:13 p.m. - "Was noticed this shift that resident had a bruise on her left ankle and on the top of her foot, bruise appears to be new and purple in color. Foot has slight edema. Resident does have tenderness to site and groans out in pain when area touched. Notified [physician name] of concern, order for ace wrap obtained . . . daughter would like for resident to have an x-ray done on Thursday January 2."
*01/01/14 at 9:12 p.m. - "Resident given PRN [as needed] oxycodone [pain medication] . . . for pain at left ankle site. Resident has tenderness at site when touched. I had started to remove ace wrap to inspect the site for decreased edema but resident unable to tolerated [sic] due to pain . . ."
*01/02/14 at 12:53 p.m. - "Spoke with [physician name] concerning resident lt ankle, orders to obtain x-ray, . . . x-ray scheduled for 1-3-14."
*01/02/14 at 2:25 p.m. - "[physician name] called back, x-ray needs to be done today . . ."
*01/03/04 at 5:01 p.m. - "Spoke with [physician name], he reports there is no fracture of ankle R/T [related to] x-ray report . . ."

Resident #7's medical record lacked evidence of an investigation as to possible causes of the injury, as well as reporting and follow-up/monitoring of the left ankle bruise and pain.

Resident #7's progress notes identified the following related to a skin tear:
*05/12/14 at 2:42 a.m. - "Resident has large skin tear on her left arm, right above her elbow. It is believed to have gotten there from a transfer into

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F 225	Continued From page 15 the bath bathing chair. It measures approx. [approximately] 7 inches long by 3 inches across. Tear was found at 9:20 a.m. in the shower . . ." *05/13/14 at 11:39 p.m. - "(late entry) Writer was informed of skin tear to left mid arm. Writer assessed site. Wound measures approx. 4.5 cm x 3 cm. Wound is approximated . . ." During an interview on the afternoon of 05/14/14, an administrative nurse (#2) stated she expected facility staff to complete incident reports on all injures. She stated incident reports were not completed for Resident #7's bruise or skin tear and the facility failed to investigate the injuries.	F 225		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide individualized activities consistent with residents' preferences and interests for 2 of 6 sampled residents (Resident #1 and #4) dependent on staff for activities and 1 of 3 sampled residents (Resident #3) identified by the facility as interviewable. Failure to provide and implement individualized activity program may negatively impact residents' quality of life. Findings include:	F 248		

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F 248	Continued From page 16	F 248	F 248 Resident's #1 and #4 now have activities that are individualized to meet their needs and interests. Resident #3 will be notified when an activity of her interest has been moved to another time and place due to other commitments. Review of all activity evaluations and care plans by 07-15-2014. All residents have the potential to be affected by this practice. Education to the activity and nursing staff will be held by 07-15-2014 to go over the new activity plans for each resident to meet their individual needs. Documentation on the resident activity log will also be discussed. The resident activity logs will be audited by the Activity Director Pending Certification daily and a weekly report will be given to the Quality Assurance committee monthly until 100% compliance is obtained and then quarterly thereafter.	07-15-2014

Review of the facility policy titled "Activity Evaluation" occurred on 05/15/14. This policy, dated September 2013, stated, "In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident . . . 5. Each resident's activities care plan shall relate to him/her comprehensive assessment and should reflect his/her individual needs . . ."

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS), dated 04/12/14, identified both long and short term memory difficulties and extensive assistance required for transfers and locomotion. The MDS identified the activities most important to Resident #1 were: books, newspapers, magazines, music, pets, outside, and religious services.

Resident #1's current care plan stated, "Problem: Activities: Unable to participate in many activities . . . Approach: *According to the daughters, [Resident #1] likes car racing, children, music . . . and chocolate. *[Resident #1] does talk out loud and will be removed from cavities if this bothers other residents *Provide TV and radio in his room or in the commons area for [Resident #1] when he is not attending activities. *We will invite [Resident #1] to come to the activities of his liking in hopes of getting him to participate. [resident name] likes one to one attention." Another activities care plan stated, ". . . [Resident #1] has been able to sit up in wheelchair at the nurses station for short periods of time . . . Approach: * [Resident #1] will have music available that he likes . . . We have placed a cd [compact disc]

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player, cd. *[Resident #1] will have things to look at in his room such as pictures, mobiles, messages, etc. *We will invite [Resident #1] to come out for live music and when children are here to entertain as he likes these activities."

Observations showed the following:
*05/12/14 from 1:15 p.m. to 4:00 p.m. showed Resident #1 in bed. At 4:25 p.m., facility staff transported him to the TV lounge. The activity calendar identified "Tye Dye Shirts" as the 3:00 p.m. activity.
*05/13/14 from 1:30 p.m. to 4:20 p.m. showed Resident #1 in bed. At 4:40 p.m., facility staff transported him to the TV lounge. The activity calendar identified "Rootbeer Floats/Contest" as the 3:00 activity.
*05/14/14 from 8:30 a.m. to 11:30 a.m. showed Resident #1 in the TV lounge sleeping in his wheelchair. The activity calendar identified "Current Events" as the 11:00 a.m. activity.
*05/14/14 from 1:00 p.m. to 4:20 p.m. showed Resident #1 in bed. At 4:20 p.m., facility staff transported him to the TV lounge. At approximately 4:22 p.m., an activity staff member (#16) transported Resident #1 to the 400 unit activity area. At 4:25 p.m., the CNA (#5) removed the resident from the activity area and brought him back to the TV lounge. The activity calendar identified live music and malts at 3:00 p.m.

Each resident's activity participation log form listed numerous activity approaches and an area to add individualized activities for the resident. Staff members mark each activity the resident had an opportunity to attend as: A -alert/active; R - refused; P - passive/assisted; O - observed; I - independent; and D - disruptive. The form contained an area for documentation of a one to

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one visit with the resident in the event staff provided this visit.

