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 _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 07/25/16 and completed on 07/28/16, the sample included 5 residents for complete review, 18 residents for focused review, and 3 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 241 SS=D	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 and staff interview, the facility failed to provide care for 2 of 23 sampled residents (Resident #4 and #18) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors or wait for a reply before entering a resident's room (Resident #4), failure to feed a resident in a dignified manner (Resident #4), and failure to intervene when a resident is demonstrating spitting behaviors during mealtime (Resident #18) does not promote residents' dignity or enhance their quality of life. Findings include: - Observations showed the following: * 07/25/16 at 5:33 p.m., a certified nursing assistant (CNA) (#8) stood over Resident #4 as	F 241	1. All staff will be re-educated on the importance of knocking on doors and waiting for response prior to entering or not entering a residents' room. Staff was also educated on sitting so they are eye level with all residents during meals. Resident #18 has supervision with all meals and is redirected when needed. Resident #4 staff was educated on importance of waiting until asked to enter residents room. 2. All residents have the potential to be at risk. 3. A mandatory in-service will be held on 8/18/16 and 8/23/16 to educate all staff on the importance of dignity for all residents.	8/24/16

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

Electronically Signed | 08/24/2016

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F 241	Continued From page 1 she attempted to feed him. Midway through the meal, a second CNA (#9) took over for her, and he too, stood over Resident #4 as he attempted to feed him the remainder of the meal. * 07/25/16 at 8:29 a.m., a nurse (#5) and a CNA (#4) provided personal cares for Resident #4. During the cares, a second CNA (#6) knocked on the resident's door and entered the room, even though she was asked to wait. Moments later, a dining aide (#7) knocked on the resident's door, and without waiting for permission, entered the room. During an interview on the morning of 07/28/16, an administrative nurse (#10) stated she expected facility staff to knock and wait for permission before entering a resident's room and to be seated when feeding residents. - Observations showed the following: * 07/25/16 at 4:45 p.m., showed Resident #18 seated in his wheel chair at a table in the dining room with two other residents and a family member. During the meal Resident #18 pursed his lips and continuously spit onto the dining room table. * 07/26/16 at 11:00 a.m., showed Resident #18 seated in his wheelchair at a table in the dining room with two other residents. During the meal Resident #18 pursed his lips and continuously spit onto the dining room table. The staff members failed to intervene to decrease Resident #18's behaviors of spitting during meals. Failure of the facility to implement approaches and to intervene with Resident #18's behaviors	F 241	4. 8/24/16 5. QA will be done by QA nurse, Social Services and Dietitian weekly for one month, monthly for 3 months and then quarterly till resolved. QA will be completed on residents and staff to ensure dignity is maintained in rooms and in dining room. QA was started on 8/8/16.	

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F 241	Continued From page 2 during meals does not promote residents' dignity or enhance their quality of life.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accommodate the needs of 3 of 16 sampled residents (Resident #3, #9, and #10) observed with limited mobility. Failure to place call lights within reach does not allow the residents to call for assistance when needed and may result in an accident. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included osteoarthritis and dizziness. The quarterly Minimum Data Set (MDS), dated 04/22/16, identified impaired range of motion (ROM) to bilateral lower extremities, limited assistance of one staff for transfers and walking in the room, and one fall without injury since the prior assessment on 01/22/16. The current care plan stated, "I have a history of falls due to unsteady gait at times, increased confusion . . . *I use a walker *I have severely impaired vision . . .	F 246	1. All staff will be re-educated on the importance of having the call-light within reach of residents at all times. Staff that cared for resident #3,#9 and #10 were individually educated and QA'd and attended mandatory in-service on call lights system on 8/18 and 8/23/16. 2. All residents have the potential to be at risk. 3. A mandatory in-service will be held on 8/18/16 and 8/23/16 to educate all staff on the importance of having the call-light within reach. 4. 8/24/16 5. QA will be done by Nurse Manager and Clinical support weekly for one month, monthly for 3 months and quarterly till resolved.	8/24/16

