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 _____	R 07/22/2014

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 An on-site revisit was conducted July 21-22, 2014 to determine compliance with the deficiencies identified during the May 12-15, 2014 survey. The revisit sample included seven (7) residents for focused review of the areas of non-compliance. The tag numbers enclosed in { } denotes citations that remained not met as dertermined by the on-site revisit.	{F 000}		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed		**F 280** 1. Resident #1's care plan and CNA care card have been reviewed and updated to reflect her individual needs for constipation, hydration needs, heel protectors and transfer aids. Resident #3's care plan and CNA care card have been reviewed and updated to reflect his individual needs for transfer aids. Resident #4's care plan and CNA care card have been reviewed and updated to reflect his individual needs for constipation, transfer aids, and hydration concerns. Resident #5's care plan and CNA care card have been reviewed and updated to reflect her individual needs for constipation and transfer aids. Resident #7's care plan and CNA care card have been reviewed and updated to reflect her individual need for transfer aids.	08-08-2014

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

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Robert Sheedy 8/8/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVE
OMB NO. 0938-039

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 _____	R 07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	304 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}		

An on-site revisit was conducted July 21-22, 2014 to determine compliance with the deficiencies identified during the May 12-15, 2014 survey. The revisit sample included seven (7) residents for focused review of the areas of non-compliance. The tag numbers enclosed in { } denotes citations that remained not met as dertermined by the on-site revisit.

F 280 SS=E 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, and staff interview, the facility failed

F 280

1. Resident #1's care plan and CNA care card have been reviewed and updated to reflect her individual needs for constipation, hydration needs, heel protectors and transfer aids.

Resident #3's care plan and CNA care card have been reviewed and updated to reflect his individual needs for transfer aids and constipation.

Resident #4's care plan and CNA care card have been reviewed and updated to reflect his individual needs for constipation, transfer aids, and hydration concerns.

Resident #5's care plan and CNA care card have been reviewed and updated to reflect her individual needs for constipation and transfer aids.

Resident #7's care plan and CNA care card have been reviewed and updated to reflect her individual need for transfer aids.

08-08-2014

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

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVI
OMB NO. 0938-03

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 _____	R 07/22/2014

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

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F 280	Continued From page 1			

to review and revise the resident's plan of care for 5 or 7 sampled residents (Resident #1, #3 #4,#5, and #7). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident.

Findings include:

Review of the facility policy titled "Care Plans - Comprehensive" occurred on 07/22/14. This policy, dated 2011, stated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . . . Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making . . . Assessments of residents are ongoing and care plans revised as information about the resident and the resident's condition change. . .

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia. Physician's orders included four different as needed (PRN) medications for constipation and/or elimination. The quarterly Minimum Data Set (MDS), dated 04/30/14, identified extensive assistance for transfers.

Resident #1's current care plan stated, ". . . Transfers: Needs extensive assist with transfers . . . Hydration concern due to receiving a tube feeding . . . Provide fluids through tube as orders . . . Risk for falls . . . Transfer aids upright for

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

3. All care plans and CNA care cards for the residents will be reviewed and updated as their status may change and in their care conferences with the resident and their families along with the Care Team doing approximately seven per week until they have all been completed and then quarterly thereafter as MDS' are scheduled.

4. Care Conferences are scheduled starting 08-07-2014 consisting of a Social Worker, MDS Coordinator, Dietary Manager, Activities, HIM, staff nurse and/or their designees. Education on the importance of interdisciplinary team work with family and resident input was done on 08-07-2014.

5. A report of the Care Team progress will be given to the Quality Improvement Committee every week for 6 weeks monthly and then monthly for a quarter and then quarterly up to a year.

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F 280	Continued From page 2	F 280		

transfer and mobility aid . . ." The certified nursing assistant (CNA) activities of daily living (ADL) resident care card identified a hoyer lift [full body mechanical lift] for transfers; heel protectors while in bed; and nothing by mouth.

Resident #1's current care plan conflicted with the current CNA ADL resident care card related to transfers (extensive assistance verses hoyer lift). The care plan failed to identify the use of heel protectors and nothing by mouth and failed to identify problems, goals, and approaches associated with constipation.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and dysphagia. Physician's orders identified two PRN medications for constipation and/or bowel elimination. The quarterly MDS, dated 04/12/14, identified extensive assistance for transfers.

Observation on 07/22/14 at 9:45 a.m. showed two CNAs (#2 and #3) utilized a hoyer (full body mechanical lift) and transferred Resident #4 from his wheelchair to bed. The CNAs failed to offer fluids before exiting the room.