Review of Resident #1's activity participation log from April 01 to May 12, 2014 identified check marks (not A, R, P, O, I, or D) as follows:
April:
*Current events - 28 of 30 days. The activity calendar did not identify current events as an activity on 4 of the 28 days.
*Spiritual - 1 of 8 opportunities to attend chapel or mass.
*Movie - 1 day
*Radio - 7 days
*TV lounge - 30 days
*Salon/Grooming - 1 day
*TV in room - 12 days
*General Store - (an opportunity to purchase items with bingo money) 2 days
*Easter egg hunt - 1 day
May:
*Bingo - 1 day
*Walks - 1 day
*Current events - 12 of 12 days. The activity calendar did not identify current events as an activity on 2 of the 12 days.
*Radio - 4 days
*Exercise - 1 day
*TV lounge - 3 days
The activity logs failed to identify staff provided an one to one activity for Resident #1.

The above observations and activity logs showed Resident #1 spent the majority of his time in the TV lounge or his room.

During an interview on 05/14/14 at 1:05 p.m., two activity staff members (#16 and #17) stated they develop an individualized activity care plan based

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on the residents' likes and needs.

- Review of Resident #4's medical record occurred on all days of survey and diagnoses included Parkinson's disease, dementia with behaviors, and depression. The annual MDS, dated 04/29/14, identified severely impaired cognition; physical, verbal, and "other" behaviors; and extensive assistance for transfers and locomotion. The MDS identified the resident enjoyed the outdoors.

The current care plan stated, "Problem: Resident has verbal behavioral symptoms directed toward others (e.g. [examples given], threatening others, screaming at others, cursing at others) . . . Approaches: . . . Provide 1:1 [one-to-one] sessions with resident while in commons area or in his room . . . Problem: Activities . . . Approaches . . . [Resident #4] does not want to be involved in activities, he likes to sit in the commons area by the tables within sight of nurses station. He does like to visit one on one when he is in a good mood . . . We will do 1:1 with him to visit as he likes to visit. . . ."

Observations of Resident #4 on May 12-14, 2014 identified the following:
*05/12/14 at 3:45 p.m. - After completing cares and assisting the resident from bed into his wheelchair, staff placed the resident in the TV Lounge. No activity occurred and the resident sat with his eyes open and head down.
*05/13/14 at 10:05 a.m. - The resident sat in his wheelchair in the TV Lounge; recorded music played in the background.
*05/13/14 at 3:00 p.m. - The resident sat in his wheelchair in the TV Lounge. No activity took place.

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*05/13/14 from 3:30 p.m. until 4:30 p.m. - The resident sat in his wheelchair in the TV Lounge.(An activity with root beer floats occurred at this time in another part of the facility.)
*05/14/14 from 8:25 a.m. until 10:45 a.m. - The resident sat in his wheelchair in the TV Lounge. Staff turned the TV on, but the resident sat away from the TV and did not actively watch.
*05/14/14 at 2:00 p.m. - The resident was agitated during cares and cursing and hitting out at staff. Once the resident calmed down, staff (#3 and #8) brought the resident out to the TV Lounge and asked an activity aide (#18) what activities were going on for Resident #4 to attend. The staff member (#18) stated the activity store was open, but the resident declined to attend. The staff members then sat the resident up to a table in the TV Lounge and failed to provide any individualized and meaningful activity.
*05/14/14 at 3:10 p.m. - The resident sat at a table in the TV Lounge with his head on the table.

The most recent activity progress note, dated 04/29/14, stated, "[Resident #4] has been up and out of his room in his wheelchair. He is not able to propel it around much any more. He does not attend many activities but is invited. He has not had as many episodes of behaviors lately. . . ."

Review of activity participation logs for April-May 12, 2014 showed the following:
*April 2014: participation in "Current Events" 29 times, "TV in room" 29 times, "TV Lounge" 27 times, "Coffee/Snack" 17 times, "Radio" four times, "Music" three times, "Bingo" twice, "Spiritual" once, and "Social Event" once
*May 2014: participation in "Current Events" 12 times, "TV in room" 10 times, "Coffee/Snack" eight times, "TV Lounge" eight times, "Radio"

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F 248	Continued From page 21 three times, "Bingo" twice, and "Salon/Grooming" once. Staff failed to identify on the activity logs if the resident was an active or passive participant in the activity. The facility failed to ensure staff provided a meaningful and individualized activity program for Resident #1 and Resident #4 specific to their interests and preferences. - Review of Resident #3's medical record occurred on all days of survey. The facility identified the resident as interviewable. During an interview on 05/13/14 at 10:00 a.m., Resident #3 identified her favorite activity as Bingo. Observation showed a display of dog and cat figurines she purchased with her Bingo money. During an interview on 05/14/14 at 9:35 a.m., when asked if she had won at Bingo the night before. Resident #3 stated the facility didn't provide Bingo and that they "were too busy." The activity calendar identified "Bingo" as the 5:45 p.m. activity. On 05/14/14 at 9:43 a.m., an activity staff member (#16) stated not enough residents were interested in Bingo the night before and staff were busy laying residents down for the evening. She stated Bingo isn't a normal activity for Tuesday nights and she added it and other activities to the calendar in recognition of "Nursing Home Week." The staff member (#16) stated the activity calendar is always subject to change.	F 248		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
PAIN MANAGEMENT:

1. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable well-being for 1 of 1 sampled resident (Resident #5) who experienced a "near fall" with fracture. Failure to assess Resident #5's continued pain and bruising in a timely manner resulted in uncontrolled pain and delayed treatment.

Findings include:

Review of the facility policy titled "Pain Assessment and Management" occurred on 05/14/14. This policy, revised October 2010, stated, ". . . Reporting, Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain . . . 3. Prolonged, unrelieved pain despite care plan interventions."

