STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	06/30/2011

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on June 27, 2011 and completed on June 30, 2011, the sample included five (5) residents for complete review, eighteen (18) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**F-225 Investigation/Report Allegations/Individual** 1. Notification of injury of unknown origin will be reported. 2. All management staff will be re-educated on investigation of all alleged violations of mistreatment or abuse including injury of Unknown Origin. 3. Abuse policy and all facility investigation forms will be reviewed and updated as necessary 4. A quarterly review by Quality Assurance committee of all injury of Unknown Origin forms to assure compliance with these requirements. Corrected	8/4/11

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

Craig Thompson — CEO — 7-29-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the State survey and certification agency regarding 1 of 1 sampled resident (Resident #9) who sustained a fracture during cares. Findings include: Review of the facility's Abuse policy took place on 06/29/11. The policy, revised 04/06/10, stated, ". . . All alleged violations involving mistreatment; neglect or abuse, including injuries of unknown source; . . . will be reported immediately to the administrator and to other officials in accordance with State law . . . including the North Dakota Health Department. . . ." Record review for Resident #9 occurred on June 28-30, 2011. The resident's diagnoses included: cerebral palsy, scoliosis, osteoporosis, pain, quadriplegia, and history of a fracture. The most recent Minimum Data Set (MDS), dated 03/28/11, identified problems with short and long term memory, nonverbal pain indicators, and required	F 225		

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F 225	Continued From page 2 total assistance of two people with transfers and bed mobility. The comprehensive care plan identified Resident #9 required a mechanical lift (Hoyer lift) for transfers with two staff members. Review of the nurses' notes, dated 12/25/10, stated, "Res. [resident] in bed for nap. Staff went to sit her up to transfer to chair and rt. [right] knee made popping/cracking noise. Res. crying. Rt. knee swollen." Review of the facility's investigation, dated 12/28/10, identified the facility investigated the incident as an injury of unknown origin, did not substantiate abuse or neglect, however, failed to notify the State survey and certification agency. During an interview on the morning of June 30, 2011, an administrative staff member (#1) stated the facility did not notify the State survey and certification agency of the fracture or the results of the investigation.	F 225		
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: 1. Based on observation, record review, review of the EZ Stand Operating Instructions, review of policy, and staff interview, the facility failed to	F 323		

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F 323	Continued From page 3 ensure adequate assistance to prevent accidents for 3 of 3 residents (Resident #1, #2 and #3) in the Special Care Unit (SCU). Facility staff failed to transport Resident #1 in a safe manner in a wheelchair following a hip fracture, and failed to utilize all safety precautions when transferring Resident #2 and #3 with a mechanical stand lift. Failure to transport Resident #1 safely following a hip fracture, and utilize all safety measures of the mechanical stand lift places residents at risk of additional injury, pain, and falls. Findings include: Review of the "EZ Stand Operating Instructions" occurred on 06/30/11. The instructions manual, undated, stated: ". . . Patients should be able to bear some weight . . . Apply harness, Position the top of the harness around the upper body of the patient (approximately 2-3 inches below the under arm) . . . For the safety of the patient, securely fasten the safety strap around the patient's chest. On harnesses with the plastic buckles, secure the buckle and pull the loose strap to tighten. . . . Raise The Patient, Position the patient's arms on the outside of the harness and place their hands on the padded handles. . . ." Review of the facility policy "GAIT BELTS/MECHANICAL LIFTS" occurred on 06/30/11. The policy, dated 01/08, defined one of the purposes of the mechanical lifts as "To prevent resident from injury." Resident #1, #2 and #3 reside in the facility's 32 bed geriatric psychiatric SCU.	F 323	**F-323 Free of Accident Hazards/Supervision/Devices** 1. Residents #2 and #3 continue to use the standing lift, belts are tightened up with all transfers to prevent accidents as per updated policy Resident #1 has foot pedals to w/c that are used with all transportation with resident. Resident #6 had bed replaced with an electric bed that has openings in the bed rail of less than 4 ¾ inches (Zone 1). ½ rails are also made of metal rather than plastic on the electric beds 2. Gait Belt/Mechanical Lift and Side Rail policy was updated and Side Rail Safety Assessment was updated. All residents that are unable to self-propel will have pedals on w/c's will have pedals on them. 3. Education was held for all Nurses, CRA's and RA's. This inservice included training on how to use the standing lift, information that pedals needed to be on all w/c's unless the resident propels self, and that ½ rails are not to be used without the nurse completing the proper assessment and consent.	

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F 323	Continued From page 4 - Review of Resident #1's record occurred on all days of survey. Resident #1's diagnoses included severe vascular dementia, cerebrovascular disease, mood disorder, dysphagia, the presence of a feeding tube, and a repair of a left hip fracture on 06/15/11. The resident returned from a hospitalization for the hip fracture on 06/17/11. Observation on the morning of 06/28/11 showed a certified nursing assistant (CNA) (#3) provided Resident #1 morning cares, and the resident kept his eyes closed throughout these cares, including through a pivot transfer from the bed to the wheelchair. The resident also provided minimal verbal interaction with the staff member. After completion of morning cares on 06/28/11, the CNA (#3) transported Resident #1 from his room to the Sunshine dining room, turned the wheelchair around; transported the resident to a table in the TV room in the second wing, turned the wheelchair around; then transported the resident back down the same hall to sit next to the nurse's station while the CNA went to the resident's room. The CNA obtained the resident's oxygen concentrator in the resident's room, and then transported the resident to the TV room in the second wing. Observation showed the resident's feet skimmed the carpeted floor throughout these transfers and the resident's eyes remained closed. Review of Resident #1's current care plan identified the problem of the left hip fracture with goals of the resident having no complications related to the healing process, and approaches including a physical therapy evaluation, and	F 323	4. QA will be done quarterly to monitor how the CRA uses the standing lift with Transfers, monitor positioning and foot pedal use, use of ½ rails. Q.A will be completed by CRA Supervisors, Nurse Managers, Q.A. Coordinator, DON. Corrected 5. Date completed 7/21/11	7/21/11

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F 323	Continued From page 5	F 323		

assistance with repositioning "per routine et [and] prn [as necessary]." The care plan also identified the resident with a problem of "Impaired cognitively d/t [due to] dementia. Disorganized thinking."