Resident #4's current care plan stated, "Hydration concerns . . . Offer fluids at meals, rounds and throughout the day . . . Falls . . . does not ambulate anymore and is a hoyer lift . . . Ensure adequate bowel elimination . . . Nutrition concerns due to hx [history] of wt [weight] loss, hx of tubefeeding . . . Monitor swallowing ability . . ." The CNA care guide identified gait belt transfers and honey thickened liquids but failed to identify the residents' increased fluid needs.

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F 280	Continued From page 3	F 280		

Resident #4's current care plan conflicted with the current CNA ADL resident care card care related to transfers. The care plan failed to identify problems, goals, and approaches associated with dysphagia and constipation.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included osteoarthrosis. The physician's orders identified four scheduled medications for constipation and/or bowel elimination and five PRN medications.

Observation on 07/22/14 at 11:45 a.m. showed two CNA's (#11 and #12) utilized a gait belt and transferred Resident #5 from a recliner to a wheelchair.

Resident #5's current care plan stated, "Self Care Deficit . . . Transfers: . . . extensive with transfers . . . Risk for falls . . . Transfer aids upright for transfer and mobility aid . . ." The CNA care guide identified the resident as independent with transfers.

Resident #5's current care plan conflicted with the current CNA ADL resident care card related to transfers. The care plan failed to identify problems, goals, and approaches associated with constipation.

- Review of Resident #3's medical record occurred on July 21-22, 2014 and diagnoses included constipation and paraplegia. Physician's orders included three scheduled medications for constipation and two PRN medications. The annual MDS, dated 07/10/14, identified the resident transferred with extensive assistance of two or more staff members.

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F 280	Continued From page 4	F 280		

Observations of cares on July 21-22, 2014 identified staff transferred Resident #3 with an EZ stand mechanical lift.

The current CNA activities of daily living (ADL) resident care card identified the resident transferred with an EZ stand mechanical lift.

The current care plan stated, "Problem: Resident is unable to walk (paraplegia) . . . Goal: Resident will safely transfer with assistance of two using the hoyer device or EZ stand . . . Approaches: . . . Transfer with assistance of two using the Hoyer device or EZ Stand . . . does well on transfer with EZ stand, evaluate often and use Hoyer lift for safety if . . . condition worsens . . . Problem: ADL functional status . . . Approach: . . . Transfer - extensive assist of two with hoyer lift or EZ Stand. . . ."

The current care plan conflicted with the current CNA ADL resident care card and identified the resident transferred with both the Hoyer and EZ Stand mechanical lift. Resident #3's care plan failed to identify problems, goals, and approaches associated with constipation.

- Resident #7's medical record occurred on July 21-22, 2014 and diagnoses included osteoarthritis and hemiplegia. The quarterly MDS, dated 06/05/14, identified the resident transferred with extensive assistance of two or more staff members.

The current CNA ADL resident care card identified the resident transferred with assistance of two staff members and a gait belt.

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F 280	Continued From page 5 The current care plan stated, "Problem: Self care deficit related to right sided weakness and decreased function and age . . . Approach: . . . needs extensive assist of one to two to transfer to wheelchair. . . ." During an interview on 07/22/14 at 12:20 p.m., an administrative nurse (#1) stated staff should transfer Resident #7 with the assistance of two staff members and a gait belt. Resident #7's current care plan conflicted with the CNA ADL resident care card and failed to identify the resident transferred with the assistance of two staff members and a gait belt.	F 280		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: BOWEL MANAGEMENT: 1. Based on record review, review of facility protocol, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 4 of 7 sampled residents (Resident #1, #3, #4, and #5) who required as needed (PRN) medications for constipation. Failure to implement less invasive interventions to		**F 309 Bowel Management** 1. Resident #1 has had her care plan and bowel protocol reviewed and updated to be consistent with the current bowel protocol and constipation issues. Resident #3 has had his care plan and bowel protocol reviewed and updated to be consistent with the current bowel protocol. Resident #4 has had his care plan and bowel protocol reviewed and updated to be consistent with the current bowel protocol. Resident #5 has had her care plan and bowel protocol reviewed and updated to be consistent with the current bowel protocol.	08-08-2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVE
OMB NO. 0938-03

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{F 309} Continued From page 6

manage constipation may have resulted in these residents receiving unnecessary suppositories.

Findings include:

Review of the facility's bowel protocol occurred on 07/22/14. This undated protocol stated, ". . . Bowel assessment done on admission. Care Plan individualized to include: Day 2 non-pharmacological interventions - prune juice, intake [fluid intake] Day 3 oral pharmacological interventions - MOM [Milk of Magnesia], Dulcolax tabs [stool softener] Day 4 Suppository followed by fleets [enema] if needed . . ."