Review of Resident #5's medical record occurred on all days of survey and diagnoses included cerebral palsy, degenerative joint disease, aphasia, and osteoporosis. The quarterly Minimum Data Set (MDS), dated 03/08/14,

07-15-2014

Pain Management

1.Resident #5 fracture is healed and he has resumed previous level of movement in arm with no post injury pain.

2.All residents have the potential to be affected by this practice.

3.A comprehensive pain assessment will be done for all residents upon admission, whenever there is a significant change in condition, when there is onset of new pain or worsening of existing pain.

Staff education will be provided to all CNAs/all staff on reporting signs and symptoms of pain to nurses by 07-15-2014. A review of policies and procedures of pain assessment management and administration of pain medications will be completed by 07-15-2014 for all staff.

4. Director of nursing or designee will complete weekly pain assessment audits by reviewing Matrix reports on PRN pain medications for eight weeks and then monthly.

5. These audits will be presented to the Quality Improvement committee monthly to maintain 100% compliance.

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identified the resident required total assistance of two or more staff members for transfers. The current care plan stated, ". . . [Resident #5] has DJD [degenerative joint disease], has chronic left hip pain and left knee discomfort . . . [Resident #5] will sign that he has pain by pointing to body area and frowning to indicate pain or discomfort . . . [Resident #5] is extensive to dependent [with] all ADL's [activities of daily living], He has cerebral palsy, has generalized spasticity and contractures of hands and feet, is tall and leans backwards when transferred . . . Hoyer lift only (revised after incident on 10/17/13). . . ."

Review of Resident #5's Progress Notes identified the following:
*10/18/13 at 1:09 p.m. - "Resident appeared to be very agitated early in this shift, his skin was cold and clammy and he seemed as though he was having some trouble breathing. He was grimacing and gesturing towards his right leg. O2 [oxygen] was 91% on RA [room air]. Resident was given PRN [as needed] Ativan and PRN ES [extra strength] tylenol of 1000 mg [milligrams] for suspected pain. Resident lyed [sic] down at 11:00 a.m. VS [vital signs] WNL [within normal limits] and resident appears to be in a better mood and appears to be feeling better."
*10/19/13 at 8:53 a.m. - "Noted redness on medial side of right forearm. Does not look bruised, but red and skin hardened. When touched [Resident #5] flinches. He has a tendency to let his right arm down to the inside of the w/c [wheelchair] next to his leg. Ice pack applied. [Resident #5] smiled and was happy about the ice bag."
*10/20/13 at 9:09 a.m. - "Resident RT [right] outer forearm continues to be red and hard, area does not seem to have grown in size since yesterday.

Continued from previous page

Proper positioning/dysphagia

1.Resident #1 A wheelchair has been provided that will allow the resident to be placed in the proper position for eating and drinking. PT evaluating resident on 06-26-2014. A new chair was ordered per PT recommendation on 07-03-14.

2. All residents have the potential to be affected by this practice.

3.Staff will be educated by registered dietician on proper fluid consistency, therapeutic diets, proper positioning and dysphagia by 07-15-2014. All care plans will be updated as needed.

Occupational therapy will evaluate all new residents as well as current residents as needed for chewing or swallowing issues.

4. The Director of nursing or her designee will do weekly audits on therapeutic diets and policy and procedures for resident #1 and all residents as needed per Occupational Therapy evaluations.

5.The Director of nursing or her designee will present audits monthly to the Quality Improvement committee for review.

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This morning however, RT forearm has a purple bruise noted over the top of the reddened area. Resident is able to move arm with regular strength. Ice pack applied to site, resident seems to be content with ice pack."
*10/20/13 at 9:48 p.m. - "resident right forearm tender when touched - did get relief with scheduled pain medication - area bruised and red with raised area at wrist - resident pleasant and cooperative - will continue to monitor."
*10/21/13 at 9:09 a.m. - "Redness noted on right medial forearm, cool to touch on 10/19/13. See previous notes. Today floor nurse notified myself that [Resident #5's] right forearm was bruised from elbow to distal fingers. No deformities noted no crepitus. Facial expression indicated flinching et [and] painful expression. [Resident #5] indicated . . . through nonverbal communication his discomfort through restlessness and anxiety and being diaphoretic. [Name of Doctor] notified and orders to obtain X-rays obtained."
*10/21/14 at 6:38 p.m. - "Res [resident] had an apt. [appointment] in [name or town], for x-ray. Res has a broken (RT) lower arm. Res returned at 5:00 p.m. with driver from facility. (RT) arm in a sock, casting and also splint stabilizer. Res. perspiring, skin cool and clammy. Oxycodone given for pain at 5:00 p.m., and also Ativan given per families [sic] request. Res assisted to bed per lift and assit [sic] of four. 6:30 p.m. Res resting quietly."

Review of a physician progress note, dated 10/21/13, stated, ". . . scheduled today after injuring his upper extremities some time over this past weekend. Reportedly he was either being transferred or using a standing type of device and his arms were in the device and his legs gave out. He slid to the floor causing some pulling type

Bowel Protocol

1. Resident #1 found to be ineffective with non-pharmacological intervention on day 2 and oral interventions on day 3. Suppositories on day 4 have been effective. Update care plan.

Resident #2 has been found to be occasionally effective at times with the new bowel protocol.

Resident #4 The new bowel protocol has irregular effects with resident #4 due to resident behaviors and compliance issues. Ongoing assessments are being completed.

Resident #7. The new bowel protocol has been offered but not effective due to non-compliance of oral intake (spits out milk of magnesia and prune juice). Ongoing assessments are being completed.

These residents will have a seven day bowel assessment.

2. All residents have the potential to be affected by these practices.

3. New bowel protocol has been put in place for all residents that includes non-pharmacological interventions being implemented on day 2, oral pharmacological meds on day 3, and with day 4 using suppository/fleets. Seven day bowel assessments will be completed for all new admission.