Record review identified physical therapy visited Resident #1 between June 20-24, 2011, and discharged the resident from service on 06/24/11. Comments written on the therapy documentation form included:
06/22/11: "Does not open eyes to voice or tapping on arm & leg . . ."
06/23/11: "Does not arouse."
06/24/11: "[not] arouse. . . . [no] grimace [with] PROM [passive range of motion]. . . . See discharge. . . . Summary of significant progress towards goals . . . Did not arouse to progress pt [patient]. Will have to stop PT [physical therapy] due to pts [decreased] level of alertness when PT comes around. Staff to continue to transfer [with] gait belt & 1-2 assist as tolerated . . . Goals unmet due to [decreased] alertness . . ."

An interview occurred on the afternoon of 06/29/11 with a physical therapy (PT) staff member (#4). The therapist stated the therapist discharged Resident #1 from therapy due to his lack of alertness, and an inability to participate, and stated during his (PT) evaluation no wheelchair mobility and positioning had occurred. The therapist stated Occupational Therapy would do that. The therapist stated utilization of foot rests on the wheelchair following hip repair would be a good safety measure to protect the hip.

An interview occurred on the morning of 06/30/11 with a supervisory staff nurse (#5). The staff

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F 323	Continued From page 6 nurse agreed utilizing foot pedals during transport should be utilized due to Resident #1's recent hip fracture. - Review of Resident #2's record occurred on all days of survey. Resident #2's diagnoses included dementia with behavioral disturbances, history of previous closed head injury with spastic quadriplegia, and unspecified personality disorder. Resident #2's current care plan identified the problems of: * "I have an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] Dementia, Limited Mobility, past TBI [traumatic Brain Injury] * Advancing postural problems" with approaches including "TRANSFER: I require extensive assist of one to two for transfers. Utilize use of standing lift when I am leaning more, more tired and/or unsafe to transfer without standing lift." * "I am at risk for falls r/t Unaware of safety needs, Gait/balance problems, left sided weakness, leans head to rithe [right] and relates dizziness when head is in upright position; this has progressed, poor positioning with gait/sitting/eating, chronic torticollis r/t TBI" with approaches including ". . . Anticipate my needs . . ." Observation of facility staff failing to tighten the safety strap around Resident #2's chest during transfer with an EZ stand lift occurred on three occasions: * On 06/27/11 at 8:40 a.m., a CNA (#6) transferred Resident #2 from his wheelchair into the bathroom. Observation showed the safety	F 323		

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F 323	Continued From page 7 strap around the resident's chest hanging loosely with the resident in the standing position. * On 06/27/11 at 1:00 p.m., a CNA (#6) transferred Resident #2 from his wheelchair into the bathroom. Observation showed the safety strap around the resident's chest hanging loosely, with the resident in the standing position. Upon reaching the bathroom, prior to the CNA lowering the resident to the seated position, the resident took both hands off the padded handles, and the CNA (#6) asked the resident to place his hands back onto the handle bars. * On 06/29/11 at 2:45 p.m., a CNA (#3) transferred Resident #2 from the bed to the bathroom. Observation showed the safety strap around the resident's chest hanging loosely with the resident in the standing position. - Review of Resident #3's record occurred on all days of survey. Resident's #3's diagnoses included dementia with behavioral disturbances, paralysis agitans (Parkinson's disease), anoxic brain damage, and cerebrovascular accident. On the morning of 06/27/11, two CNAs (#6 and #7) transferred Resident #3 with an EZ stand lift from his bed to the bathroom and then to the wheelchair. During these transfers, the CNAs failed to tighten the safety strap around the resident's chest. During the transfer to the bathroom, observation showed Resident #3 angry and hollering at staff. When staff raised Resident #3 into an upright position to provide pericare, Resident #3 raised his hands upright as though reaching to strike outward and let go of both handle bars of the EZ stand lift during those cares. Record review, included a Minimum Data Set	F 323		

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F 323	Continued From page 8 quarterly summary, dated 05/05/2011, which stated, ". . . with dx. [diagnosis] of dementia with behavioral disturbances . . . Has periods of yelling out and combative behavior toward staff during cares, which occurs 5 to 6 times a week . . . Requires assist of one or two with transfers and needs the standing mechanical lift for all transfers . . ." An interview occurred on the afternoon of 06/29/11 with an administrative staff member (#1). The staff member (#1) stated the safety strap on the EZ stand lift should be tightened upon moving residents to the standing position if the belt loosens with the change in position from sitting to standing. The staff member agreed this should have occurred with both Resident #2 and #3. 2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure the environment was as free of accident hazards as possible regarding potential entrapment for 1 of 1 sampled resident (Resident #6) with a large opening within a bed side rail. Openings within the bed side rail of greater than four and three quarter (4 3/4) inches pose potential entrapment risks to residents. Findings include: The Food and Drug Administration (FDA) recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. . .	F 323		

