STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 For the standard Medicare/Medicaid recertification survey started on 08/31/15 and completed on 09/03/15, the sample included 2 residents for complete review, 8 residents for focused review, and one closed record for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to provide privacy for 3 of 3 sampled residents (Resident #1, #9, and #10) observed using a bedside commode and during 4 random observations of insulin administration (Resident #12, #13, #14, and one unidentified resident). Failure to ensure privacy when using a bedside commode or administering an injection does not promote residents' dignity, self esteem, self worth, or enhance their quality of life, and may cause discomfort or embarrassment to those witnessing the breach of privacy. Findings include: Review of the facility policy titled "Confidentiality, Privacy, and Dignity" occurred on 09/03/15. This	F 241	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 10/2/15 on the policies titled "Confidentiality, Privacy, and Dignity" and "Medication Administration." These instructions were for resident #12, #13, #14, #1, #9, and #10 as well as any other resident who may be affected. 2) Any resident requiring insulin or who uses a bedside commode has a potential to be affected. All staff who provide care or administer insulin to residents will be educated and evaluated on the importance of providing privacy when caring or giving treatment to a resident	10/2/15

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

Electronically Signed | 10/05/2015

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F 241	Continued From page 1 policy revised in March 2012, stated, ". . . All facility staff will protect and promote the right of confidentiality, dignity, and privacy of each resident . . . All staff will knock before entering a resident/patient's room and allow resident/patient's privacy when receiving treatment and caring for their personal needs. . . ." - Observation on 09/02/15 at 1:33 p.m., showed two certified nursing assistants (CNAs) (#4 and #5) assisted Resident #9 onto the bedside commode. The CNAs exited the room allowing other residents, staff, or visitors in the hallway to view Resident #9 while seated on the bedside commode. During an interview on 09/03/15 at 09:35 a.m. two administrative staff members (#2 and #3) confirmed staff are expected to provide privacy when a resident uses a bedside commode. - Observation on 09/02/15 at 7:58 a.m. showed a CNA (#12) removed Resident #1's gown and provided morning cares. The resident laid in bed with only a washcloth over his groin area. Someone knocked at the door, and the CNA stated, "Come on in." A CNA (#8) entered the room. The two CNAs (#12 and #8) assisted the resident to dress, and transfer to the commode in the center of the room using a sit-to-stand lift. As the resident voided in the commode, one CNA (#8) stated she would be back when the resident finished, and left the room. The other CNA (#12) also left the room and returned swinging the door wide open to push a wheelchair through the doorway while the resident sat on the commode,	F 241	and making sure to knock and identify who is at the door prior to entry. Rolling privacy screens were purchased for resident #1, #9, #10 any other resident who uses a bedside commode. 3) Nursing staff were in-serviced on the revised policy on 10/2/15 regarding medication administration and providing privacy while giving insulin injections. Nursing staff also were in-serviced on the revised policy on "Confidentiality, Privacy, and Dignity" that states all staff will use portable private screens when a resident is using a bedside commode to allow for privacy. Also in-serviced on the revised policy "Medication Administration" that states to make sure to give insulin injections in resident rooms or another private area where no other individuals are present. 4) The QA Coordinator or nursing designee will monitor resident #1, #9, #10, #12, #13, #14 and any other residents requiring portable private screens to be used during care and insulin given in resident's room or another private area monthly X 3, then quarterly for one year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 241	Continued From page 2 visible from the hallway. During an interview in the afternoon on 09/03/15, an administrative nurse (#3) confirmed staff need to provide privacy while providing care, and stated she thought staff may need further education regarding privacy. - On 09/03/15 at 9:37 a.m., observation showed two CNAs (#11 and #14) knocked, opened the door, and entered Resident #10's room. Observation showed Resident #10 sitting on a commode next to her bed. A nurse (#17) in the room finished administering medications to Resident #10, opened the door and left the room. The staff failed to ensure the resident's privacy while toileting from passersby in the hallway. - Observation showed a nurse (#17) administered subcutaneous insulin injections to the following residents in the lounge next to the dining room within potential or actual view of other residents, visitors, or staff: * 09/01/15 at 7:45 a.m. - Resident #12 - injection into abdomen, while a second nurse passed medications in the same area * 09/01/15 at 8:01 a.m. - Resident #13 - injection into abdomen, with four other residents in the room and another resident passed by Resident #13 in his wheelchair * 09/02/15 at 7:44 a.m. - Resident #14 - injection in right upper arm * 09/03/15 at 7:35 a.m. - unidentified resident - injection in right upper arm with other residents and staff in view	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		10/15/15

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F 253	Continued From page 3 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and orderly environment for 1 of 1 activity room. Failure to maintain the environment in the activity room may contribute to a diminished quality of life for residents utilizing the activity room. Findings include: Observation during the environmental tour on 09/02/15 at 1:30 p.m., showed nine out of ten chairs in the activity room had torn/ripped vinyl on the armrests. During an interview on the environment tour, the environmental supervisor (#1) stated the chairs needed to be replaced.	F 253	1) Housekeeping Staff will be instructed on 10/6/15 on the importance of doing routine inspections on all furniture to make sure it is free of any cracks, rips, or tears. This instruction was for the Activity Room or any other area that has the potential to be affected. All chairs with cracks have been removed from the Activity Department. New chairs have been ordered. 2) Any resident who sits in a chair that has torn/ripped vinyl has the potential to be affected. 3) Housekeeping staff will be in-serviced on 10/6/15 that while doing routine cleaning of chairs, to watch for ripped/torn chairs, and if any are found that are damaged to report it to maintenance for repair or replacement as soon as possible. 4) Maintenance or designee will monitor Activity Room and any other room with chairs monthly X 3, then quarterly X 1 year. Monitoring to begin 10/6/15. Results will be reported to the Plant Operations Director. If concerns are identified, immediate corrective action will be	