4.Mandatory in services will be held by 07-15-2014 for the new bowel protocol of non-pharmacological interventions, care plan individualized and updated. Three bowel assessment audits will be completed on weekly basis until all resident care plans are reviewed and updated.

5.The Director of Nursing or her designee will present the audit reports Quality Improvement committee meeting for review monthly for compliance on new bowel protocol.

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injury to both upper extremities, nursing contacted me today stating he was having a lot of swelling to the right upper extremity and bruising, some on the left, appeared to have some significant pain to the right upper extremity . . . He has cerebral palsy and communicates by gesturing and some hand signals . . . On the right upper extremity he has a large area of ecchymosis [bruising] from below his elbow to his left hand and thumb . . . x-ray shows a displaced, spiral fracture of the right, mid to distal ulna . . . He is placed in a soft roll wrap and then a forearm splint. Will contact orthopedics regarding further management . . . He has Tylenol and Tramadol for pain already and Rx [prescription] for Oxycodone 5 mg . . . provided."

An investigation completed by the facility on 10/25/13, stated, ". . . During the course of the investigation all staff that had been on duty 1 day prior to the bruise being noted were interviewed. It was during these interviews that we learned of a near fall from the sit/stand lift on October 17th 2013 . . . The two aides caring for him on 10/17/13 demonstrated what happened when resident's leg buckled and caused him to almost fall . . . The staff were able to lift him from the strapped position and get him into a chair where they then called for the nurse . . . The aides demonstrated and described how he 'hung on' on the lift while they transferred him. . . ."

Staff interviews completed during the above investigation of Resident #5's injury identified the following:
*". . . the day of Oct. 17, 2013 when we were hoyering him into bed . . . was favoring that arm (Rt) and we had to assist him more to turn him. . . "

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F 309	Continued From page 26 *". . . Friday the 18th . . . he seemed agitated and would hollar out. . . ." *". . . Friday 18th crying . . . not acting himself. . . ." *". . . Friday pm he used his Rt hand to tap his knee. This is what he does to tell us his knee hurts. . . ." *". . . On Friday Oct. [October] 18th . . . noticed a bruise on his right arm. It was not very big . . . On Saturday Oct 19th . . . his whole right arm was bruised. He seemed like he was in pain and when we moved him onto his right side . . . we could hear him cry (scream) so we went back . . . we kept on his left side the rest of the night. . . ." *". . . On Sat (Saturday - 10/19/13) - he was very agitated . . . kept right arm close to side. . . ." *". . . 10-21-13 - [Right] arm swollen bruised - left under arm bruised. . . ." During an interview on 05/14/14 at 2:20 p.m., an administrative nurse (#2) stated the staff members on duty failed to report and document the incident with the stand lift at the time it occurred (10/17/13). Failure to report Resident #5's "near fall" resulted in unnecessary pain and delayed treatment. DYSPHAGIA: 2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the care and services necessary to attain the highest degree of safety possible for 1 of 1 sampled resident (Resident #1) with a diagnoses of dysphagia. Failure to ensure proper positioning and correct fluid consistency placed Resident #1 at risk for aspiration.	F 309		

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Findings include:

Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, page 125, stated, ". . . During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 [degree] angle, whether in a bed or in a chair . . ."

Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dysphagia, dementia, and Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 04/12/14, identified extensive assistance for eating and a mechanically altered diet (pureed foods and honey thickened fluids). The current care plan stated, ". . . Monitor swallowing ability . . ."

A dietary progress note, dated 04/14/14, stated, ". . . [Resident #1] receives a pureed diet with honey thick liquids. [Resident #1] has a hx [history] of both chewing and swallowing difficulties . . ."

- Observation on all days of survey showed a mug of un-thickened water and a straw on Resident #1's night stand. Observation on all days of survey showed Resident #1 at approximately a 45 degree angle while seated in his wheelchair.

- Observation on 05/12/14 at 12:10 p.m. showed Resident #1 in the dining room and seated in his wheelchair. An unidentified staff member fed the resident and failed to position him to an upright position.

- Observation on 05/13/14 at 12:20 p.m. showed

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Resident #1 in the dining room and seated in wheelchair. The Certified Nursing Assistant (CNA) (#9) fed the resident a pureed diet and honey thickened juice and water. The CNA failed to thicken Resident #1's chocolate milk and position him to an upright position.

- Observation on 05/13/14 at 4:20 p.m. showed Resident #1 seated in his wheelchair. The CNA (#6) assisted Resident #1 with a cup of Ensure (a nutritional drink). The CNA failed to thicken the Ensure and failed to position the resident to an upright position.

- Observation on 05/14/14 at 9:35 a.m. showed Resident #1 seated in his wheelchair. The nurse (#19) assisted the resident with a cup of Ensure. When asked if she had thickened the Ensure, the nurse stated she had thickened to nectar consistency. The nurse (#19) failed to thicken the Ensure to honey consistency and failed to position Resident #1 to an upright position.

- Observation on 05/14/14 at 4:25 p.m. showed Resident #1 seated in his wheelchair. The CNA (#5) assisted the resident with a cup of Ensure with a straw. The CNA failed to thicken the Ensure and failed to position Resident #1 to an upright position.

During an interview on the afternoon of 05/14/14, an administrative nurse (#2) stated the facility recently placed Resident #1 in the current wheelchair because the chairs' reclining ability and better positioning for the resident. The nurse (#2) expected staff to place Resident #1's chair in an upright position during meals, and when providing fluids and expected all fluids thickened to honey consistency.

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BOWEL MANAGEMENT:

3. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage constipation for 4 of 4 sampled residents (Resident #1, #2, #4, and #7) who required frequent as needed (PRN) medications for constipation. Failure to implement less invasive interventions to manage constipation may have resulted in these residents receiving unnecessary suppositories.