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F 323	Continued From page 9 DIMENSIONAL LIMITS FOR IDENTIFIED ENTRAPMENT ZONES 1-4 . . . ZONE 1 -WITHIN THE RAIL, Zone 1 is any open space within the perimeter of the rail. . . . recommend that the space be less than 120 mm [millimeters] (4 3/4 inches . . .)" Review of Resident #6's medical record occurred on June 27-30, 2011. The facility admitted the resident in April 2004. The resident's current diagnoses included right extremities weakness due to previous stroke and convulsions. The resident's quarterly Minimum Data Set (MDS), dated 04/30/11, identified short and long term memory problems, required extensive assistance of one person for bed mobility, a bed rail used less than daily, and the resident's weight of 249 pounds. Resident #6's Restraint Care Area Assessment, dated 01/30/11, identified the resident used a side rail for mobility only. The resident's Side Rail/Safety Assessment, dated 06/26/11, identified the resident used a side rail for bed mobility and repositioning in bed at his request. The Assessment lacked identification of the spacing within the side rail, the stability of the side rail, and the resident's history of convulsions or seizures. Resident #6's current care plan, dated 02/09/11, stated "Focus, I have Seizure Disorder . . . Interventions . . . SEIZURE PRECAUTIONS: Protect from injury . . . Focus, I have an ADL [Activities of Daily Living] Self Care Performance Deficit . . . BED MOBILITY: . . . I like to have my siderails up at all times when in bed as I can move side [sic] and assist with turning. [modified	F 323		

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F 323	Continued From page 10 06/26/11] Uses 1/2 rails to aid [with] repositioning. Consent obtained, not a restraint. . . ." Resident #6's Nurse's Progress Notes identified the resident experienced seizures, observed by facility staff, while in his wheelchair on 11/14/10 and 04/14/11. Observation throughout the survey identified a side rail at the top half, on the right side of Resident #6's bed. The side rail was constructed of light weight plastic material approximately one half inch square with spaces of approximately eight inches between the supports within the side rail. Observation on 06/28/11 identified Resident #6 supine in bed and received a dressing change at 7:45 a.m.; and, received morning cares and was dressed by a facility staff member at 8:15 a.m. During these observations the resident rolled partially to his right, grasped the right side rail with his left hand, and assisted to turn to his right side with the side rail. The side rail bent to approximately a 45 degree angle to the bed when Resident #6 pulled on the rail. During interview, on 06/30/11 at 9:00 a.m., a supervisory nursing staff member (#5) reported the facility did not consider the side rail spacing as an entrapment hazard, the stability of the side rail, or the resident's seizure disorder, when the assessment was completed. Failure to consider the spacing within the side rail and Resident #6's recent history of seizures placed him at risk of entrapment and injury in the side rail. The resident's size and use of the side	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 11 rail for bed mobility placed a strain on the side rail which also placed the resident at risk of injury if the side rail broke.	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 observation, record review, policy and procedure review, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #15) who experienced weight loss. Failure to implement interventions or evaluate the effectiveness of current interventions may have contributed to Resident #15's severe weight loss. Findings include: Review of the facility's policy "Nutritional Supplementation" occurred on the morning of 06/30/11. The policy, revised February 2010, stated, ". . . 2. Nourishments will be offered with meals as determined by the LRD [Licensed Registered Dietitian]/Nutrition Coordinator/Diet	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 12 Clerk. . . ." Review of the facility's policy "Adaptive Equipment Usage" occurred on the afternoon of 06/30/11. The policy, revised February 2010, stated, ". . . 2. RDLRD [Registered Dietitian Licensed Registered Dietitian] will observe resident at a meal and assess for adaptive equipment. The appropriate utensil/cup/equipment will be offered and assessed for acceptance and usage. . . ." Review of Resident #15's medical record occurred June 28-30, 2011. The resident's medical diagnoses included Alzheimer's disease, anemia, delusional disorder, depressive disorder, and anxiety. Review of Resident #15's "Nutritional Risk Assessments," completed on 03/17/11 and 06/17/11 identified the resident at high nutritional risk. The assessment identified the resident's current weight of 97.2 pounds and her IBW (Ideal Body Weight) as between 100-122 pounds. Review of Resident #15's weight summary showed a severe weight loss (15.2 pounds or 14.3% in 180 days). Weekly weights included the following: *January, Week 1, - 106.2 # *February, Week 1 - 102.8 # *March, Week 1 - 101.4 # *April, Week 1 - 100.2 # *May, Week 1 - 97.2 # *June, Week 1 - 92.8 # *June, Week 2 - 97.2 # *June, Week 3 - 91.8 # *June, Week 4 - 91.0 #	F 325	**F-0325 Maintain Nutrition Status Unless Unavoidable** 1. Resident #15 Supplements and food items listed on resident diet card are provided at meal service. Adaptive Equipment (Sippy Cups) are provided at meals and portion size listed on diet card is followed. 2. Identify needs at initial and quarterly assessment, also PRN basis. In-service dietary staff on following Therapeutic menu and portion sizes. Diet Card will list items such as supplements, adaptive equipment. Hi=-cal food items and other nutritional interventions need to be followed. Awareness of Supplement List will be made to staff on Adaptive Equipment List and Hi-cal Potatoes List. 3. List of Supplements, adaptive Equipment, and Hi-Cal Potatoes will be available in all dining areas for staff reference. Educate staff on lists' purpose and location. 4. Nutritional Monitoring assessment will be completed for resident identified with significant weight loss. Chart intake of supplements at meals, snack and PRN. Title of person monitoring Nutrition Coordinator. 5. Date completed.	8/4/11

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	355077	A. BUILDING _____ B. WING _____	06/30/2011