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F 246	Continued From page 3 Interventions: . . . Encourage resident to use call light . . ." On 07/27/16 at 7:45 a.m., observation showed Resident #3 sitting up on the edge of the bed, calling out, "I need to go to the bathroom." The paddle-type call light rested out of the resident's reach on a table next to a recliner. The staff failed to place the call light within Resident #3's reach. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included congestive heart failure, osteoarthritis, peripheral vascular disease, and chronic obstructive disease. The quarterly MDS, dated 06/01/16, identified impairment on both upper and lower extremities and extensive assistance of one person for bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene, and bathing. Resident #9's current care plan stated, ". . . Focus, I have potential for falls . . . Interventions/Tasks . . . Keep call light . . . within reach. Respond to call light promptly . . . Remind me to use my call light and request assistance with all mobility . . ." Observation on 07/25/16 at 4:10 p.m., showed Resident #9 seated in her wheelchair near the head of her bed with her call light placed at the foot end of the bed underneath a pillow. The staff failed to place the call light within Resident #9's reach. During an interview on 07/27/16 at 5:00 p.m., an administrative staff (#10) confirmed the call light should be within Resident #9's reach.	F 246	QA will be completed to ensure all residents have their call light within reach. QA was started on 8/8/16.	

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F 246	Continued From page 4 - Review of Resident 10's medical record occurred on all days of survey. Diagnoses included stroke, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness affecting one side of the body) affecting the right side, and osteoarthritis. Resident #10's quarterly MDS, dated 04/30/16, identified impairment on one side of the upper extremity, impairment on both sides of the lower extremities, and extensive assistance of one person for bed mobility, transfers, dressing, eating, toileting, bathing and personal hygiene. Review of Resident #10's current care plan stated, ". . . Focus, I have residual effects of Cerebral Vascular Accident [stroke] . . . Interventions/Tasks . . . Keep call light within reach at all times . . ." Observations showed the following: * 07/27/16 at 8:30 a.m.: Resident #10 laying in bed with the call light positioned at the foot end of the bed. * 07/27/16 at 10:20 a.m.: Resident #10 laying in bed with the call light positioned at the foot end of the bed. The staff failed to place the call light within Resident #10's reach. The facility's failure to ensure accessibility of resident call lights placed the residents at risk of injury and falls.	F 246		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		8/24/16

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F 280	Continued From page 5 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the careplan for 3 of 23 sampled residents (Resident #7, #18 and #29). Failure to review and revise the careplan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity in care. Findings include: Review of the facility policy titled "Care plan" occurred on 07/28/16. This policy, revised June 2016, stated, " . . . Care plans will be developed and updated . . . for each resident on admission,	F 280	1. All care plans for 7, 18, and 29 have been updated and plan of care is current. 2. All residents have the potential to be affected. 3. A care plan review will be done monthly by nursing, to ensure care plan is current with a PFA and residents assistance. The interdisciplinary team will meet quarterly to ensure all updates are reviewed, completed and dated. A mandatory in-service will be held on 8/18 and 8/23/16 on the care plan and where to look for information needed to complete	

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F 280	Continued From page 6 quarterly and annually, as well as post hospital and if a significant change in the resident's status occurs. They also must be updated on a continual basis as resident's needs change to ensure that the care plan adequately reflects the resident's status at that point and time . . ." - Review of Resident #18's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and Down Syndrome. The current care plan identified "Focus . . . My mother passed away . . . I am grieving over my loss . . . Goal . . . Interventions . . . Discuss the opportunity to communicate feelings regarding NH [nursing home] placement with my mother, annually . . . Focus . . . Interventions/Tasks . . . Followed by psychiatry routinely . . . " During an interview on 07/28/16, at 11:30 a.m., an administrative staff (#13) stated Resident #18's mother passed away May 2016, the careplan failed to reflect consistent approaches to address the resident's mother's death, and the resident is not followed by psychiatry. - Review of Resident #29's medical record occurred on July 27-28, 2016. Review of the resident's PFA assessment identified the resident had a complicated feeding problem and was not approved for a PFA. The current care plan stated, ". . . May be fed PFA if necessary . . ." - Review of Resident #7's medical record occurred July 25-28, 2016 and revealed the facility identified Resident #7 as appropriate for the paid feeding program even though she	F 280	the plan of care. 4. 8/24/16 5. QA will be completed by Nurse Manager and Social Services weekly for one month, monthly for three months and then quarterly till resolved. QA will be completed to make sure all care plans are accurate with level of care. QA was started on 8/8/16.	