Findings include:

During an interview on the morning of 05/15/14, an administrative nurse (#2) stated the facility does not have a written policy related to bowel management. The nurse stated if a resident does not have a bowel movement by the third day, the nursing staff administer an as needed (PRN) medication. The nurse (#2) stated she would expect Milk of Magnesia (MOM) (a laxative) administered before a suppository or enema.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. Medications included MOM PRN, bisacodyl suppository PRN, and a Fleets enema PRN. The record showed Resident #1 received no scheduled medication or dietary intervention for management of constipation.

Resident #1's quarterly Minimum Data Set (MDS), dated 04/12/14, identified memory problems, required extensive assistance for toilet use, and always incontinent of bowel. The current care plan stated, ". . . Ensure adequate bowel

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elimination . . ."

Resident #1's April 2014 and May 01-13, 2014 Medication Administration Record (MAR) identified the following:
April:
*MOM administered twice: April 4 and 26
*Dulcolax suppository administered 6 times: April 14, 17, 20, 24, 27, and 30
May:
*Dulcolax suppository administered 4 times: May 3, 7, 10, and 13

The bowel movement (BM) records for April and May 01-13, 2014 identified Resident #1 had a BM every third day except once (no BM April 11, 12, or 13). The facility failed to attempt less invasive interventions for bowel managment, including dietary interventions, prior to the administration of a suppository five times in April and four times in May.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. Medications included Senna (laxative) daily, MOM PRN, and bisacodyl suppository PRN. The record showed no dietary interventions for the management of constipation.

The quarterly MDS, dated 01/29/14, identified Resident #2 required extensive assistance for toileting. The care plan failed to identify any concerns related to constipation.

Resident #2's April 2014 and May 01-13, 2014 MAR identified the following:
April:
*MOM administered 4 times: April 13, 15, 19, and

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*Dulcolax suppository administered 5 times: April 2, 5, 8, 22, and 28
May:
*MOM administered twice: May 7 and 13
Dulcolax suppository administered twice: May 4 and 8

The BM records for April and May 01-13, 2014 identified Resident #2 had a BM at least every other day except once (no BM May 2, 3, or 4). The facility failed to attempt less invasive interventions for bowel management, including dietary interventions, prior to the administration of a suppository five times in April and once in May.

- Review of Resident #7's medical record occurred on May 13-14, 2014. Diagnoses included dementia, Alzheimer's disease, and constipation. Medications included Colace syrup (laxative) three times a day, Miralax (laxative) every other day, MOM PRN, and Dulcolax suppository PRN. The record showed no dietary interventions for the management of constipation.

The quarterly MDS, dated 03/01/14, identified Resident #7 required total assistance for toilet use and always incontinent of bowel. The current care plan stated, ". . . Administer bowel protocol prn and document effectiveness . . ."

Resident #7's April 2014 and May 01-13, 2014 MAR identified the following:
April:
*No MOM administered
*Dulcolax suppository administered 10 times: April 4, 8, 10, 12, 15, 20, 23, 25, 27, and 30
May:
*MOM administered once: May 9

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	355081	A. BUILDING _____ B. WING _____	05/15/2014

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*Dulcolax suppository administered 3 times: May 3, 7, and 9

The BM records for April 16-30 and May 01-13, 2014 identified Resident #7 had a BM at least every third day. The facility failed to attempt less invasive interventions for bowel managment, including dietary interventions, prior to the administration of a suppository 10 times in April and twice in May.

- Review of Resident #4's medical record occurred on all days of survey and diagnoses included Parkinson's disease. The resident's bowel medications included Miralax every morning, MOM PRN, Dulcolax suppository PRN, and a Fleets enema PRN. The record identified Resident #4 received no dietary interventions for managing the resident's constipation. The current care plan failed to address the resident's constipation and necessary bowel interventions.

Resident #4's April and May 01-13, 2014 MAR identified the following:
April
*MOM administered three times: April 10, 14, and 20
*Dulcolax suppository administered three times: April 11, 15, and 27
*Fleets enema administered five times: April 1, 4, 21, 24, and 28
May
*Dulcolax suppository administered twice: May 3 and 5
*Fleets enema administered four times: May 1, 7, 10, and 13

The BM records for April and May 01-13, 2014 identified Resident #4 had a BM at least every

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F 309	Continued From page 33 three to four days. The facility failed to attempt less invasive interventions for bowel management, including dietary interventions, prior to the administration of suppositories and enemas.	F 309		
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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure adequate use of assistive devices to prevent accidents for 4 of 9 sampled residents (Resident #2, #4, #5, and #6). Failure to properly use an EZ stand (Resident #4) and gait belt (Resident #2) and failure to clearly identify how staff are expected to transfer residents (Resident "#2, #5, and #6) increased the risk of falls, pain, and injury to residents. Findings include: Review of the facility policy titled "Safe Lifting and Movement of Residents" occurred on 05/15/14. This undated policy stated, ". . . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will	F 323		

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F 323	Continued From page 34	F 323	F 323 1.Resident #2, #4, #5, and #6 have had their individual care plans and PT evaluations reviewed and updated to reflect their individual needs for transfers and locomotion. 2.All residents do have the potential for affects from this practice. 3.The Director of Nursing or her designee will review lifting policy and care plans for each resident by 07-15-2014 and for all new admits for their individual needs. The Director of Nursing has provided education on the proper use of lifts and gait belts to all staff by 07-15-2014. 4.The Director of Nursing or her designee will do daily review of use of the lifts and gait belts for one week and then weekly times one month and quarterly while maintaining 100% compliance. 5. This will be presented to the Quality Improvement monthly for one year.	07-15-2014

document resident transferring and lifting needs in the care plan. Such assessment shall include: . . . b. Resident's mobility (degree of dependency); . . . d. Weight-bearing ability; e. Cognitive status; f. Whether the resident is usually cooperative with staff; . . . 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts . . .) and mechanical lifting devices . . ."