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F 325	Continued From page 13 A 10% weight loss or more in 180 days indicates a severe weight loss. Review of Dietary notes identified the following: *04/20/11 - "Diet order, weight, variance, intake, lab assessment. Showing a significant weight loss . . . Offer high calorie mashed potatoes prn. . . ." *06/16/11 - "Diet/Consistency and Nutritional Supplement Order, Intake, weight and status: Wt. 97.2#, 7.9% in 6 months IBW 100-122# Regular, NAS diet intake 25-75% of meals with 540 cc's [cubic centimeters]. Upper and lower dentures fair, not able to chew tough foods, no swallowing difficulties, feeds self. 5/11 labs reveal low Hgb. [Hemoglobin] Skin is intact. Change in Dining abilities: No change. Action Plan: Continue to monitor. . . ." Review of Resident #15's care plan, initiated on 04/21/08, identified "Alt [Alteration] in Nutrition" and the handwritten addition dated 06/08/11 of "significant wt. [weight] loss." The care plan included the following interventions: *11/04/10 - "Offer 8 oz milk at brunch, dixie cup [ice cream], offer 4 oz Nutrashake (a high calorie and protein supplement) at brunch and dinner." *04/21/08 - "Offer candy bars prn [as needed]." *04/21/08 - "Offer 6 oz meat qd [every day], Vit C JC [vitamin C juice] bid [twice a day] *04/21/08 - "Monitor intake q [every] shift." *10/16/09 - "Offer 1/2 servings of potatoes, vegetable, dessert except meat and fruit, 1/2 sl [slice] bread." *11/04/10 - "Offer sipper cups with meals." *04/19/11 - "Offer [high] cal [calorie] potatoes [prepared with half and half and butter by dietary	F 325		

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F 325	Continued From page 14 staff] [at] dinner when on menu." *06/08/11- "Offer [high] cal potatoes at dinner [and] brunch." Observation of the evening meals, on 06/28/11 and 06/29/11, showed facility staff failed to serve Resident #15 a 4 oz Nutrashake. Observation of the brunch meals on these days also showed the resident consumed none of her 4 oz. Nutrashake. Observation of the brunch and evening meals, on 06/28/11 and 06/29/11, showed facility staff failed to serve Resident #15's fluids in sipper cups. Observation of the brunch meal on 06/28/11 and the brunch and evening meals on 06/29/11, showed facility staff failed to serve Resident #15 high calorie mashed potatoes. Observation of the brunch and evening meals on 06/28/11 and 06/29/11, showed facility staff failed to serve Resident #15 half servings of potatoes, vegetables, and dessert. Observation of the brunch meal on 06/29/11, showed facility staff failed to serve the resident a half serving of bread. Review of the Nurse's Notes and an interview of the administrative dietary staff member (#9) on the morning of 06/30/11, identified Resident #15 had no edema [swelling] caused by fluid gain or loss, illnesses, or hospitalizations which would have contributed to the resident's weight loss. Interviews on the morning of 06/30/11, identified the following: Regarding the Nutrashake supplement- *CNAs (#10 and #11) stated Resident #15	F 325		

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F 325	Continued From page 15 "sometimes" drinks her Nutrashake. *Dietary staff member (#12) stated she does not consistently record meal intakes when short dietary staff. *Administrative dietary staff member (#9) stated facility staff members should provide Resident #15 with a "Nutrashake" supplement as indicated on the resident's diet card. *Administrative dietary staff member (#9) also stated dietary staff record a hard copy of meal intakes only if computer system problems occur. This staff member identified the computer system used for recording meal intakes did not identify the residents' supplement intake. Review of the six hard copy meal intake records available for the last month, revealed no supplement provided for 5 of 6 dinner meals and the supplement not consumed for 1 of 6 dinner meals. Regarding the sipper cups: *Administrative dietary staff member (#9) stated the observed glasses with straws would not be the same as sipper cups. This staff member stated dietary staff members are to review, the "Feeding Devices Report" prior to setting tables and should set them with the planned assistive devices. Review of this report and the resident's diet card showed both included SC (sipper cups) (with) lids for Resident #15. On the afternoon of 06/30/11, this staff member provided a Progress Note, dated 12/02/09, which stated, "[increased] spillage [with] glasses. Offered sipper cups [with] gd [good] results. Offer sipper cups [with] meals." Regarding the high calorie potatoes and half portions: *Dietary staff member (#13) confirmed she did not serve high calorie mashed potatoes to	F 325		

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F 325	Continued From page 16 Resident #15 as indicated on the "Hi Cal Potatoes" list and the resident's diet card at 3 of 4 observed meals. The dietary staff member (#13) stated either the meal included potatoes (i.e. tator tot hotdish), potatoes were not included with the meal (i.e. soft shell taco), or it "overwhelms" the resident (i.e. egg mcmuffin). When asked if Resident #15 received small portions, the dietary staff member (#13) stated she did not provide the resident small portions. *Administrative dietary staff member (#9) confirmed Resident #15 is to receive high calorie potatoes at all brunch and dinner meals. The staff member also confirmed Resident #15 is to receive small portions, except for meat and fruit as identified on the resident's diet card. Failure to provide all the planned nutritional interventions (high calorie/protein supplement, high calorie potatoes, small portions, and sipper cup assistive devices) at all meals as care planned and failure to monitor for implementation/effectiveness of these interventions may have contributed to Resident #15's severe weight loss.	F 325		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1) received medications through a	F 333		