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F 253	Continued From page 4	F 253	implemented. The Plant Operations Director will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 280 SS=D	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/04/2014. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the plan of care for 3 of 10 sampled residents (Resident #4, #5, and #6)	F 280	1) Nursing staff were instructed on 10/2/15 on the policy entitled "Resident Care Planning." This instruction was for resident #4, #5, and #6 as well as any other resident who may be affected. 2) Any resident requiring a care plan	10/2/15

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F 280	Continued From page 5 regarding falls/air mattress setting (Resident #4), pressure ulcers, weight loss, and toileting (Resident #5), and constipation (Resident #6). 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. Finding include: Review of the facility's policy titled "Resident Care Planning" occurred on 09/03/15. This policy, revised May 2006, stated," . . . The care plan will be reviewed and revised by the Interdisciplinary Team after each assessment and as needed. . . 11. Care plans reviewed at A.M. and P.M. nursing report with appropriate changes made. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included pressure ulcer, history of transient ischemic attack, and chronic pain. A quarterly Minimum Data Set (MDS) , dated 08/11/15, identified extensive assistance of two or more persons needed for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #5's care plan stated, ". . . Toilet [Resident #5] every 2-3 hours using bedpan . . . NUTRITION: [Resident #5] usually eats most of food at most meals. . . . Serve no added salt diet, serve pureed diet . . . SKIN INTEGRITY: Potential for skin breakdown r/t [related to] immobility . . . Variable density mattress, assist with changing positions frequently to avoid breakdown, ro-ho cushion for wc [wheelchair] . . ."	F 280	review has the potential to be affected. All staff who review or update care plans will be educated on the importance of updating the care plan to reflect the current status of a resident. 3) Nursing staff were in-serviced on the updates to care plans for resident #4, #5 and #6 on 10/2/15 and also reviewed the "Resident Care Planning" policy. 4) The QA Coordinator or nursing designee will monitor resident #4, #5, and #6 and any other resident requiring updates to care plans monthly X 3, then quarterly for one year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 280	Continued From page 6 Resident #5's "Pressure Ulcer Status Assessment" identified the following: * 08/19/15 pressure ulcer to the right inner buttocks * 08/25/15 pressure ulcer to the left inner buttocks Treatment to the pressure ulcers included the following: * 08/19/15 Restore (gel like dressing) to the open areas * 08/21/15 Allevyn (absorbent dressing) to open areas The care plan failed to address the resident's pressure ulcers and identified interventions. Resident #5's dietary progress notes stated the following: * 07/27/15 - ". . . continued wt [weight] decline - will add suppl. [supplement] 1x/day [one times per day] . . ." * 08/31/15 - ". . . will try adding 4 oz [ounce] mighty shake II to aid in healing and to keep wt stable." The care plan failed to address the resident's weight loss and identified interventions. Observation on 08/31/15 and 09/01/15 showed the CNAs checked and changed Resident #5's brief every two hours, while the care plan stated to toilet Resident #5 every two to three hours using the bedpan. During an interview on 09/03/15 at 09:35 a.m. two administrative staff members (#2 and #3) confirmed Resident #5's care plan needed updating.	F 280		

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F 280	Continued From page 7 - Review of Resident #4's medical record occurred on all days of survey. The resident's comprehensive MDS assessment, dated 03/18/15, identified the resident experienced one fall without injury during the assessment period, and the quarterly MDS, dated 06/18/15, identified the resident experienced two or more non-injury falls during the assessment period. Review of a "Resident/Patient Incident/Near Miss" form for a fall that occurred on 12/25/14 at 5:10 a.m. showed the resident, ". . . was found laying on blue mat in front of her bed in fetal position, bed alarm was sounding. Settings on air mattress were set too high causing mattress to be too firm . . . air mattress setting to [sic] high causing mattress to be higher in center ['and' symbol] lower @ [at] edges . . ." Review of additional fall investigations identified Resident #4 fell near her bed again on 04/26/15, 05/31/15, and 06/29/15. Observation on 08/31/15 at 3:52 p.m. showed a CNA (#11) adjusted the inflation setting of the resident's air mattress before and after the CNAs (#10 and #11) provided care to the resident as she lay in bed. Observation on 09/01/15 at 9:03 a.m., showed two CNAs (#10 and #11) assisted the resident into bed. The air mattress pump showed the mattress inflated to the highest setting (10). After providing care, staff left the room at 9:12 a.m. Observation at 9:25 a.m. showed the mattress remained on the firmest setting of 10. The resident's care plan identified, "*FALLS: At risk for falls r/t [related to] hx.[history] of falls. . . ."	F 280		

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F 280	Continued From page 8 but failed to identify the need to have the mattress remain at the proper firmness setting. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation. Medications included the following laxatives: * Milk of Magnesia, Bisacodyl suppository, and Phosphate enema, as needed (PRN), started 08/27/09 * Senna Plus 2 tablets daily, started 11/29/13 Record review identified Resident #6 required a PRN bowel medication to treat constipation 19 times in June-August 2015. The care plan failed to address constipation, including dietary, medications, and/or other interventions to treat Resident #6's constipation. See F309.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 5 of 10 sampled residents (Resident #4, #5, #6, #7, and #10) requiring as needed (PRN) bowel medications. Failure to follow standards of practice by documenting PRN medications on the medication administration record (MAR) may result in medication errors and does not allow for effective review of each resident's medication regimen.	F 281	1) Nursing staff were instructed on 10/2/15 on the policy entitled "Medication Administration." This instruction was for resident #4, #5, #6, #7 and #10 as well as any other resident who may be affected. 2) Any resident requiring a bowel medication has the potential to be affected. All staff who give bowel medications were educated and will be evaluated on the importance of charting	10/2/15