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F 280	Continued From page 7 demonstrated "difficulty swallowing" and would "spit and pocket her medications." The current care plan failed to address that through assessment, the facility determined Resident #7's spitting and pocketing behaviors were behaviors and not signs/symptoms of dysphagia.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to ensure competency of 1 of 1 staff nurse (#7) regarding the facility's emergency suction machine. Staff's lack of knowledge of the location of the suction machine in case of an emergency situation placed residents at risk for not receiving assistance during respiratory distress. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 1406-1407, states, ". . . Suctioning . . . When clients have difficulty handling their secretions or an artificial airway is in place, suctioning may be necessary to clear air passages . . . The nurse decides when suctioning is needed by assessing the client for signs of respiratory distress or evidence that the client is	F 281	1. Staff member #7 was re-educated on location of suction machine. 2. All residents have potential to be at risk. 3. All staff will be educated on location of suction/CPR on each floor on 8/18/16 and 8/23/16. 4. 8/24/16 5. QA will be completed by DON and MDS coordinator weekly for one month, monthly for three months and then quarterly till resolved. QA will be completed on nursing staff on location of suction/CPR cart in each area.	8/24/16

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F 281	Continued From page 8 unable to cough up and expectorate secretions. Dyspnea, bubbling or rattling breath sounds, poor skin color . . . or decreased oxygen saturation . . . levels . . . may indicate the need for suctioning. . . ." During interview on 07/26/16 at 5:11 p.m., a nurse (#7) stated he/she was unaware of the location of the emergency suction machine. Review of the nurse's (#7) orientation competency checklist occurred on the afternoon of 07/28/16. The checklist included ". . . Equipment and supplies 1. Locate standby oxygen concentrator . . . 5. Floor/unit storage of miscellaneous equipment . . ." The nurse's orientation checklist lacked a completion date and a signature of the nurse (#7), ensuring all the information on the checklist was provided as part of the orientation. During an interview on the morning of 07/28/16, the administrative nurse (#10) stated she expected all nursing staff to know the location of the emergency suction machine.	F 281		
F 315 SS=E	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.	F 315		8/24/16

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F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of the facility's Certified Nursing Assistant skills validation check list, and staff interview, the facility failed to provide appropriate catheter and perineal cares for 4 of 15 sampled residents (Resident # 6, #7, #10, and #16) observed during personal cares. Failure to provide appropriate catheter and perineal cares may result in urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Foley catheter and bags care" occurred on 07/28/16. The policy, dated June 2016, stated " PROCEDURE: . . . 5. Residents that are ambulatory during the day will have a leg bag at that time and bed bag at night. 6. Cleaning of bags: . . . b. Cleanse the disconnected bag with 30 ml [milliliters] of vinegar and 60 ml of water. Leave the solution in the bag until ready to use again and store in a clean container that is covered with a cloth, should not be an airtight cover. Rinse bag thoroughly before connecting bag to Foley catheter." Review of a skills validation check list used for training Certified Nursing Assistants (CNAs) occurred on 07/28/16. The undated check list stated "Attaching a Leg Bag . . . 3. Disconnect foley from catheter bag 4. Clean foley cath and leg bag with alcohol swab 5. Attach leg bag . . ." - Observation on 07/26/16 at 9:52 a.m. showed	F 315	1. All nursing staff will be re-educated on catheter care, catheter bag changes and pericare to prevent UTI's or the spread of infections. Staff that cared for #6, #7, #10 and #16 were individually educated and QA and attended mandatory in-service. 2. All residents have the potential to be at risk. 3. A mandatory in-service will be held 8/18/16 and 8/23/16 to educate all nursing staff on proper catheter care, catheter bag changes, pericare to aid in the prevention of UTI's 4. 8/24/16 5. QA will be completed by Nurse Managers and QA nurse, weekly for one month, then monthly for three months and then quarterly till resolved. On proper catheter care, catheter bag changes and pericare to prevent UTI. QA was started on 8/8/16.	

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Resident #16 seated at the edge of her bed with a bedside drainage bag in place. A CNA (#24) emptied the urine from the bedside bag into a container and wiped the drainage spout with a cloth hand towel. The CNA (#24) then removed the bedside drainage bag, placed it in a basin, and attached a leg bag to the Foley catheter, wiping the connection with a cloth hand towel prior to connecting the bedside bag. The CNA (#24) then took the basin containing the bedside drainage bag to the resident's bathroom and placed it on the floor.

After assisting Resident #16 with cares, including washing the resident's face, hands, back, and axillae with soap and water, the CNA assisted the resident to walk to the bathroom and sit on the toilet. The CNA then took the water used for washing the resident and emptied it into the basin containing the bedside drainage bag with two open port sites.