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated 01/29/14, identified extensive assistance for transfers and toilet use two falls without injury. Resident #2's care plan stated, "Problem: Resident has impaired balance during transfers . . . Approach: . . . needs assist of one to two to ambulate . . ."

A PT progress note, dated 04/09/14, stated, "Resident [#2] has been having more trouble with transfers in the morning especially. We have tried both an EZ stand and a hoyer lift [full body mechanical lift] with the resident and she did well with the hoyer but did not like the EZ stand as it seemed to make her very uneasy. I recommend a hoyer lift to be used as needed in the morning for transfers."

A PT quarterly assessment, dated 04/23/14, stated, "[Resident #2] has declined slightly over the last several months. She mostly ambulates with hand held assist or MIN [minimal] assist due to poor balance . . . At times, she will require a sit to stand (EZ Stand) lift to assist with transfers . . ."

The PT progress note and the PT quarterly

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assessment fail to clearly identify how facility staff should transfer Resident #2.

Observation on 05/13/14 at 8:35 a.m. showed two Certified Nursing Assistants (CNAs) (#5 and #10) applied a gait belt to Resident #2. Both CNAs lifted the resident to an upright position with one hand on the gait belt and the other hand under her armpits and walked her from the TV lounge to her room.

Observation on 05/13/14 at 10:57 a.m. showed two CNAs (#5 and #10) assisted Resident #2 up from the toilet. The CNAs lifted the resident to an upright position with one hand on the gait belt and the other hand under her armpits. Although the gait belt remained around Resident #2's waist, the CNA failed to use it and instead walked the resident down the hall with one hand under her left armpit.

During an interview on the afternoon of 05/14/14, an administrative nurse (#2) stated the CNAs utilized the gait belt incorrectly for Resident #2. The nurse (#2) agreed Resident #2's care plan, PT progress note, and PT assessment fail to clearly identify how facility staff should transfer Resident #2.

- Review of Resident #4's medical record occurred on all days of survey and diagnoses included Parkinson's disease and arthropathy. The annual MDS, dated 04/29/14, identified extensive assistance from two or more staff members for transfers and a history of falls. The current care plan stated, ". . . Bilateral upper and lower extremity weakness. [Resident #4] is unable to stand per self. Needs staff extensive assist . . . Uses W/C [wheelchair] as a main

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mode of transportation . . . may walk with extensive assist of two with gait belt and wheelchair nearby, but has been refusing to walk most days . . . uses the EZ stand to transfer. . . ."

Observation on 05/12/14 at 1:30 p.m. showed two CNAs (#12 and #13) toileted Resident #4 using a EZ stand. Observation identified the strap around the resident's chest was loosely secured. The CNAs (#12 and #13) failed to tighten the chest strap and failed to secure the strap around the resident's calves.

During an interview on the morning of 05/15/14, an administrative nurse (#2) stated she expected staff to tighten the strap around the resident's chest and to secure the strap around the resident's calves when using the EZ stand.

- Review of Resident #5's medical record occurred on all days of survey and diagnoses included cerebral palsy and degenerative joint disease. The quarterly MDS, dated 03/08/14, identified total assistance of two or more staff members for transfers. The current care plan stated, "[Resident #5] is extensive to dependent [with] all ADL's [activities of daily living], He has cerebral palsy, has generalized spasticity and contractures of hands and feet, is tall and leans backwards when transferred . . . TRANSFERS, Hoyer lift only (revised on 10/17/13). . . ."

A PT progress note, dated 03/05/14, stated, "There have not been any major changes with [Resident #5] this quarter. He continues to spend most of his time up in a wheelchair observing activity around him. He transfers using either the hoyer lift OR he can now use the EZ . . . lift as well, however, there was an incident where he

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F 323	Continued From page 37 somehow ended up with a spiral fracture in his arm, and since then he hasn't been able to use the EZ stand. . . ." The PT progress note failed to clearly identify how facility staff should transfer Resident #5. - Review of Resident #6's medical record occurred on all days of survey and diagnoses included paraplegia. The quarterly MDS, dated 04/10/14, identified extensive assistance of two or more staff members for transfers. The current care plan stated, ". . . Resident is unable to walk (paraplegia) . . . Transfer with assistance of two using the Hoyer device or EZ stand. [Resident #6] does well on [sic] transfer with EZ stand, evaluate often and use Hoyer lift for safety if [Resident #6's] condition worsens. . . ." A PT progress note, dated 04/09/14, stated, "[Resident #6] is non-ambulatory and has been for some time. Transfers are done using a hoyer lift or EZ stand lift but usually a hoyer is used. . . ." The PT progress note and care plan failed to clearly identify how facility staff should transfer Resident #6.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 327		

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facility policy, and staff interview, the facility failed to offer fluids to 4 of 6 sampled residents (Residents #1, #2, #4, and #7) who are dependent on staff for fluids needs. Failure to offer fluids during cares increased the residents' risk of dehydration.

Findings include:

Review of the facility policy titled "Resident Hydration and Prevention of Dehydration" occurred on 05/15/14. This policy, dated December 2011, stated, ". . . This facility will endeavor to provide adequate hydration and to prevent and treat dehydration. . . . 7. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. . . . 9. Orders may be written for extra fluids to be encouraged between meals and/or with medication passes. . . ."

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and dysphasia. Physician's orders included honey-thick liquids. The current care plan stated, "Resident is at risk for dehydration . . . Offer [Resident #1] fluids often because he will only take small amounts at a time."

On 05/12/14, a Certified Nursing Assistant (CNA) (#3) stated she assisted Resident #1 to bed about 1:15 p.m. At 2:10 p.m., the CNA (#3) and another CNA (#4) checked the resident's brief (dry) and repositioned him in bed. One of the CNAs stated, "Would you like some juice [name of resident]?" The resident did not respond and both CNAs then exited the room. At 4:00 p.m., two CNAs (#5 and

F 327

1.Fluid intake for resident #1 was reviewed and found to be sufficient.