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F 281	Continued From page 9 Findings include: Review of the facility policy titled "Medication Administration" occurred on 09/03/15. This policy, dated March 2007, stated, ". . . 18. PRN medication is charted on the PRN MAR with reason, initials and time given. . . The results of the PRN medication are recorded on the PRN MAR. . . ." - Review of Resident #4, #5, #6, #7 and #10's medical records occurred on all days of survey. Diagnoses for Resident #5, #6, #7, and #10 included constipation. Resident #4's annual MDS, dated 03/18/15, identified constipation present during the assessment period. Medications for all five residents included Milk of Magnesia (MOM) if no bowel movement (BM) in 3 days and Bisacodyl suppository on day 4 if no result from the MOM. Review of the June, July, and August Bowel Tracking Records identified staff administered, but failed to document PRN bowel medications on the MAR the following number of times: * Resident #4 - 20 out of 33 times * Resident #5 - 14 out of 29 times * Resident #6 - 12 out of 19 times * Resident #7 - 2 out of 7 times * Resident #10 - 2 out of 2 times During an interview on 09/03/15 at 8:57 a.m., an administrative nurse (#2) stated nurses are expected to chart bowel medications administered on resident's MARs.	F 281	bowel medications administered on the residents' PRN MAR. 3) The current policy "Medication Administration" was reviewed with all nursing staff on 10/2/15. For all residents who require a PRN medication to promote bowel movements, the PRN medication must be listed on the residents' MAR. 4) The QA Coordinator or nursing designee will monitor resident #4, #5, #6, #7, #10 and any other resident requiring PRN medications monthly X 3, then quarterly for one year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		10/2/15

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F 309 SS=D	Continued From page 10 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/06/2014. Based on record review and review of facility policy, the facility failed to provide interventions to promote regular bowel elimination for 1 of 10 sampled residents (Resident #6) requiring bowel medications. Failure to follow the facility bowel protocol and implement appropriate dietary interventions to relieve constipation does not ensure regular bowel evacuation and may cause the resident unnecessary discomfort. Findings include: Review of the facility policy titled "Bowel Protocol" occurred on 09/03/15. This policy, revised August 2014, stated, ". . . Procedure: 1. Daily at the beginning of the morning shift, the nurse will review each resident's bowel record to assess if a bowel movement has occurred and if there is a need for bowel interventions. 2. If resident is on the 3rd day with no bowel movement, a bowel aide will be given. Standing orders for Milk of Magnesia or bowel care of	F 309	1) Nursing staff were instructed on 10/2/15 on the policy entitled "Bowel Protocol." This instruction was for resident #6 as well as any other resident who may be affected. 2) Any resident requiring interventions to promote bowel elimination has the potential to be affected. All staff who review residents bowel records were educated on the importance of following the "Bowel Protocol" policy. 3) Nursing staff were in-serviced on the policy of "Bowel Protocol" on 10/2/15 and on updates to resident #6's care plan in regards to constipation. Nursing staff were instructed on the medication administration policy that states PRN medication is charted on the PRN MAR with the reason, initials, and time given. Nursing staff are administering resident #6 Senna Plus 2 tabs orally daily to help with constipation. Resident #6 currently doesn't receive dietary interventions;	

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F 309	Continued From page 11 choice as ordered by provider. This will be left to nursing discretion based on resident preference or resident history. 3. On the 4th day of no B.M. [bowel movement], a suppository or fleets enema may be given depending on the provider's order, unless this is 'normal' for the resident. The nurse may do a digital exam prior to see if stool is present. 4. The provider shall be notified at anytime deemed appropriate by the nurse, if the nurse feels the above does not fit the individual needs of the resident. 5. Document the bowel aide of choice used on the prn [as needed] sheet." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation. The quarterly Minimum Data Set (MDS), dated 08/22/15, indicated severely impaired cognitive skills, extensive assistance of two or more people for toileting, and always incontinent of bowel and bladder. The care plan failed to address constipation. Standing Physician orders for constipation included: "If no BM in 3 days give MOM [Milk of Magnesia] 30cc [cubic centimeters] PO [per oral], if no results from MOM on 4th day give Bisacodyl supp [suppository] PR [per rectum]. If no results give phosphate enema PR," and "Phosphate enema q [every] 3-4 days PRN (R) [rectally] for constipation." Medication orders, dated 11/29/13, stated, "Senna Plus 2 tabs [tablets] (o) [orally] QD [everyday] - constipation" and dated 08/28/14, stated, "If resident is on the 3rd day with no BM, a bowel aide will be given. S.O. [standing order] of Milk of Magnesia or bowel care of choice as ordered by provider."	F 309	however, will start resident on pureed prunes daily at breakfast beginning on 10/14/15. 4) The QA Coordinator or nursing designee will monitor resident #6 and any other resident requiring bowel aides to ensure the nursing assessment includes either dietary interventions or other bowel aides to make sure a resident is having a bowel movement every three days and to ensure PRN medication is documented on the MAR and dietary supplements are given as ordered monthly X 3, then quarterly for one year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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	355044	A. BUILDING _____ B. WING _____	09/03/2015

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F 309	Continued From page 12 Resident #6's bowel records for June - August 2015, showed the following days without a BM and interventions staff provided: * 06/11/15 = 7 days; MOM on day 4 and suppository on day 7 * 06/20/15 = 5 days; MOM on day 3 and suppository on day 5 * 07/03/15 = 4 days; no interventions documented * 07/27/15 = 4 days; suppository on day 4 * 08/16/15 = 4 days; suppository on day 4 * 08/28/15 = 5 days; MOM on day 3 and suppository on day 5 Staff failed to administer MOM on day 3 on four occasions and a suppository on day 4 on four occasions per the facility bowel protocol and per the physician standing orders. Staff also failed to administer an enema when indicated on three of the above occasions. Resident #6's record lacked documentation of the bowel aide used on the PRN Medication Administration Record (MAR) on 12 of 19 times administered in the last three months. See F281. Resident #6's record lacked a dietary assessment or dietary interventions related to constipation. Failure to assess Resident #6 who had a diagnosis of constipation and provide appropriate interventions, including medication and dietary, placed the resident at risk for continued constipation.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		10/2/15