- Review of Resident #3's medical record occurred on July 21-22, 2014 and diagnoses included paraplegia. Medications ordered to prevent constipation and/or aid in bowel movements included Miralax daily, Colace twice daily, and Senna-S daily. PRN medications included Dulcolax suppository and MOM. Non-pharmacological PRN interventions included prune juice, fruit crax [a fruit mixture], or prunes. Resident #3's care plan failed to identify a concern related to constipation.

The bowel movement (BM) records for July 13-21, 2014 identified Resident #3 had a BM on July 13th, July 17th, and July 21st. The Medication Administration Record (MAR) identified Resident #3 received a suppository on July 17th and July 21st. (The resident declined prune juice or fruit crax on July 19th).

The facility failed to follow their bowel protocol and offer MOM or oral Dulcolax tablets prior to administering suppositories.

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

3. Nurses have been educated individually on the understanding of the bowel protocol medication administration regimen. See exhibit F 309 A. Matrix systems has been updated to allow CNAs to chart BMs on Point of Care which will tabulate with the Matrix system. CNAs have been trained on POC Bowel Movement charting. See exhibit F 309 B. Each resident does have prn administration of non-pharmacological medications on eMar for better tracking of interventions being utilized. Matrix has been set up to run daily reports for updating bowel management which will be run for 10% of our residents with a history of constipation. All care plans will be reviewed and updated by Friday, 08-08-2014.
4. Matrix BM Reports will be run and reviewed weekly for auditing by a licensed nurse.

5. Reports on the Matrix BM Reviews will be presented to the Quality Improvement committee weekly for one month, monthly for one quarter and then quarterly up to one year.

F 309 Heel Protectors
1. Resident #1 had her care plan and CNA care card reviewed and updated for the use of heel protectors when in bed on 08-06-2014.
2. All residents have the potential to be affected by this deficient practice.
3. All staff were educated on which residents require the use of heel protectors when in bed. See exhibit F 309 C.
4. A weekly audit will be done on the residents who have heel protectors by a designated nursing staff.
5. This will be reported to the Quality Improvement meeting weekly for one month, monthly for one quarter and then quarterly up to a year.

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ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

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{F 309}	Continued From page 7 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia. Medications ordered to prevent constipation and/or aid in bowel elimination included Miralax PRN, Colace/Senekot PRN, and a bisacodyl suppository PRN. Non-pharmacological interventions included prune juice PRN. Resident #1's care plan failed to identify a concern related to constipation. The BM records for July 14-21, 2014 identified Resident #1 had a BM on July 14 and not again until July 18. The MAR identified Resident #1 received a suppository on July 18, the fourth day without a BM. The facility failed to attempt less invasive interventions for bowel management, including dietary interventions, prior to the administration of a suppository. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. Medications ordered to prevent constipation and/or aid in bowel elimination included MOM PRN, and a bisacodyl suppository PRN. Non pharmacological interventions included prune juice/fruit crax/prunes every day PRN (initiated on 07/21/14). The BM records for July 15-21, 2014 identified Resident #3 had a BM on July 15 and not again until July 19. The MAR identified the resident received a suppository on July 18, the third day without a BM. The facility failed to attempt less invasive		4. A weekly audit will be done on the residents who have heel protectors by a designated nursing staff. 5. This will be reported to the Quality Improvement meeting on a monthly basis for one quarter and then quarterly up to a year. Duplicate from previous page KB	

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{F 309}	Continued From page 8	{F 309}		

interventions for bowel management, including dietary interventions, prior to the administration of a suppository.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included chronic kidney disease and diabetes mellitus. Medications administered daily to prevent constipation and/or aid in bowel elimination included Colace three times a day, Dulcolax tablets at bedtime, and MOM every other day. PRN medications included Miralax, Colace, Senokot S, a bisacodyl suppository, and a Fleets enema. Non pharmacological interventions included prune juice and fruit crax. Resident #4's care plan failed to identify a concern related to constipation.

The BM records for July 15-21, 2014 identified Resident #4 had a BM on July 17 and not again until July 21. The MAR and progress notes identified Resident #4 received a tablespoon of fruit crax and prune juice on July 19, no PRN medications or dietary interventions on July 20, and a suppository on July 21, the fourth day without a BM.

The facility failed to follow their bowel protocol and administer an oral pharmacological medication on Resident #4's third day without a BM.

During an interview on the morning of 07/22/14, an administrative nurse (#1) stated she would expect nursing staff to follow the facility's bowel protocol.