Director of Nursing or designee will review intake logs and care plans for dehydration issues of all residents involved.

2.All residents have the potential to be affected by this practice, all care plans have been reviewed to address hydration/dehydration.

3. The Facilities' Director of Nursing or designee will educate all staff on the facility policy of resident hydration, importance of resident hydration and prevention of dehydration by 07-15-2014. The Dietician will provide education to all staff in regards to the proper thickening of fluids by 07-15-2014.

4.Fluid intake logs will be reviewed and audits will be completed by Director of Nursing or her designee weekly times two weeks and then monthly for one quarter. Dietician will review each resident's records for hydration/dehydration quarterly.

5.The audits will be presented to Quality Improvement monthly for review for potential risk for dehydration for a year. Care plans will be reviewed and updated.

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#6) provided personal cares for the resident, transferred him out of bed and into a wheelchair, and transported him to the TV lounge area. The CNAs failed to provide Resident #1 with fluids during cares.

Observation on 05/13/14 at 9:25 a.m. showed three CNAs (#7, #8, and #9) transferred Resident #1 from his wheelchair to bed and provided personal cares. The CNAs failed to provide Resident #1 fluids with cares.

Observation on 05/13/14 at 1:30 p.m. showed two CNAs (#8 and #10) transferred Resident #1 from his wheelchair to bed, provided personal cares, and exited the room. The CNAs failed to offer/assist with fluids.

Observation on 05/13/14 at 4:20 p.m. showed two CNAs (#4 and #6) provided personal cares, assisted Resident #1 from bed to his wheelchair, and transported him to the TV lounge. The CNAs failed to offer/assist with fluids.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The current care plan stated, "Problem: Swallowing . . . Approach: . . . Offer fluids at meals, rounds and throughout the day. Report any signs or symptoms of dehydration."

Observation on 05/12/14 at 1:47 p.m. showed two CNAs (#7 and #12) assisted Resident #2 to the bathroom, provided personal cares, and assisted her to bed. The CNAs failed to offer fluids.

Observation on 05/12/14 at 4:55 p.m. showed two CNAs (#5 and #6) assisted Resident #2 from bed

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to a wheelchair and transported her to the dining room. The CNAs failed to offer fluids.

- Review of Resident #7's medical record occurred on May 14-15, 2014. Diagnoses included Alzheimer's disease and dementia. Physician's orders included honey-thick fluids. The current care plan stated, "Problem: Hydration . . . Approach: Offer fluids throughout the day and monitor intake . . ."

Observation on 05/14/14 at 10:45 a.m. showed two CNAs (#3 and #8) provided personal cares for Resident #7, transferred her into a wheelchair, and transported her to the TV lounge. The CNAs failed to offer/assist with fluids.

Observation on 05/14/14 at 3:25 p.m. showed two CNAs (#5 and #7) provided personal cares for Resident #7, transferred her into a wheelchair, and transported her to the 400 wing activity area. The CNAs failed to offer/assist with fluids.

- Review of Resident #4's medical record occurred on all days of survey and identified diagnoses of Parkinson's Disease, dementia with behaviors, diabetes, and arthropathy. The annual MDS, dated 04/29/14, identified limited assistance needed for eating. A nutrition assessment, dated 04/28/14, identified the resident required 2000-2400 cc [cubic centimeters] of fluids daily and stated, "Staff continue to monitor fluid intake daily and encourage intake at meals, rounds and throughout the day."

The current care plan stated, "Problem: Hydration . . . Approaches . . . Offer fluids at meals, rounds and throughout the day. . . ."

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F 327	Continued From page 41 Observations of Resident #4 identified the following: *05/12/14 at 1:30 p.m. - Two CNAs (#12 and #13) toileted the resident and transferred him from his wheelchair and into bed. The staff members (#12 and #13) failed to offer the resident fluids during cares. *05/12/14 at 3:45 p.m. - Two CNAs (#5 and #6) changed the resident's brief, transferred him into his wheelchair, and assisted the resident to a table in the living area. The CNAs failed to offer the resident fluids during cares and while he sat at the table in the living area. *05/13/14 at 10:05 a.m. - The resident sat at a table in the living area without access to fluids. *05/13/14 at 12:20 p.m. - The resident did not drink any fluids with his noon meal. Staff assisted him to a table in the living area and failed to provide fluids for him to drink. *05/13/14 from 3:00 p.m. to approximately 4:30 p.m. - The resident sat at a table in the living area without access to fluids. *05/14/14 from 8:25 a.m. to approximately 10:45 a.m. - The resident sat at a table in the living area without access to fluids. During an interview on 05/14/14 at 5:00 p.m., two administrative nurses (#2 and #14) stated they expected staff to offer residents fluids during cares.	F 327		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 6 of 8 sampled residents (Resident #1, #3, #4, #5,

F 441

1.Residents #1, #3, #4, #5, #6 and #7 have all been evaluated and have no effects from the deficient practice.

2.All residents have the potential for affects of this practice.

3.Director of Nursing or designee will provide education and review of all policies for hand washing, handling of soiled linen, perineal care by 07-15-2014.

4.Director of Nursing or designee will complete random audits of one hand washing, perineal care, and proper transportation of soiled linen of one staff member daily for one month. There will be three random audits per month thereafter.

Any dressing changes for wound care will be audited weekly by the Director of Nursing or her Designee for three months and monthly thereafter.

5.These audits will be taken to the Quality Improvement committee monthly by the Director of Nursing or her designee and will be reviewed for compliance.

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#6, and #7). Failure to follow infection control practices related to dressing changes, handwashing, perineal cares, and handling of soiled linen has the potential to cause or spread infection within the facility.