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F 314	Continued From page 13 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and professional reference, the facility failed to provide the necessary treatment and services to promote healing and prevent infection for 2 of 3 sampled residents (Resident #4 and #5) with pressure ulcers. Failure to properly change pressure ulcer dressings, consistently implement pressure relieving interventions (air mattress and Roho cushion), and ensure the accuracy of wound measurements for wound monitoring has the potential to delay the healing and increase the risk of developing new pressure ulcers. Findings include: - Review of Resident #4's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS) assessment, dated 06/18/15, identified the resident with short and long term memory problems, required total assistance of two staff members for bed mobility and transfers, at risk for pressure ulcers, and had a stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed) present. It also identified Resident #4 had a pressure	F 314	1) Nursing staff were instructed on 10/2/15 on the importance of providing necessary treatment and services to promote healing and prevent infection. This instruction was for resident #4 and #5 as well as any other resident who may be affected. 2) Any resident requiring a changing of pressure ulcer dressing, implementing pressure relieving interventions and measuring wounds accurately has the potential to be affected. All staff who change and measure pressure dressings and provide pressure relieving interventions were educated on the importance of providing correct and accurate documentation, correct dressing changing techniques and providing pressure relieving intervention. 3) Nursing staff were in-serviced on the new guidelines entitled "Clean Dressing Technique, Measurement, and Documentation for Wound Care" on	

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F 314	Continued From page 14 reducing device for the bed and chair, and received ulcer care. The resident's care plan stated, ". . . Risk for pressure ulcer r/t [related to] impaired mobility. . . *Special Air Mattress . . . *Dressing change to non-healing wound on right hip per md [medical doctor] orders, monitor for changes and s/s [signs and symptoms] infection. Report as indicated . . . Roho cushion in recliner when sitting in it. . . ." Review of Resident #4's right hip stage 3 pressure ulcer wound assessment form measurements included the following: *07/27/15 - 2.5 centimeters (cm) length, 0.5 cm width, 0.5 cm depth *08/03/15 - 1.5 cm length, 0.5 cm width, 1.0 cm depth *08/10/15 - 1.5 cm length, 0.5 cm width, 1.0 cm depth *08/17/15 - 0.7 cm length, 1.0 cm width, 0.5 cm depth *08/24/15 - 1.5 cm length, 0.5 cm width, 1.0 cm depth *08/31/15 - 1.1 cm length, 0.3 cm width, 1.0 cm depth Tunneling (channeling from the wound edge that runs through to other tissue) measurements related to the above wound measurements included the following: *07/27/15 - 12 o'clock 4.0 cm, 3 o'clock 3.0 cm, 6 o'clock 0.2 cm, 9 o'clock 0.7 cm *08/03/15 - 12 o'clock 1.7 cm, 3 o'clock 2.0 cm, 6 o'clock 4.0 cm, 9 o'clock 2.5 cm *08/10/15 - 12 o'clock 3.5 cm, 3 o'clock 2.5 cm, 6 o'clock 3.5 cm, 9 o'clock 2.0 cm *08/17/15 - 12 o'clock 3.5 cm, 4 o'clock 2.6 cm, 6 o'clock 3.2 cm, 8 o'clock 4.2 cm	F 314	10/2/15. All staff were instructed on resident #4, to make sure roho cushion is in wheelchair or recliner while resident is up and also instructed on leaving the air mattress on setting #4 and may inflate during care. This instruction was also for any other resident that may have a special cushion in chairs or a special mattress. 4)The QA Coordinator or nursing designee will monitor resident #4 and #5 and any other resident requiring treatment and services to promote healing and prevent infection with pressure ulcers monthly X 3, then quarterly X 1 year and will monitor resident #4 and any other resident requiring a roho cushion be placed in their wheelchair or recliner or requiring a special mattress monthly X3, then quarterly X 1 year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 314	Continued From page 15 *08/24/15 - 12 o'clock 1.5 cm, 3 o'clock 3.0 cm, 6 o'clock 3.0 cm, 9 o'clock 4.5 cm *08/31/15 - 12 o'clock 5.3 cm, 3 o'clock 3.4 cm, 6 o'clock 3.0 cm, 9 o'clock 3.1 cm Observation on 08/31/15 at 3:52 p.m. showed two CNAs (#10 and #11) assisted the resident into her recliner with pillows positioned on both sides of the resident's hips. At that time, the CNA (#11) stated the resident only used pillows and no other cushions. During an interview on 09/03/15 at 9:45 a.m., a CNA (#8) stated the resident did not have a Roho cushion (pressure relieving cushion) for her recliner. Observation on 09/03/15 at 9:57 a.m. showed Resident #4 sat in a recliner with no Roho cushion in place. During an interview on 09/03/15 at 10:12 a.m., a therapy staff member (#9) stated the resident had a Roho cushion to use in her wheelchair for pressure relief. The staff member stated she had not considered it, but thought it would be a good idea to also use the Roho cushion in the recliner. Observation on 09/01/15 at 9:03 a.m. showed two CNAs (#10 and #11) assisted Resident #4 into bed. The air mattress control box showed the mattress inflated to the firmest setting (10 on a 1 to 10 scale). After providing care, staff left the room at 9:12 a.m.. Observation at 9:25 a.m. showed the mattress still on the firmest setting of 10. Observation 09/01/15 at 10:40 a.m. showed two	F 314		

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licensed nurses (#16 and #17) changed Resident #4's pressure ulcer dressing. The licensed nurse (#17) applied gloves and opened the side table drawers, organized supplies, moved the trash can, and placed dressing supplies on the bed. The nurse moved the trash can again, looked through the drawers and pulled out a box of gloves, and moved the trash can a third time. The nurse (#17) wearing the same gloves removed Resident #4's pressure ulcer dressing, removed the wound's packing, sprayed the wound with cleanser, and wiped the wound, then removed her gloves. The nurse (#17) failed to ensure she wore clean gloves when initiating the dressing change of the open wound.