HEEL BOOTS

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{F 309}	Continued From page 9	{F 309}		

2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to prevent pressure ulcers for 1 of 1 sampled resident (Resident #1) with heel boots. Failure to apply heel boots to the resident's feet while in bed may result in the development of pressure ulcers.

Findings include:

Review of Resident #1's record occurred on all days of survey. Diagnoses included dementia. The resident's quarterly Minimum Data Set (MDS), dated 04/30/14, identified long and short term memory problems and extensive assistance of two staff members for bed mobility, transfers, and dressing.

Resident #1's care plan failed to identify any skin concerns or a risk for pressure ulcers; however, the certified nursing assistants' (CNAs) care guide identified the use of heel protectors while in bed.

- Observation on 07/21/14 at 1:00 p.m. showed two CNAs (#3 and #4) transferred Resident #1 from the wheelchair to bed, provided perineal care, and positioned her in bed on her back with her heels resting directly on the mattress. Observations showed blue heel boots on the unoccupied bed in the room. At 5:05 p.m., observation showed Resident #1 remained on her back in bed, heels directly on the mattress, and no heel boots.

- On 07/22/14 at 9:35 a.m., two CNAs (#2 and #3) transferred Resident #1 from the wheelchair to bed. After providing cares, the CNAs positioned the resident on her back with her heels resting

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{F 309}	Continued From page 10	{F 309}		

directly on the mattress. Observation showed the heel boots on the unoccupied bed in the room.

During an interview on the morning of 07/22/14, an administrative nurse (#1) stated she would expect facility staff to place the heel boots on Resident #1's feet while in bed.

{F 323} SS=D 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 appropriate use of assistive devices to prevent accidents for 1 of 2 sampled residents (Resident #7) transferred with a gait belt. Failure to properly use a gait belt increased the risk of falls, pain, and injury to residents.

Findings include:

Review of the facility's policy titled "Transferring with a Gait Belt" occurred on 07/22/14. This undated policy stated, ". . . Always use a gait belt unless the client is totally independent with transfers . . . Before you start the lift, grab onto the gait belt. It should be very tight, just enough room to get your fingers between the belt and the

F 323 Gait Belts

1. Resident #7 had her care plan and CNA care card reviewed and updated for the proper transfer aid as of 08-06-2014.

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

3. Education has been provided to the staff on the proper use of gait belts on 07-23-2014 thru 08-06-2014.

4. Audits will be done and monitored by a designated licensed nurse and will be monitored for compliance on gait belts and lifts. Audits were started as of 07-24-2014 for proper use of gait belts and mechanical lifts. See exhibit D.

5. Audit reports will be given to the Quality Improvement committee weekly for one month, then 1 month for a quarter and then quarterly up to a year.

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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 _____	R 07/22/2014

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{F 323}	Continued From page 11 resident's body. . . ." Review of Resident #7's medical record occurred on July 21-22, 2014 and identified diagnoses of osteoarthritis and hemiplegia. The quarterly Minimum Data Set (MDS), dated 06/05/14, identified extensive assistance of two or more staff members for transfers. The current certified nursing assistant (CNA) activities of daily living (ADL) resident care card identified the resident transferred with assistance from two staff members and a gait belt. Observation on 07/21/14 at 3:45 p.m. identified two CNAs (#7 and #8) transferred Resident #7 from her bed to her wheelchair using a gait belt. During the transfer, a CNA (#8) held onto the gait belt with one hand and lifted under the resident's left arm with her other hand. Observation on 07/21/14 at 4:30 p.m. identified three CNAs (#8, #9, and #10) transferred Resident #7 from her wheelchair to the toilet and back to her wheelchair without using a gait belt. A CNA (#9) transferred Resident #7 by grasping her sides and pivoting her on and off the toilet. During an interview on 07/22/14 at 12:20 p.m., an administrative nurse (#1) stated staff should use a gait belt when transferring Resident #7 and avoid lifting on the resident's arms.	{F 323}		
{F 327} SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.		**F 327 Sufficient fluid to maintain hydration** 1. Resident #6 has been assessed and shows no signs or symptoms of dehydration as of 08-06-2014.	08-08-2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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{F 327}	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to offer fluids to 2 of 3 sampled residents (Residents #4 and #6) 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 07/22/14. This policy, revised 06/25/14, 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. . . ." - Review of Resident #6's medical record occurred on July 21-22, 2014 and diagnoses included Alzheimer's dementia and constipation. The quarterly Minimum Data Set (MDS), dated 06/01/14, identified total dependence of one staff member for eating and a mechanically altered diet. The current care plan stated, "Problem: Hydration . . . Approach . . . Offer fluids throughout the day and monitor intake. . . ." Observation on 07/21/14 at 3:00 p.m. showed two certified nursing assistants (CNAs) (#7 and #8) provided personal cares for Resident #6, transferred her into a wheelchair, and transported her to the TV lounge. The CNAs failed to offer the resident fluids.		Care card has been reviewed and updated to address hydration issues on 08-06-2014. Resident #4 has been assessed and shows no signs or symptoms of dehydration on 08-06-2014. Care plan and care card have been reviewed and updated on 08-05-2014 to address hydration issues. 2. All residents have the potential to have affects from this deficient practice. 3. All staff have been educated on offering fluids to the residents along with the thickening of fluids beginning on 07-07-2014. See exhibit F. 4. Implemented are weekly audits on fluid intake for residents #3, 4, 6, & 7 by designated nursing staff member. Also signs and symptoms assessments will be done on residents #3, 4, 6, and 7 will be our audit. who are at higher risk for dehydration each week. 5. These reports will be given to the Quality Improvement Committee weekly for one month, then monthly for one quarter and then quarterly up to one year.	