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F 333	Continued From page 17 feeding tube according to professional standards of care. Failure to verify medication orders prior to administration may jeopardize the resident's health, and failure to administer medications properly may affect the patency of the resident's feeding tube and cause unnecessary replacement of the feeding tube. Findings include: Review of the facility policy "Medication administration via the feeding tube" occurred on 06/28/11. The policy, dated 02/10, stated: "A physician's order is required for the administration of any medication via feeding tube. Liquid dosage forms should be ordered if available. Tablets that must be crushed prior to administration via feeding tube require a specific order. . . . PROCEDURE: 1. Confirm the physician's order. 2. Assemble all equipment and supplies. 3. Prepare the medications for administration. Do not mix different medications unless there is a specific Physicians order to do so. a. Tablets - crush tablets to a fine powder and mix with 30 ml [milliliters] of water or other appropriate liquid to form slurry. b. Capsules - open and mix with 30 ml of water or other appropriate liquid to disperse well. . . . d. Liquid medications - dilute with 30 ml of water. . . . 13. Administer prescribed medication by pouring the liquefied medication into the syringe and allowing gravity flow. Never force medication into the tube. Gentle instillation may be necessary. 14. After administering each medication	F 333	**F-0333 Resident Free of Significant Med Error** 1. Nurse involved with both of these incidents has since resigned. Medication Administration per Feeding tube is done according to updated policy. All medications are given as ordered and updated policies are followed. 2. All residents with feeding tubes will have the updated policy followed for medication administration. The above policies were updated on 7/19/2011. Included in this POC No medications will be given if there are discrepancies between the prescription label and the MAR, as per updated policy. 3. All nurses were educated on the updated "Medication Administration via feeding tube policy". All nurses and medication assistants were educated on Medication Administration. See Nurses Meeting Minutes, included in this POC 4. Date of Completion is 7/20/11 5. QA on "Medication Administration" will be done quarterly by the Nurse Managers, Quality Coordinator and the DON.	7/20/11

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F 333	Continued From page 18 individually, flush the tube with 30 ml of water or prescribed flush to clear tube and decrease chance of clogging. . . . 22. Document in the MAR [Medication Administration Record]." Review of the facility policy "Administration of Medicines Orally" occurred on 06/28/11. The policy, reviewed/revised 01/08, stated: ". . . STEPS IN THE PROCEDURE: 1. Remove medication from resident's drawer in med cart. 2. Put verified dose into medicine cup, checking the label three times. a. When removing from drawer. b. When pouring. c. When returning to drawer. . . ." - On 06/28/11 at 7:40 a.m., observation showed a staff nurse (#2) holding a 60 cubic centimeter (cc) syringe connected to Resident #1's feeding tube. The nurse stated the feeding tube was "clogged" with the medications she was administering and asked the CNA (#3) for assistance. The nurse requested the CNA to obtain another syringe for her. The nurse stated the resident's medications included capsules (that she had opened up) and tablets (that she had crushed), which she had prepared for administration into one medicine cup. The nurse stated she administers the medications by mixing water into a medicine cup and swirls the water around just prior to pouring the medicine into the syringe. The nurse stated she does not dissolve the medicines in advance, nor does she mix each medication separately into individual medication cups. The CNA returned with a new syringe. The nurse	F 333		

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F 333	Continued From page 19 aspirated water into the new syringe, attached it to the feeding tube port, and applied pressure in an attempt to unclog the feeding tube. The nurse added water to the remainder of medications in a medication cup at the resident's bedside, swirled the medication cup, and poured them into the 60 cc syringe, and administered them per gravity and flushed the tubing with water. Review of Resident #1's current medication administration record (MAR) occurred following the above observation. The MAR identified a new order, (first dose administered on this a.m.) dated 06/27/11, for "Augmentin 815 po [by mouth] BID [two times a day]" for 10 days. The nurse showed the surveyor the pharmacy (medication) card. The card label read "Augmentin 875/125" milligrams. When the nurse was questioned regarding the discrepancy with the MAR, the nurse took an ink pen and wrote on the MAR, "125 mg" so the MAR now read "Augmentin 815 po 125 mg BID." When the nurse was questioned a second time about the discrepancy with the Augmentin dose, the nurse then checked the physician's order and stated the physician's order was for 875 mg of Augmentin. Review of the physician's order, dated 06/27/11, stated, "start Augmentin 875 BID x 10 d [days]." The nurse stated she would check with pharmacy at 9:00 that morning as well. The nurse failed to clarify the dose of the Augmentin prior to administering that first dose. The dose written on the MAR was inconsistent with the physician order, and the medication card. The morning medications administered by the nurse (#2) via the feeding tube included seven crushed medications, two opened capsules, and	F 333		