During an interview on the afternoon of 09/03/15, with two administrative nurses (#2 and #3) administrative nurse (#3) stated she expected staff to apply gloves immediately before removing the wound dressing, and confirmed contaminated gloves could introduce new bacteria into the wound. The other administrative nurse (#2) stated the mattress setting was programmed to the recommended level in relation to the resident's weight and she expected staff to not adjust it. She further stated the wound measurements did have inconsistencies related to the wound being measured by the nurse on duty at the time the measurement was due. Both of the administrative nurses (#2 and #3) stated they expected the staff to follow the care plan when providing resident care.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included pressure ulcer. Physician orders included change Allevyn dressing to the coccyx

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F 314	Continued From page 17 every three days. Observation on 09/01/15 at 5:14 p.m. showed Resident #5 in bed. The Allevyn dressing to the resident's pressure ulcer contained a large amount of drainage. The licensed nurse (#13) donned gloves, removed the dressing, disposed of the dressing and the gloves, completed hand hygiene, donned gloves, and applied a new dressing to the affected area. The nurse (#13) failed to cleanse the pressure ulcer drainage before applying a new dressing. During an interview on 09/03/15 at 09:35 a.m. with two administrative staff members (#2 and #3) an administrative staff member (#3) confirmed she expected staff to cleanse Resident #5's pressure ulcer before applying a new dressing.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and policy review, the facility failed to	F 315	1) Nursing staff were instructed on 10/2/15 on the importance of toileting	10/2/15

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F 315	Continued From page 18 ensure 1 of 6 sampled residents experiencing incontinence (Resident #1) received consistent treatment and services to restore or maintain as much bladder function as possible. The failure to provide a consistent plan of care to maintain bladder function and treat incontinence may result in avoidable incontinence and a loss of dignity. Findings include: Review of the facility policy titled "BOWEL AND BLADDER MANAGEMENT POLICY AND PROCEDURE" occurred on 09/03/15. This policy, dated 7/2011, stated, "POLICY: To ensure that a resident who is incontinent of bladder/bowel receives appropriate treatment and services to prevent urinary tract infections, and to restore as much normal bladder/bowel function as possible. Resident will be assessed regarding reasons for incontinence and appropriate interventions implemented to promote continence or maintain dignity when continence is not possible. . . . 4. A bladder/bowel continence assessment . . . will be completed after 7 days. The nurse after 7 days will review the bowel and bladder tracking form for patterns and make adjustments to toileting times to establish a schedule based on the toileting pattern, if a pattern can be identified. . . ." Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS) assessment, dated 06/30/15, identified the resident with moderately impaired cognition, required extensive assistance of 2 staff members for toilet use, and frequently incontinent of urine and continent of bowel. The resident's	F 315	residents upon rising in the a.m. This instruction was for resident #1 as well as any other resident who may be affected. 2) Any resident requiring assistance to the restroom has the potential to be affected. All staff who care for residents that have a change in continence were educated on doing a daily bowel and bladder toileting record for four days to determine bladder needs. This instruction was for resident #1 and any other resident that has the potential to be affected. 3) Nursing staff were in-serviced on 10/2/15 on the current policy entitled "Bowel and Bladder Management" and on doing a bowel and bladder toileting record and evaluation for resident #1 and for any other resident who has a change in continence. 4) The QA Coordinator or nursing designee will monitor resident #1 and any other resident who has a change in incontinence to ensure that through the bladder assessment, if a pattern is identified, toileting will be scheduled at that time. This will be monitored monthly X 3, then quarterly X 1 year. Monitoring will begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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care plan stated, "INCONTINENCE: *[Resident] is incontinent of urine r/t [related to] overactive bladder, dependence on staff for ADL [activities of daily living] cares, and medications. . . . Assist [Resident] to use the restroom as needed or requested. . . . ADLS: [Resident] is dependent on staff for ADL cares . . . [Resident] is using the bedside commode for toileting . . ."

Observation on 09/01/15 at 8:28 a.m. showed two certified nurse aides (CNAs) (#6 and #11) assisted Resident #1 to transfer via a sit-to-stand lift to the bath chair. One CNA (#6) removed the resident's brief (incontinent of bowel), provided incontinence care, and the two CNAs lowered the resident onto the bath chair. Immediately afterward, the resident voided a large amount of urine on the floor. The CNAs did not offer to assist the resident to the commode upon rising/prior to transferring to the bath chair.

Observation on 09/01/15 at 5:52 p.m. showed two CNAs (#7 and #10) entered the resident's room. The CNA (#7) asked if the resident needed to use the restroom, and the resident replied he did. The CNAs assisted the resident to the commode, the resident voided, and staff assisted him with perineal care. The CNA (#7) stated the resident had incontinence of urine and bowel at times, and staff were to ask the resident if he needed to use the commode when they went into his room. The CNA (#7) stated she thought the resident knew when he needed to use the bathroom, but was not always reliable to call when he needed to go. The CNA (#7) stated she went into Resident #1's room approximately every 1.5 hours and asked him.