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{F 327}	Continued From page 13	{F 327}		

- Review of Resident #4'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, "Hydration concerns: . . . Offer fluids at meals, rounds and throughout the day. . . ."

Observation on 07/22/14 at 9:35 a.m. showed two CNAs (#2 and #3) transferred Resident #4 from his wheelchair to bed, provided personal cares, and exited the room. The CNAs failed to offer/assist with fluids.

The CNAs failed to notify this surveyor from 07/21/14 at 1:35 p.m. to 07/22/14 at 11:45 a.m. for cares (except for the above observations) provided for Resident #4, so it is uncertain whether fluids were offered with any cares.

During an interview on 07/22/14 at 11:45 a.m., an administrative nurse (#1) stated she expected staff to offer/assist with fluids during cares.

{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;		**F 441 Infection Control** 1. Resident #1 shows no signs or symptoms of infection from the deficient practice on 07-22-2014. Resident #4 shows no signs or symptoms of infection from the deficient practice on 07-22-2014. Resident #5 shows no signs or symptoms of infection from the deficient practice 07-22-2014. 2. All resident do have the potential for infection due to these deficient practices.	08-08-2014

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{F 441}	Continued From page 14 (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 3 of 6 sampled residents (Resident #1, #4, and #5) observed during personal cares. Failure to follow infection control practices related to handwashing, perineal cares, and handling of soiled linen has the potential to cause or spread infection within the facility. Findings include:		3. We have implemented as of 07-24-2014 a designated staff member who is monitoring and observing staff on pericare, hand washing and soiled linen. Staff are being educated immediately for non-compliant practices with follow-up by the infection nurse for further instruction. See exhibit F 441 G. 4. Audits will be done weekly by a designated nursing staff member. 5. These reports will be given to the Quality Improvement committee weekly for one month, then monthly for a quarter and then quarterly up to a year.	

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{F 441}	Continued From page 15 Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 07/22/14. This policy, revised 06/24/14 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 07/22/14. This policy, revised 06/24/14, 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 . . ." - Observation on 07/21/14 at 2:10 p.m. identified two certified nursing assistants (CNAs) (#6 and #7) assisted Resident #5 with toileting. After performing perineal cares, the CNA (#7) removed her gloves, assisted the other CNA (#6) to transfer the resident back to her wheelchair, transported Resident #5 to the living area, transferred the resident into her recliner, and went to assist another resident. The CNA (#7) failed to perform hand hygiene after completing perineal care, prior to completing other tasks and prior to assisting another resident.	{F 441}		

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{F 441}	Continued From page 16 - Observation on 07/21/14 at 1:00 p.m. showed two CNAs (#3 and #4) donned gloves and while one CNA (#3) positioned Resident #1 on her side, the other CNA (#4) provided incontinence cares. That CNA (#4) failed to perform hand hygiene before exiting the room. - Observation on 07/22/14 at 9:45 a.m. showed two CNAs (#2 and #3) transferred Resident #4 from his wheelchair to bed. The CNAs removed the resident's pants and placed them on the floor. The CNA (#2) stated Resident #3 had "spit up" on the pants. At the completion of cares, both CNAs washed their hands and the CNA (#2) removed the garbage bag and the un-bagged soiled pants and carried them down the hallway to the soiled utility room. The CNA (#2) failed to bag the soiled pants, failed to apply gloves before handling the pants, and failed to sanitize her hands after disposing of the pants. During an interview on 07/22/14 at 11:45, two administrative nurses (#1 and #5) stated they expect staff to perform hand hygiene after providing pericares and before exiting a resident's room, and expect soiled linen/clothing bagged before exiting the room.	{F 441}		