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F 333	Continued From page 20 two liquid medications: * Augmentin 875 milligrams (mg) tablet, crushed * Celexa 30 mg tablet, crushed * Digoxin 0.125 mg tablet, crushed * Diltiazem CD 120 mg capsule, opened * Aspirin 81 mg tablet, crushed * Hydrochlorothiazide 25 mg tablet, crushed * Atarax 25 mg, liquid * Iron 300 mg, liquid * Neurontin 300 mg capsule, opened * Tylenol 1000 mg tablets, crushed * Risperdal 1 mg tablet, crushed During interview on the morning of 06/28/11, the staff nurse (#2) stated that occasionally Resident #1's feeding tube gets clogged when she is administering medications and she will utilize a syringe to get it unclogged by applying pressure with water. The nurse reiterated she does not mix each medication with water prior to administration. An interview occurred with an administrative staff member (#1) on the afternoon of 06/29/11. The staff member stated medications administered through the feeding tube should be given individually as per facility policy and water should be given between each medication. The staff member stated medications should be verified prior to administration, if necessary. The staff member stated a liquid dosage form should be used for all medication given through a feeding tube when liquids are available, including the Augmentin.	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 21 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to act upon on the consultant pharmacist's report of a medication irregularity for 1 of 1 sampled resident (Resident #6)receiving a prophylactic antibiotic. Failure to act on the consultant pharmacist's report placed the resident at risk of side effects and undesired responses to the antibiotic. Findings include: Nursing 2011, 31st edition, Lippincott, Williams and Wilkins, Philadelphia, pages 267 - 270, regarding Septra DS, identified this medication as "Anti-infective, sulfonamide [antibiotic] . . . ADVERSE REACTIONS, CNS [Central Nervous System]: seizures . . . INTERACTIONS, Drug-drug. . . . Warfarin [Coumadin]: May increase anticoagulant [blood thinning] effect. . . . NURSING CONSIDERATIONS . . . 'DS' product means 'double strength' . . ." Review of Resident #6's medical record occurred on June 27-30, 2011. The facility admitted the	F 428	**F-0428 Drug Regiment Review, Report Irregular, Act On** 1. Resident #6 had recommendation reviewed by physician and the medication was decreased 2. Pharmacy reviews are done monthly. Nurse Managers will leave all recommendations written for physicians in their folders on the unit to be addressed monthly per "Medical Review Regimen" policy 3. Policy updated and Nurse Managers Educated on the updates. Included in this POC. 4. Date of Completion is 7/20/11 5. QA on Pharmacy Recommendations will be done quarterly by the DON.	7/20/11

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F 428	Continued From page 22 resident in April 2004. Current diagnoses included convulsions, chronic urinary tract infections (UTIs), and right extremities weakness due to previous stroke. The resident's current physician orders, renewed on 05/19/11, included the following: *Coumadin 5 milligrams (mg), half tablet, daily, Monday *Coumadin 5 mg, one tablet, daily, Tuesday through Sunday *Septra DS, one tablet, two times each day, initiated on 03/23/09 Resident #6's current care plan, dated 02/09/11, stated "Focus, I am on Antibiotic Therapy long term r/t [related to] chronic UTI's. . . . Interventions . . . Administer medication as ordered. Ask physician to review medication for possible dose reduction every three months. . . ." Resident #6's Nurses' Progress Notes identified the resident experienced seizures on 11/14/10 and 04/14/11. Resident #6's medical record included a Consultant Pharmacist's Medication Review, dated 02/11/11, which stated "IRREGULARITY . . . 2. Patient has been taking treatment dose of Septra since March 2009. The typical preventive Septra dose is one tab [tablet] once daily. SUGGESTED COURSE(S) OF ACTION . . . 2. Consider reducing Septra DS to QD [every day]. . . . IMPLEMENTATION TIME FRAME . . . Review with the resident's physician during his/her next visit, but no later than two (2) months. . . ." This Review form was signed by a supervisory nurse (#5) on 03/17/11.	F 428		

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F 428	Continued From page 23 The medical record lacked evidence facility staff made Resident #6's physician aware of or responded to the consultant pharmacist's recommendation of 02/11/11. During interview, on 06/30/11 at 9:00 a.m., the supervisory nursing staff member (#5) confirmed Resident #6's physician did not respond to the consultant pharmacist's recommendation. Staff member (#5) was uncertain if the facility staff had made the physician aware of the recommendation. Resident #6 receives scheduled anticoagulant medications and has a history of seizures, which may be affected by Septra. The resident experienced recent seizures. Resident #6 has received Septra DS two times each day for more than two years which may have affected the amount of anticoagulant medication required and may have contributed to his recent seizures. Failure to ensure the resident's physician was aware of and responded to the consultant pharmacist's recommendation for dose reduction of the Septra DS placed Resident #6 at risk of receiving excessive antibiotic and anticoagulant medications, and placed him at increased risk of seizures.	F 428		
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 -	F 441		

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F 441	Continued From page 24 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policies and procedures, and staff interview, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 3 of 22 sampled residents (Resident #1, #2, and #8) and one supplemental resident (Resident #27). Failure to maintain a safe and sanitary	F 441	**F-0441 Infection Control, Prevent Spread, Linens** 1. The CNA's involved directly in the deficiency (#3 and #16) were educated on the Infection Control policies they had failed to follow. This education included: Hand Hygiene, Handling of Contaminated Articles and Standard Precautions and Glove usage. 2. All residents and staff have the potential to be affected by this deficient practice, so along with providing initial education to direct care providers, there will be on-going education provided through monthly staff meetings and in-services through out the year. 3. Education was provided for the Nurses, CNAs and RAs, which was completed on 7/21/2011. The in-services included education regarding the Infection Control Policies that were not followed. Education included hand hygiene, glove usage, standard precautions, handling contaminated articles and/or material containing blood or body fluids. The initial education was completed on 7/21/2011. 4. QA will be done on a monthly	7/21/11

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	355077	A. BUILDING _____ B. WING _____	06/30/2011