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F 315	Continued From page 20 During an interview on 09/03/15 at 9:45 a.m., a CNA (#8) stated the resident had the ability to use his call light when needing assistance. When questioned how the CNA knew when to toilet the resident, she stated she watched for the resident's call light. On 09/03/15 at 8:30 a.m., an administrative nurse (#2) stated no resident in the facility had an individualized toileting plan, including Resident #1. She stated she did expect staff to assist the resident to the bathroom upon rising in the morning, after meals, and "the usual times." Failure to adequately assess and implement an individualized toileting program consistent with the resident's determined voiding habits/patterns placed Resident #1 at risk for skin breakdown and avoidable bladder incontinence.	F 315		
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, staff interview, record review, and policy review, the facility failed to ensure each resident's environment remained free from accident hazards, and provide assistive devices for 2 of 5 sampled residents (Resident	F 323	1) Nursing staff were instructed on 10/2/15 on the policy entitled "Call Lights" and were instructed on how to use the air mattress appropriately. This instruction was for resident #1 and #4 as well as any	10/2/15

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F 323	Continued From page 21 #1 and #4) who experienced falls. The facility failed to thoroughly investigate each fall in order to identify root causes and implement effective interventions, ensure a resident's mattress remained at a safe inflation setting, and ensure each resident had an effective way to alert staff when needing assistance. Findings include: Review of the facility policy titled "CALL LIGHTS POLICY AND PROCEDURE" occurred on 09/03/15. This policy, dated February 2006, stated, "POLICY: Every resident/patient shall have a functioning call light within reach. . . . 7. If call light is defective, report immediately to Plant Operations. Place hand bell within reach and check room frequently until call light is repaired. . . ." Resident #4's comprehensive Minimum Data Set (MDS) assessment, dated 03/18/15, identified one fall without injury, and the quarterly MDS, dated 06/18/15, identified 2 or more falls without injury. The resident's care plan identified, "*FALLS: At risk for falls r/t [related to] hx.[history] of falls. . . ." Review of a "Resident/Patient Incident/Near Miss" form for a fall that occurred on 12/25/14 at 5:10 a.m. stated, ". . . was found laying on blue mat in front of her bed in fetal position, bed alarm was sounding. Settings on air mattress were set too high causing mattress to be too firm . . . air mattress setting to [sic] high causing mattress to be higher in center ['and' symbol] lower @ [at] edges . . ." Review revealed staff found the resident on the mat beside her bed again on	F 323	other resident who may be affected. 2) Any resident requiring a special air mattress or who has a defective call light has the potential to be affected. All staff who provide care to a resident who has a special air mattress or a defective call light will be educated on the proper way to use the air mattress and what to do if a resident's call light is defective. 3) Nursing staff were in-serviced on how to operate the air mattress and what to do if a resident's call light is defective. 4) The QA Coordinator or nursing designee will monitor resident #1 and #4 and any other resident requiring an air mattress or who has a defective call light monthly X 3, then quarterly X 1 year. Monitoring to begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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04/26/15, 05/31/15, and 06/29/15, but the investigations did not include whether the resident's mattress had been at the proper firmness setting.

Observation on 08/31/15 at 3:52 p.m. showed two certified nurse aides (CNAs) (#10 and #11) assisted Resident #4 to bed. The staff members assisted the resident to turn back and forth, then the CNA (#11) reached over and pressed a button on the control box of the resident's air mattress. The air mattress inflated more, staff finished cares, and then the CNA (#11) returned the mattress to its beginning setting. The CNA (#11) stated inflating the mattress made it easier to turn the resident back and forth during cares.

Observation on 09/01/15 at 9:03 a.m. showed two CNAs (#10 and #11) assisted the resident to bed. The air mattress pump showed the mattress inflated to the highest setting (10 on a 1 to 10 setting scale). After providing care, staff left the room at 9:12 a.m.. Observation at 9:25 a.m. showed the resident in bed with the mattress still on the firmest setting. At 10:28 a.m., the mattress setting was observed to be between a 4 and 5.

During an interview on the afternoon of 09/03/15, an administrative nursing staff member (#3) confirmed the resident had a fall due to the mattress being over inflated. An administrative nurse (#2) stated the mattress setting is programmed to the recommended level in relation to the resident's weight, and she expected staff to not adjust it. The nurse (#2) confirmed the fall investigations for similar falls the resident experienced afterward did not

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F 323	Continued From page 23	F 323		

include whether the mattress had been at the appropriate setting.

- Observation in Resident #1's room on 09/01/15 at 8:28 a.m. showed a CNA (#6) picked up the resident's call light and stated maintenance needed to look at it. Observation showed the cored had pulled away from the handle exposing the inner wires.

Observation on 09/01/15 at 11:50 a.m. showed Resident #1 sat in his recliner with the same call light clipped to the recliner's arm rest. The resident stated he was ready to go down for the noon meal. When cued to press his call light for assistance, Resident #1 replied, "I do. It doesn't work." The call light signaled after multiple attempts, and staff entered. A CNA (#10) pressed the call light several times and confirmed it did not work. The CNA also confirmed the call light had wires sticking out between the call light handle and cord, and another CNA (#11) stated they would notify maintenance.

Observation on 09/01/15 at 1:30 P.M. showed Resident #1 sat in his recliner in his room. The same call light with frayed wiring remained in the room, attached to the resident's recliner. At 1:35 p.m., an administrative nurse (#3) viewed the call light, confirmed it did not trigger the light to call for assistance, and stated she planned to go speak with maintenance right away.

During an interview on 09/02/15 at 1:30 p.m., an environmental supervisor (#1) stated when he arrived at work around 7:00 a.m. (on 09/01/15), staff had notified him via the maintenance repair book that Resident #1's call light needed repair.