Observation on 07/26/16 at 11:00 a.m. showed the drainage bag remained in the basin of water in the resident's bathroom.

During an interview on 07/26/16 at 2:30 p.m. an administrative nurse (#25) stated the CNA (#24) should have cleansed the ports of the catheter with alcohol when providing catheter cares for Resident #16 and should not have emptied the water used for resident cares into the basin containing the bedside drainage bag.

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included history of Cerebral Vascular Accident (stroke), Hemiplegia (paralysis of one side of the

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F 315	Continued From page 11	F 315		

body), Hemiparesis (weakness affecting one side of the the body), and recurring urinary tract infections. The quarterly Minimum Data Set (MDS), dated 04/30/16, identified the resident had an indwelling catheter and requires extensive assistance with toileting.

Review of Resident #10's current care plan identified ". . . I have Indwelling Catheter . . . Catheter cares . . . per Sheyenne Care Center [SCC] policy . . ."

Observation on 07/26/16 at 9:25 a.m., showed a CNA (#15) donned gloves, emptied Resident #10's urinary drainage bag into a container, disconnected the tubing from the drainage bag and catheter tubing. The CNA then connected the leg bag to the0 catheter tubing without first cleansing the catheter tubing with alcohol.

During an interview on 07/27/16 at 5:00 p.m., an administrative nurse (#10) confirmed staff should clean the drain tube with alcohol prior to connecting it to the resident's catheter tubing.

- Review of Resident #6's medical record occurred on July 25-27, 2016. An admission Minimum Data Set (MDS), dated 05/10/16, identified Resident #6 required one person assistance with toileting/personal hygiene, and was occasionally incontinent of urine. Resident #6's current care plan stated, ". . . I have history of chronic Urinary Tract Infections . . . Check on resident throughout the day and offer assistance with toileting as she requests. . . . Wash, rinse and dry soiled areas. . ."

Observation on 07/26/16 at 9:07 a.m. showed a

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(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 315	Continued From page 12 certified nursing assistant (CNA) (#2) assisted Resident #6 to the bathroom. The CNA (#2) cleansed the resident's rectal area with cleansing cream and a wet wipe, then cleansed the frontal area with the same wipe. The CNA (#2) failed to cleanse the frontal perineal area before cleansing the back perineal area. - Review of Resident #7's medical record occurred on July 25-27, 2016. A significant change MDS, dated 06/30/16, identified Resident #7 required one person assistance with toileting/personal hygiene, was frequently incontinent of urine and occasionally incontinent of bowel. Resident #7's current care plan stated, ". . . I have chronic Urinary Tract Infections . . . Check at least every 2 hours for incontinence. Wash, rinse and dry soiled areas. . ." Observation on 07/26/16 at 9:15 a.m. showed a CNA (#1) assisted Resident #7 to the bathroom. The CNA (#1) wiped the rectal area with a wet wipe, then cleansed the frontal area with the same wipe. The CNA (#1) failed to wash the frontal perineal area before cleansing the back perineal area.	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.	F 323		8/24/16

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	355077	A. BUILDING _____ B. WING _____	07/28/2016

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 3 of 18 sampled residents (Resident #10, #12, and #16) who required extensive assistance with transfers. Failure to use a gait belt with transfers (Resident #12 and #16) and provide adequate supervision for safety (Resident #10) placed the residents at risk for sustaining a fall or injury. Findings include: Review of the facility policy titled "Lifts and transfers" occurred on 07/28/16. This policy, revised June 2016, stated, ". . . Residents will be moved and/or re-positioned in a manner that will ensure resident comfort and reduce risk of injury to resident and/or staff. . . . Gait Belts: 1. CNAs [certified nursing assistants] and bath aids will use gait belts when assist is needed for transferring and ambulating residents, . . . CRA [certified resident assistant] may guide by using arms/under arms as long as gait belt is on and being used correctly. . . . Mechanical Lifts: . . . 2. When a mechanical lift is determined as necessary it will be placed on resident's care plan by nurse or nurse manager. - Resident #10's medical record, reviewed on all days of survey, identified diagnoses including hemiplegia (weakness of one side). A quarterly Minimum Data Set, dated 04/30/16, identified the resident required extensive assistance with bed mobility and transfers.	F 323	1. All nursing staff will be educated on the correct use of gait belts, mechanical standing lifts.#10,#12 and #16 CRA's were individually educated on proper use of gait belts and standing lift transfers and attended mandatory in-service. 2. All residents who are in need of assistance with a gait belt or a mechanical standing lift to transfer have the potential to be at risk. 3. All Nursing staff will have a mandatory in-service on 8/18/16 and 8/23/16 on correct use of a gait belt and mechanical standing lift. 4. 8/24/16 5. QA will be completed by QA Nurse & Nurse Manager weekly for one month, monthly for three months and then quarterly till resolved. QA will be done on proper transfer techniques with gait-belt and standing lift. QA was started 8/8/16.	