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F 441	Continued From page 25 environment has the potential to place all residents, visitors, staff, and the public at risk of developing disease and infections. Findings include: Review of infection control policies and procedures occurred on all days of survey. The following policies and procedures stated: * Hand Hygiene, revised 03/01/10: "Hand Hygiene: This is a general term that applies to washing hands with either water and plain soap or soap detergent containing an antiseptic agent or thoroughly applying an alcohol-based hand rub. Gloves are not a substitute for hand hygiene. Hand Washing: This refers to washing hands with plain soap and water. . . . 1. HAND HYGIENE WITH HAND SANITIZER SHOULD BE PRACTICED: . . . f. Before and after assisting a resident with personal care (e.g. oral care, bathing). . . . i. Upon and after coming in contact with a resident's intact skin (e.g. when taking a pulse or blood pressure, and lifting a resident). . . . m. After removing gloves or aprons. . . . For food service or other employees handling or processing foods, hands must be washed with plain soap and water." * Standard Precautions, revised 03/10: "Sheyenne Care Center practices Standard (Universal) Precautions with all residents when there is potential for blood, semen, body tissue, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, saliva in dental procedures and other body fluids containing visible blood. Body	F 441	basis on random staff and shifts to monitor compliance of the involved Infection Control Policies. The Monthly QA Report Sheet has been updated to include more details on specific items. Persons responsible for monitoring will be CNA Supervisors, QA Coordinator and DON. The findings are discussed at our QA meetings to help direct education and QA needs. **2. Part** 1. Nursing staff member #14 has corrected records to reflect the missing culture results and added the name of organism to the floor plan used for mapping if applicable. 2. All residents and staff have the potential to be affected by this deficient practice. 3. The Quality Assurance Coordinator/Infection Control Nurse (staff member #14) updated the Infection Control Log on 7/6/2011 to include onset information (Nosocomial or Admission). Also, the causative agent/organism will now be identified on the Infection Control Log and the floor plan (see attached example of floor plan). All causative agents/organisms will be discussed at monthly QA Meetings	

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F 441	Continued From page 26 fluids are always considered infectious, if there is any doubt. . . . 1. GENERAL: . . . F. Spills of body fluids are cleaned up immediately after the occurrence of the spill by gloved personnel using products from the 'Spill Kit'. 1. The Spill Kit is kept in the Nurses Stations: See policy 'Handling of Contaminated Articles'. 2. RESIDENT SERVICES: . . . B. All linen removed from resident beds is immediately placed into the plastic lined soiled linen hamper, which was brought into the resident's room or in the doorway of the resident's room. . . . D. All disposable briefs are singly bagged and tied to prevent leakage and placed in the garbage bucket. . . . G. Reusable equipment with body fluid exposure are bagged and then taken to the Soiled Utility Room. 1. Wearing gloves, the equipment is cleaned with the facility disinfectant. 2. The reusable equipment is sprayed with the facility disinfectant. 3. Large items are cleaned in the resident's room with the facility disinfectant. . . ." * Handling of Contaminated Articles and/or Materials contaminated with Blood or Body Materials, revised 02/08/07: "POLICY: Any articles and/or material in your work area which become contaminated with blood or body fluids containing visible blood must be handled with safe technique and proper equipment. . . . PROCEDURE: 1. When a blood or body fluid containing visible	F 441	and meeting minutes will reflect such. 4. Forms were updated and the changes in documentation began on 7/6/2011. 5. The Quality Assurance Coordinator/Infection Control Nurse will be responsible to report on all completed culture results to the QA Committee on a monthly basis. It will also be the responsibility of this person to keep accurate and complete records of all infections and the causative agent/organism.	7/6/11

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F 441	Continued From page 27 blood spill occurs, notify housekeeper on duty. . . 4. Put on gloves. 5. If spill is minimal, apply disinfectant cleaner as directed on container. . . . Wipe with paper towel. . . . Remove gloves and dispose of them. . . ." - Observation on the morning of 06/28/11, showed a certified nursing assistant (CNA) (#3) provided bathing, incontinence, and oral cares for Resident #1. The resident wore a brief saturated with urine, and during incontinence cares, observation showed incontinence of bowel movement (BM). Throughout the bathing and incontinence cares, the CNA utilized a plastic lined garbage can at the resident's bedside to throw the towels, washcloths, the urine saturated incontinent brief, disposable wipes (some contaminated with BM), and toothettes used for the oral care. The linens draped over the outside of the garbage can. The CNA failed to use a separate soiled linen cart from soiled waste receptacle throughout the cares provided. After transferring Resident #1 from the bed to the wheelchair and performing oral cares with a toothette, the CNA (#3) exited the resident's room, transporting the resident in his wheelchair. The CNA failed to remove her gloves and perform hand hygiene prior to exiting the room. The CNA continued to wear the same pair of gloves as she transported Resident #1 throughout the hallway. The CNA, wearing the same gloves, returned to the resident's room, obtained the resident's oxygen concentrator, and then pushed the concentrator and resident to the second wing TV room. At that time, the CNA applied the resident's oxygen cannula to his nares, and then removed her gloves. The CNA	F 441		

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F 441	Continued From page 28 then walked to the Sunshine diner kitchenette. The surveyor approached the CNA and asked her to wash her hands. The CNA stated she used the hand sanitizer on the wall as she entered the kitchenette. The CNA entered the kitchenette to obtain breakfast for Resident #1. Observation showed no dietary staff members present to assist with any food preparation. The CNA failed to wash her hands with soap and water prior to handling food. During an interview on the afternoon of 06/29/11, an administrative staff member (#1) stated a garbage can should not be used for throwing linens into during personal cares and stated a linen cart should have been used for that purpose. The staff member also stated the CNA should have performed hand hygiene prior to exiting Resident #1's room, and hand washing should have occurred prior to obtaining food from the kitchenette. - On 06/27/11 at 8:20 a.m., Resident #2 sat in his wheelchair in the third wing dining room of the special care unit (SCU). Observation showed a large amount of sputum on Resident #2's right wheelchair arm rest, and a staff nurse (#8) obtained two paper towels and wiped off the sputum. The nurse performed hand hygiene, however failed to sanitize the resident's wheelchair arm rest. During an interview on the afternoon of 06/29/11, an administrative staff member (#1) stated surfaces should be cleaned after soiled with sputum, and would expect more than just wiping the surface with a paper towel.	F 441		