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F 323	Continued From page 24 During an interview on the afternoon of 09/03/15, an administrative nurse (#3) stated she expected all residents to have a properly functioning call light.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to implement and monitor interventions to prevent weight loss and maintain nutritional status for 2 of 2 sampled residents (Resident #5 and #6) who experienced weight loss. Failure to initiate timely and effective interventions may have resulted in severe weight loss for Resident #5 and #6. Findings include: Review of the facility policy titled "Significant Weight Loss" occurred on 09/03/15. This undated policy stated, "Policy: The goal of the medical	F 325	Dietary and Nursing staff were instructed on policy entitled "Significant Weight Loss and Following Dietician's Recommendations" on 10/2/15. This instruction was for resident #5, #6, and any other resident who may be affected. 2) Any resident that has a documented significant weight change or any resident requiring a supplement ordered by the Dietician has the potential to be affected. All staff who administer supplements or weigh residents were educated on the importance of making sure resident is receiving supplements as ordered and	10/2/15

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F 325	Continued From page 25 nutrition therapy (MNT) is to identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem and stabilize the weight. Procedure: Appropriate members of the interdisciplinary team will: 1. Identify individuals with significant/severe weight losses: Significant Weight Loss 1-2% weight loss in a week, 5% weight loss in 1 month, 7.5% weight loss in 3 months, 10% weight loss in 6 months. Severe weight loss > [greater than] 1-2% in a week, > 5% weight loss in 1 month, >7.5% weight loss in 3 months, >10% weight loss in 6 months. . . . n. Request/implement nutrition interventions based on individual case. . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included pressure ulcer, history of transient ischemic attack, and chronic pain. A quarterly Minimum Data Set (MDS), dated 08/11/15, identified short term memory loss and total assistance of one person for eating. The care plan stated, ". . . Nutritional: . . . Serve No added salt diet, Serve pureed diet, assist [Resident #5] with eating, offer Arginaid daily . . ." Resident #5's weight log identified the following: * 10/06/14 - 180 lbs * 11/08/14 - 181 lbs * 12/01/14 - 176 lbs * 01/05/15 - 170 lbs * 02/02/15 - 167 lbs * 03/02/15 - 166 lbs * 04/13/15 - 165.5 lbs * 05/04/15 - 162 lbs - 11% weight loss in six months	F 325	making sure weights are recorded and monitored. 3) Dietary and nursing staff were in-serviced on making sure dietary recommendations are followed through and recorded on new weight tracking form that was developed by Dietary Manager. 4) Dietary Manager or designee will monitor resident #5, #6 and any other resident requiring supplements or who has a significant weight change monthly X 3, then quarterly X 1 year. Monitoring to begin 10/2/15. Results will be reported to the Dietician. If concerns are identified, immediate corrective action will be implemented. The Dietary Manager will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 325	Continued From page 26 * 06/01/15 - 163.5 lbs * 07/06/15 - 160 lbs * 08/03/15 - 163 lbs * 08/10/15 - 161 lbs * 08/17/15 - 160 lbs * 08/24/15 - 156 lbs * 08/31/15 - 152.2 lbs - 27.8 lb weight loss `Review of Res #5's dietary progress notes stated the following: * 07/27/15 - "Annual Review wt 160# [down] 20# (11%) x 1 yr. . . . receives [pureed] NAS [no added salt] [with] [greater or equal to] 75% intake. Continued wt. decline - will add suppl. [supplement] 1x [per] day to aid in healing, bring alb [albumin] WNL [within normal limits] and to help wt become stable. . . ." * 08/31/15 - Wt 156# [down] 4# (2.5%) x 30 days. . . . Arginaid offered 1x/day to aid in healing. . . . NAS diet provided w/ [with] fair to good intake. will try adding 4oz. mighty shake II to aid in healing and to keep wt stable. . . ." Review of dietary intake chart for August 2015 failed to identify Resident #5 received a supplement the dietician recommended on 07/27/15. During an interview on the afternoon of 09/02/15 the dietary manager (#18) stated Resident #5 received ensure (nutritional supplement) at supper as recommended by the dietician and the dietician changed this to a mighty shake II on 08/31/15. This staff member stated she lacked awareness of Resident #5 having a severe weight loss. The facility failed to implement timely	F 325		

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F 325	Continued From page 27 interventions for Resident #5's weight loss. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included adult failure to thrive and dementia. The quarterly Minimum Data Set (MDS), dated 05/22/15, indicated a weight loss of 5% or more in the last month or a loss of 10% or more in the last six months, not physician-prescribed. Resident #6's current care plan stated, "Problem: Nutritional: Food intakes are inconsistent, eating 50% food at most of meals . . . Gradual, steady weight loss . . . Approaches: May offer [name of Resident] a supplement, Is on comfort measures . . . Pureed diet, Fortify foods, Needs assistance at meals . . ." Resident #6's weights revealed the following: * 11/07/14 = 135 lbs * 02/05/15 = 131.5 lbs * 04/02/15 = 126 lbs * 05/07/15 = 118.5 lbs -5.9% weight loss in one month, 9.8% in three months, and 12.2% in six months. * 06/04/15 = 124.5 lbs * 08/06/15 = 123 lbs Res # 6's medical record included the following dietary progress notes: * 11/20/14, stated, "Annual review - wt [weight] 135#, [down] 15# (# = lbs) (10%) x [times] 1 yr [year]. . . . [down] 7-1/2# x quarter. Receives a Regular diet w/ [with] [greater than or equal] 50% intake. . . . Will try adding supplement 1x/day [once per day] . . ." * 08/25/15, stated, "[name of resident] has	F 325		

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F 325	Continued From page 28 maintained a consistant [sic] weight." Resident #6's intake form failed to show the resident received a supplement following the dietician's recommendation on 11/20/14. The record lacked a nutritional assessment or dietary notes from 11/20/14 until 08/25/15, a period of nine months. During an interview on 09/03/15 at 8:05 a.m., a dietary supervisor (#18) stated the resident received fortified food, but does not receive a supplement, and agreed the record lacked an assessment of the significant weight loss in May as well as additional interventions at that time to address the weight loss. Failure to monitor, assess, and implement additional interventions regarding Resident #6's weight loss, may have contributed to her gradual and severe weight loss.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		10/2/15

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F 431	Continued From page 29 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to ensure safe medication storage for 3 of 6 supplemental residents (Resident #15, #16, and #17) with insulin-dependent diabetes and for one random observation of an unlocked medication cart. Failure to dispose of insulin by the recommended time frame has the potential to affect the potency and efficacy of the medication. Failure to ensure only authorized personnel have access to medications may lead to loss or theft of medications, or inappropriate ingestion of medication. Findings include:	F 431	1) Nursing staff were instructed on 10/2/15 on the policy entitled "Vials and Ampules of Injectable Medications" and "Medication Administration." This instruction was for resident #15, #16, and #17 as well as any other resident who may be affected. 2) Any resident requiring insulin administration has the potential to be affected. All staff who give insulin and who control a medication cart were instructed on the importance of making sure to check the dates on all insulin bottles and making sure the medication cart is locked when not in view.	