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F 323	Continued From page 14 Observation at 07/26/16 at 10:00 a.m. showed a CNA (#15) prepared to transfer Resident #10 from the bed to the wheel chair with a stand lift. The CNA (#15) attempted to sit Resident #10 up on the side of the bed. Resident #10 was unable to sit upright. The CNA (#15) exited the room, leaving the bed in the high position and the resident lying sideways with her head against the wall and legs hanging over the edge of the bed, with the call light not within reach. The CNA (#15) returned four minutes later with another CNA. The CNA (#15) failed to ensure the resident was in a safe position before leaving the room. - Resident #16's medical record, reviewed on all days of survey, identified diagnoses including Parkinson's Disease and polymyalgia rheumatica (muscle pain). A quarterly Minimum Data Set (MDS), dated 05/06/16 identified the resident required extensive assistance for transfers and walking in the room. The current care plan, revised on 02/03/16, identified an "ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] Pain . . ." Approaches included; " . . .I require staff assistance of 1 with transfers and ambulation. . . ." On 07/26/16 at 9:52 a.m., observation showed a Resident #16 seated at the edge of her bed. A CNA (#24) assisted Resident #16 to stand and ambulate to the bathroom. The CNA (#24) failed to utilize a gait belt when ambulating the resident. An interview with a group of residents occurred on 07/26/16 at 1:00 p.m. During the interview, Resident #16 stated she does not feel safe when staff transfer her and during transfers staff will	F 323		

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F 323	Continued From page 15 instruct her to hold onto the bedside table. During an interview on 07/26/16 at 2:30 p.m. an administrative nurse (#25) stated staff member should use a gait belt when ambulating Resident #16. - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included history of a cerebral infarction (stroke) without residual, history of transient ischemic attack (short term symptoms of a stroke), and dementia with behavioral disturbance. Review of a quarterly MDS, dated 06/11/16, identified the resident required extensive assistance of one person for transfers and ambulation in the room. The care plan identified the problem of "I have, an ADL [activities of daily living] Self Care Performance r/t [related to] Stroke and behavior" with approaches including "AMBULATION: I require extensive assist of 1 and gaitbelt and walker with ambulation in my room. . . . I will refuse to ambulate with my walker in my room at times. . . . TRANSFERS: I require extensive assist of 1 for transfers . . ." The care plan also identified the problem of "I am risk for falls." During observation on 07/26/16 at 10:12 a.m. a CNA (#21) failed to provide assistance with ambulation from the resident's bathroom to bed utilizing a gait belt.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		8/24/16

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F 371	Continued From page 16 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions during 1 of 2 days (07/26/16) of observation of the breakfast meal. Failure to wash hands before prepping food, after handling dirty dishes, between tasks, and failure to prevent bare-hand contact with ready-to-eat food increases the risk of food-borne illness. Findings include: Review of the facility policy titled "Sanitation in Food Preparation - Handling Uncooked Food and Cooking of Food" occurred on 07/28/16. This policy, dated 02/15/10, stated, ". . . 1. Wash hands with soap and water for 20-30 seconds before handling any food. (No hand sanitizers are allowed) . . . 3. Wear plastic gloves or use tongs, scoops, etc. whenever handling food. . . ." On 07/26/16 from 8:07 a.m. to 8:52 a.m., observation in a second floor dining room showed a staff member (#23) serving breakfast. As a resident arrived in the dining room, the staff member prepared and delivered food to the resident, patted the resident's shoulder, and	F 371	1. All staff will be educated on food preparation, hand washing and proper food handling techniques while serving meals. 2. All residents have the potential to be at risk. 3. A mandatory all staff in-service on 8/18/16 and 8/24/16 to educate staff on the importance of hand washing, food prep and correct method of food handling during meal preparation. 4. 8/24/16 5. QA will be completed by Dietician weekly for one month, monthly for three months and quarterly till resolved. QA will be completed to ensure proper hand-washing with food preparation and sanitation is being maintained. QA was started on 8/8/16.	