Findings include:

Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 05/15/14. This undated policy stated, "This facility considers hand hygiene the primary means to prevent the spread of infections. . . . 5. Employees must wash their hands . . . under the following conditions: . . . b. When hands are visibly soiled (hand washing with soap and water); c. Before and after direct resident contact . . . h. Before and after assisting a resident with personal care; . . . k. Before and after change a dressing; . . . n. Before and after assisting a resident with toileting (hand washing with soap and water); . . . u. After removing gloves . . ."

Review of the facility policy titled "Laundry and Bedding, Soiled" occurred on 05/15/14. This policy, dated February 2013, stated, "Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. . . . 2. Place contaminated laundry in a bag or container at the location where it is used . . . 4. Anyone who handles soiled laundry must wear protective gloves . . ."

Review of the facility policy titled "Wound Care" occurred on 05/13/14. This policy, dated April 2014, stated, ". . . Steps in the Procedure . . . 2. Wash and dry your hands thoroughly . . . 4. Put on exam glove. Loosen tape and remove

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	355081	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a coccyx pressure ulcer.

Observation on the morning of 05/13/14 showed a nurse (#11) donned gloves and removed the soiled dressing from Resident #3's coccyx pressure ulcer. The nurse removed her gloves and donned clean gloves. The nurse (#11) failed to wash her hands after removing her soiled gloves and before donning clean gloves as per facility policy.

During an interview on 05/14/14 at 5:45 p.m., an administrative nurse (#2) stated she expected nurses to wash their hands after removing soiled gloves and before donning clean gloves.

- Observation on 05/12/14 at 4:00 p.m. showed two Certified Nursing Assistants (CNAs) (#5 and #6) donned gloves, positioned Resident #1 on his bed, and removed his brief soiled with urine and stool. The CNA (#5) provided perineal cares. Both CNAs applied a clean brief to the resident and pulled up his pants. The CNA (#5) removed the soiled linen protector from under the resident, placed it on the floor, and obtained the hoyer (full body mechanical lift) sling. The CNA (#5) began to place the sling under the resident but stopped and stated Resident #1 had previously vomited on the sling and they needed a clean sling. The CNA (#6) removed her gloves, exited the room (without performing hand hygiene), and returned with a clean sling. Both CNAs positioned the new sling under Resident #1 and utilized the hoyer to

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transfer him from bed to a wheelchair. After this transfer, the CNA (#5) finally removed her soiled gloves. The CNA (#5) donned clean gloves, knotted the garbage bag, picked up the un-bagged soiled linen protector and sling from the floor, and exited Resident #1's room. The CNA (#5) walked down the hallway to the soiled utility room and disposed of the garbage and un-bagged soiled sling and linen protector.

- Observation on 05/14/14 at 4:05 p.m. showed two CNAs (#5 and #15) completed perineal cares for Resident #7 and washed their hands. The CNA (#15) donned a clean pair of gloves, removed the un-bagged soiled linen protector and garbage from the room, walked down the hallway to the soiled utility room, and disposed of the items.

- Observation on 05/12/14 at 1:30 p.m. identified two CNAs (#12 and #13) assisted Resident #4 with toileting. The resident's brief was wet with urine. After performing perineal cares, the CNA (#12) removed her gloves, changed the resident's slacks, assisted the other CNA (#13) to transfer the resident to bed using a mechanical lift, positioned and covered the resident, applied sheepskin boots, lowered the bed, and placed a fall mat by the bed. Then the CNA (#12) bagged the garbage and exited the resident's room. The CNA (#12) failed to perform hand hygiene after completing perineal care and prior to completing other tasks.

- Observation on 05/12/14 at 1:50 p.m. identified two CNAs (#3 and #13) transferred Resident #5 into his bed and changed his brief, soiled with urine and stool. After performing perineal cares, the CNA (#13) removed her gloves, positioned

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the resident to his left side, covered him with a blanket, applied bilateral heel boots, lowered his bed, placed his call light within reach, and washed her hands before exiting the room. The CNA (#13) failed to perform hand hygiene after completing perineal care and prior to completing other tasks.

- Observation on 05/12/14 at 3:00 p.m. showed two CNAs (#5 and #6) changed Resident #5's brief, wet with urine. After performing perineal cares, the CNA (#5) removed her gloves, put clean pants on the resident, transferred him into his wheelchair, applied his arm sling and shoes, attached his lap belt, and washed her hands. The CNA (#5) failed to perform hand hygiene after completing perineal care and prior to completing other tasks.

- Observation on 05/12/14 at 3:45 p.m. showed two CNAs (#5 and #6) changed Resident #4's brief, wet with urine. After performing perineal cares, the CNA (#5) removed her gloves, placed slippers on the resident, transferred the resident to his wheelchair using a mechanical lift, and then exited the room. The CNA (#5) failed to perform hand hygiene after completing perineal cares.

- Observation on 05/13/14 at 1:25 p.m. identified two CNAs (#9 and #13) transferred Resident #5 into his bed and changed his brief, wet with urine. After completing perineal cares, the CNA (#13) removed her gloves, repositioned the resident, applied his heel boots, placed his call light within reach, lowered the bed, and washed her hands before exiting the resident's room. The CNA (#13) failed to perform hand hygiene after completing perineal care and prior to completing other tasks.

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F 441	Continued From page 47 - Observation on 05/13/14 at 2:15 p.m. identified two CNAs (#9 and #13) assisted Resident #6 with personal cares. A CNA (#9) removed the glove on her right hand, and with a glove on her left hand, carried the resident's linen bed protector out of his room and down the corridor to the soiled utility room. Observation showed a smear of bowel movement on the linen bed protector. The CNA (#9) failed to place the soiled linen in a bag prior to exiting Resident #6's room. During an interview on 05/14/14 at 5:00 p.m., two administrative nurses (#2 and #14) stated they expected staff to perform hand hygiene after completing perineal care and prior to completing other tasks. The nurse (#2) stated staff should bag linen before exiting a resident's room, unless staff placed a linen cart in the corridor outside the resident's door.	F 441		