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F 431	Continued From page 30 Review of the facility policy titled "Vials and Ampules of Injectable Medications" occurred on 09/03/15. This policy, revised April 2006, stated, "Procedure: . . . 2. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials. Insulins will be discarded after 28 days of the date of open. . . ." Review of the facility policy titled "Medication Administration" occurred on 09/03/15. This policy, revised March 2007, stated, ". . . Procedures: . . . 10. Close medication drawer after each Resident's medication is poured. Lock the medication cart if you will turn or step away from cart and the cart is not within your field of vision. . . ." - On 08/31/15 at 5:15 p.m., observation showed a licensed nurse (#16) drew up 2 units of NovoLog insulin for administration to Resident #17. The date on the insulin label was 07/29/2015 (33 days ago). Upon interview, the nurse stated staff mark the insulin with the date it is first opened. The nurse discarded the insulin already drawn up and retrieved a new vial. At 5:25 p.m., a licensed nurse (#16) took Resident #15's Humulin Regular insulin vial from the medication cart, observed the "open" date written on the label as 07/29/15 (33 days ago), and stated she would obtain a new vial to use for the resident. During an interview on 08/31/15 at 5:45 p.m., a licensed nurse (#16) stated six of the facility's residents are insulin-dependent diabetics. Observation of the six residents' insulin vials also showed Resident #16's Humalog insulin labeled	F 431	3) Nursing staff were in-serviced on the importance of checking for expired insulin bottles in the medication center weekly, checking insulin dates prior to administering insulin, and also to make sure the medication cart is locked at all times when not with the cart. Expired insulin was disposed of by pharmacy on resident #15, #16, and #17. Nursing staff checks and replaces expired meds in the medication cart and fridge the first and third Wednesday of each month. 4) The QA Coordinator or nursing designee will monitor resident #15, #16, and #17 and any other resident requiring insulin to be sure insulin is not expired and also will monitor to make sure medication carts are locked when not in nurse's view monthly X 3, then quarterly X 1 year. Monitoring to begin 10/2/15. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 431	Continued From page 31 with an "open" date of 07/25/15 (37 days ago), and Resident #17's Lantus insulin labeled 07/29/15 (33 days ago). - On 09/02/15 at 6:05 p.m., observation showed an unattended and unlocked medication cart in the lounge next to the dining room, with several drawers pulled open exposing medications. Several over-the-counter medication bottles sat on top of the cart. Observation showed no licensed nurse or medication aide remained by the cart, but several residents were in the lounge. A licensed nurse (#19) entered the lounge from within the dining room and stated awareness of the unlocked and open medication cart. During an interview on 09/03/15 at 8:55 a.m. regarding the unsecured medications in and on the cart in the lounge, an administrative nurse (#2) stated, "The nurse should have had the (medication cart) drawers shut and cart locked while administering medications to residents in the dining room."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		10/2/15

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F 441	Continued From page 32 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, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 2 of 10 sampled residents (Resident #1 and #5) observed during personal cares. Failure to follow established infection control practice for cleaning the floor after an incontinent episode and proper storage of hand sanitizer may result in the spread of infection within the facility	F 441	1)Nursing Staff were instructed on 10/2/2015 on the policy entitled "Cleaning Spills of Blood or Body Fluids." This instruction was for resident #1 and any other resident who has the potential to be affected. 2) Any resident who is incontinent of urine has the potential to be affected. All staff were educated on the importance of spraying disinfectant on any spill and	

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F 441	Continued From page 33 Findings include: Review of the facility policy titled "CLEANING SPILLS OF BLOOD OR BODY FLUIDS" occurred on 09/03/15. This undated policy stated, ". . . 4. Clean floor with the spray disinfectant as above to remove all of substance 5. Spray area with disinfectant spray until area glistens 6. Allow to air dry . . ." - Observation in Resident #1's room on 09/01/15 at 8:40 a.m. showed two certified nurse aides (CNAs) (#6 and #11) transferred the resident to a bath chair who then voided a large amount of urine onto the floor. One CNA (#11) reported she planned to get housekeeping and left the room. The other CNA (#6) waited for a few minutes, and then left the room stating she planned to get someone to help. An unidentified housekeeping staff member entered the room and placed several paper towels on the floor. The CNA (#6) pushed the resident from the room on the bath chair toward the bath house. Observation showed the bath chair's wheels left wet streaks trailing from the room several feet into the hallway. Observation between 8:52 to 9:02 a.m. showed the housekeeping staff member cleaned in the resident's room. Observation at 9:15 a.m. showed two CNAs (#6 and #15) and Resident #1 back in the resident's room. The CNAs assisted the resident with cares, and transferred him into his recliner. The CNA (#15) stated she had not seen anyone clean the hallway floors. During an interview on 09/01/15 at 9:40 a.m., an administrative nurse (#2) stated she expected CNAs to call housekeeping and have them clean	F 441	allowing it to air dry. 3) Nursing staff were in-serviced on the importance of making sure all spills are cleaned up prior to leaving the room to prevent the spread of infections. 4) The QA Coordinator or nursing designee will monitor resident #1 and any other resident who is incontinent of body fluids and will monitor any floor spills monthly X 3, then quarterly X 1 year. Monitoring to begin 10/2/15. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 441	Continued From page 34 the area after a resident experienced an incontinent episode on the floor.	F 441		