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F 371	Continued From page 17	F 371		

returned to the counter to repeat the process for the next resident. The staff member (#23) failed to wash her hands before, between, or after these tasks.

At 9:15 a.m., the staff member (#23) held a plastic glove in one hand, grabbed a slice of bread with the glove, placed the bread in the toaster, and repeated this process with a second slice of bread. Without gloves, she then removed dirty dishes from the sink and placed them in the tub to be returned to the main kitchen for washing, poured and delivered juice for several residents, straightened the kitchen area, and placed more dirty cups in the tub. The staff member failed to wash her hands or wear gloves before, during, or after these tasks.

At 9:19 a.m., the staff member (#23) removed the toast from the toaster with her bare hands, donned a glove to her left hand, and prepared instant oatmeal. She then picked up the toast with both hands (right not gloved), placed the toast on a plate, and brought the toast to Resident #1. She retrieved dirty dishes from dining room tables and placed them in the tub, replaced condiments into the cupboards and more dirty dishes into the tub. She then placed clean plates into the cupboard, placed a twist tie on the bread bag, and put juice containers into the refrigerator. The staff member (#23) failed to wash her hands after handling dirty dishes and before handling clean items.

During an interview on 07/27/16 at 4:25 p.m., a dietary manager (#22) stated staff "should use tongs to handle bread" and "should wash their hands after handling dirty dishes."

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F 371	Continued From page 18 During an interview on 07/27/16 at 5:35 p.m., a nurse administrator (#10) stated staff are expected to wash their hands between clean and dirty tasks when serving breakfast.	F 371		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid	F 373		8/24/16

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F 373	Continued From page 19 feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/17/16 Based on record review and staff interview, the facility failed to ensure 3 of 3 supplemental residents (Resident #27, #28, #29) were appropriate to be fed by a paid feeding assistant (PFA) or correctly identified to be fed by a PFA. Failure to assess residents to ensure they can safely be fed by a PFA placed residents at risk for	F 373	1. Residents #27 and #29 PFA assessment and care plans were reviewed and updated to match the level of assistance needed. Information on eating abilities will only be listed under the ADL section of the care plan. Resident #28 was discharged to another facility. 2. All residents, who are in the need of CNA assistance while eating, have the	

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F 373	Continued From page 20 choking and aspiration. Findings include: Review of the facility's PFA list located in the first floor dining room identified Resident #27, #28, and #29 could be fed by a PFA. - Review of Resident #29's medical record occurred on July 27-28, 2016. Review of the resident's PFA assessment identified the resident had a complicated feeding problem and was not approved for a PFA. Resident #29's swallow evaluation, dated 05/06/16, identified dysphagia (difficulty swallowing). The current care plan stated, ". . . May be fed PFA if necessary . . ." The facility assessment identified the resident had a complicated feeding problem and did not approve the resident to be fed by a PFA, however, the care plan and the facility list of resident's who could be fed by a PFA did. - Review of Resident #28's medical record occurred on July 27-28, 2016. Review of the resident's PFA assessment identified the resident not approved to be fed by a PFA, but the resident's name appeared on the PFA list in the dining room. - Review of Resident #27's medical record occurred on July 27-28, 2016. The resident's PFA assessment identified the resident has a complicated feeding problem and approved for PFA. The resident's current care plan stated, ". . . May be supervised by PFA . . ." The facility failed to recognize the assessment and listed the resident on the PFA list located in the dining room.	F 373	potential to be at risk. 3. PFA's will work on 1st floor and COLC only. The Nurse Manager will complete PFA's assessments and ensure that the care plan and PFA assessment information match. A list of Residents who may be fed by PFA is kept in the dining room cupboard for all nursing and dietary staff to review. The list will be updated by nurse manager as needed. Education on PFA list and location will be provided at mandatory in-service on 8/18/ and 8/23/16. 4. 8/24/16 5. QA will be completed by Nurse Managers and QA nurse, weekly for one month, then monthly for three months and then quarterly till resolved. QA on care-plan, PFA assessment and list in cupboard will be QA to ensure they all have the same information for staff on who can be assisted by PFA. QA was started 8/8/16.	

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