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F 441	Continued From page 29 - On 06/29/11 at 5:45 p.m., Resident #27 sat in her wheelchair in the hallway between the elevator and nurses' station. Nasal secretions extended from the resident's nose to the surface of her wheelchair's tray table. Observation showed one unidentified CNA knelt before the resident to adjust her feet and two unidentified CNAs passed by the resident. The CNAs failed to assist the resident with personal hygiene and/or sanitize the resident's wheelchair tray table. During an interview on 06/30/11 at 10:05 a.m., an administrative nursing staff member (#15) stated a CNA should have assisted Resident #27 to "blow her nose and wash her hands," and then "clean and sanitize" the table tray. - During the initial facility tour, on 06/27/11 at approximately 11:15 a.m., a supervisory nursing staff member (#5) reported Resident #8 returned to the facility over the weekend with respiratory "MRSA" (Methicillin Resistant Staphylococcus Aureus) infection control precautions. Review of Resident #8's medical record occurred on June 27-30, 2011. The facility originally admitted the resident in June 2010. The resident's most recent acute hospitalization was June 23-25, 2011. The resident's current diagnoses included pneumonia. Resident #8's medical record included a Microbiology Report from the acute care facility, dated 06/24/11, which stated "MRSA screen - positive. Place pt. [patient] in contact isolation." The resident's annual Minimum Data Set (MDS), dated 06/03/11, identified the resident was cognitively intact, required extensive assistance	F 441		

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F 441	Continued From page 30 of one person to transfer, and for toilet use. The resident's current care plan, dated 06/13/11, stated "Focus, I have an ADL [Activities of Daily Living] Self Care Performance Deficit . . . Interventions . . . Transfer: I require extensive assist of one staff participation and stand-up lift with transfers. . . . [modified 06/25/11] Problems . . . I have mild pneumonia, hx [history] [of] MRSA - cognitively aware enough to cover cough. No precautions other than cover cough. . . . Approaches . . . 5. Cover cough @ [at] all times. . . ." Observation throughout the day on 06/28/11 identified Resident #8 with a non-productive cough, sometimes covering her mouth with her bare hand, sometimes with a tissue, and sometimes without covering. Observation on 06/28/11 at 10:25 a.m. identified a CNA (#16) using a stand lift to transfer Resident #8 to and from the bathroom for morning cares and toileting. During this process, the resident held on to the handles of the lift. At the completion of care, the CNA (#16) removed the stand lift from the resident's room and placed it in an alcove down the hall from the resident's room, along with other lifts available for use by other staff members for other residents. The CNA (#16) then brought the bagged garbage and soiled linen from the resident's room to the soiled utility room and went to the dining room to obtain Resident #8's requested in-room lunch. Before reaching the dining room, the surveyor stopped the CNA (#16) and asked the CNA if she had cleaned the stand lift after using it with Resident #8. The CNA (#16) responded that Resident #8 had "some type of infection," the	F 441		

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F 441	Continued From page 31 resident should cover her cough, and she (the CNA) had forgotten to clean the stand lift. The CNA (#16) continued to the dining room, assisted residents with their noon meals, and obtained Resident #8's in-room lunch. The CNA (#16) failed to clean the stand lift with the facility's disinfectant after use with Resident #8 and after prompting by the surveyor. During interview, on 06/28/11 at approximately 12:00 noon, the CNA (#16) reported she did clean the lift after obtaining Resident #8's lunch. The stand lift remained in the alcove, available for use by other staff with other facility residents without being cleaned for approximately one hour. It is unknown if it was used during this period. During interview, on 06/30/11 at 9:00 a.m., a supervisory nursing staff member (#5) confirmed the CNA (#16) should have cleaned the lift after removing it from Resident #8's room and before going to the dining room. Failure to clean the stand lift with the facility's disinfectant after use by a resident with known MRSA placed other staff and residents at risk of contact with MRSA. 2. Based on review of the facility's infection control program, review of facility policy and procedure, and staff interview, the facility failed to maintain an infection control program designed to track, analyze, and prevent the spread of infections within the facility for 6 of 6 months (January - June 2011) reviewed. Failure to track and analyze infections has the potential to affect the health and safety of facility residents, staff, and visitors.	F 441		

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F 441	Continued From page 32 Findings include: Review of the facility's policy "Infection Control Program" occurred on the afternoon of 06/30/11. The policy, revised February 2010, stated, ". . . Objectives: . . . 2. Attempt to limit the development and transmission of infections. . . . Procedure: 1. The Resident Infection Log . . . will be use for identifying and documenting both Admission and Nosocomial [facility acquired] infections. Investigation of each report will be completed by Infection Control Nurse. . . ." Review of the facility's policy "QI [Quality Indicators]/Infection Control Committee" occurred on the afternoon of 06/30/11. The policy, revised February 2010, stated, ". . . 3. Cultures of drainage may be obtained by professional staff as deemed appropriate and reported to the Infection Control Nurse . . . ." Review of the Infection Control Log for the past six months (January - June 2011) occurred on the morning of 06/30/11. For all entries, the log failed to include evidence of a completed culture and the causative agent/organism identified on the culture. During an interview on 06/30/11 at 1:15 p.m., a nursing staff member (#14) 1) agreed tracking and trending of the completed cultures, and 2) review of the results (causative agent/organism and susceptibility of the organism to antibiotics) should be completed and shared at Quality Assurance meetings. This staff member stated she lacked evidence she had completed this tracking, trending, and reporting of results to the	F 441		

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F 441	Continued From page 33 facility's Quality Assurance Committee.	F 441		