STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355057	A. BUILDING _____ B. WING _____ JAN 3 2011	12/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBILIER NURSING CENTER	500 DELANO AVE WALHALLA, ND 58282

(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 11/29/10 and completed on 12/01/10 the sample included two residents for complete review, seven residents for focused review, and one closed record for review. The sample included one additional resident 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, review of facility policy, and staff interview, the facility failed to provide care in a manner and in an environment that maintained or enhanced each resident's dignity for 2 of 9 sampled residents (Resident #1 and #5) and 1 supplemental resident (Resident #11). The facility failed to assist the resident in a dignified manner during meals (Resident #1 and #11), failed to knock before entering a resident's room (Resident #1 and #5), and failed to change visibly dirty bed linens (Resident #5). Failure to feed residents in a dignified manner, enter a resident's room only when invited, and failure to remove and replace dirty linens does not maintain or enhance the residents' dignity, self worth or self esteem. Findings include: Review of the facility policy titled ". . . Quality of Life" occurred on 12/01/10. This undated policy	F 241	1. Resident #1, #5, and #11 will be reviewed on resident dignity related to feeding, techniques, entrance into resident rooms, and changing of soiled linens by the interdisciplinary team. Information will be provided in the care plan team report to all staff. 2. All staff in the facility will be in-serviced on 1/10/11 by the Director of Nursing on dignity issues and concerns related to feeding residents, entering resident rooms, and use of clean linens and clothing. 3. The Director of Nursing will perform quality assurance *studies* monthly for six months on feeding techniques, resident privacy, and cleanliness of linens and clothing to ensure all residents' environment and dignity are maintained. 4. The Director of Nursing will report her findings at quarterly Quality Assurance meetings. 5.	~~1/31/11~~ 01/11/11 Phone Call w/ D. Fraser 01/04/11 KH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Fraser | TITLE: Administrator | (X6) DATE: 12/28/10

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 241	Continued From page 1	F 241		

stated, "Remember to: Knock before entering the person's room. Address the person by name. Introduce yourself by name and title . . . Wiped [sic] the person's mouth with a napkin as needed. . . ."

- Observation of Resident #11 in the facility dining room during the noon meal on 11/30/10 at 11:55 a.m., showed a certified staff member (#9) feeding Resident #11 his meal. This staff member stood at the resident's side and leaned over him, bending forward to spoon the meal items and then feed the resident.

- On 11/30/10 at 9:20 a.m., a certified nursing assistant (CNA) (#4) obtained the linen protector pad from under Resident #3's blankets and placed it on top of her bed. Observation showed the protector visibly soiled with dry stool. The CNA transferred Resident #3 from her wheelchair to the bed and layed her down on the soiled protector. The CNA (#4) failed to obtain a clean linen protector pad.

- Resident #5 participated in an individual interview on 11/30/10 at 1:30 p.m. During the interview, a CNA (#4) entered the room without knocking or introducing herself, emptied the resident's pitcher of water in the sink, and left some fresh water. The CNA (#4) failed to respect Resident #5's privacy by entering her room without knocking and waiting for permission to enter and failed to leave the room when she realized Resident #5 had a visitor.

- Observation in the dining room on 11/30/10 at 12:05 p.m. showed a CNA (#4) feeding Resident #1. The CNA scraped the potatoes from the resident's face with a spoon multiple times and

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F 241	Continued From page 2 failed to use the napkin provided on the table to wipe or remove the excess food off of the resident's face. - Observation on 12/1/10 at 7:40 a.m. showed a CNA (#4) giving Resident #1 a bedbath. Staff members (#5, #7, #1 and #2) briefly knocked and entered the resident's room without announcing themselves or waiting for a response four consecutive times. The resident's body remained exposed on each occasion. During an interview on 12/01/10 at 10:00 a.m., two administrative staff members (#1 and #2) stated they expected facility staff to knock on the resident's door and wait for an invitation to enter the room. They stated facility staff received education on the proper ways to assist residents during a meal; staff members are expected to sit while they feed the residents and they are expected to wipe the residents' mouth with a napkin, not the eating utensil.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of resident activity participation records, review of the facility's monthly event calendars, family interview, and staff interview, the facility failed to provide an on-going individualized program of	F 248	1. Residents #1, #4, #7, and #9 will all receive activity programs in accordance with their current care plans. Additional staff have been added to the Activity Program three times per week to ensure goals are met. 2. All documentation for the Activity Program has been revised. All activities will be documented. A separate binder has been developed for residents who require one-to-one focused activities. All care plans will be updated and staff will be educated on 1/3/11 to ensure all activities are recorded and completed. 3. Two new activity logs have been developed. Activity staffing has been increased, allowing more staff to be available to complete one-to-one	

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F 248	Continued From page 3 activities for 4 of 9 sampled residents (Resident #1, #4, #7, and #9). Failure to provide meaningful activities with respect to each resident's individualized interests and needs, does not allow residents the opportunity to maximize their highest practicable quality of life and overall well-being. Findings include: Review of facility policy, titled "Activities Policy Statement", occurred on 12/01/10. This undated policy stated, "It is the policy of [name of facility] to provide a planned and diversified program of therapeutic activities and recreational programming to all residents based on their individual needs and capabilities in accordance with the interests and the physical, mental and psychosocial well-being of each resident. . . ." - Review of Resident #4's medical record occurred on all days of survey. The resident's diagnoses included progressive Multiple Sclerosis with tube feeding secondary to severe dysphagia, debility, seizure disorder, depression, and anxiety. The resident's Minimum Data Set (MDS), dated 11/07/10, indicated severe impairment with decision making, making self understood, and understanding others, and required total assist for all activities of daily living. Resident #4's care plan, dated 11/09/10, stated, "PROBLEM: Activities APPROACHES: Post activity calendar in room. Invite resident out to all activities and assist to activities of her choice. Introduce her to staff and other residents. Encourage attendance. Help with set up while in activities prn [as needed]. Will evaluate and offer talking books as needed. Offer resident 2-3	F 248	--Continued from page 3 -- 01/03/11 KH activities. All volunteers will be trained by ~~1/31/11~~ on documenting all activities with residents. 4. Activity logs will be reviewed weekly for three months by the Administrator and Director of Nursing. All results of weekly audits will be discussed weekly at the care plan meetings to ensure all residents are provided with individualized, meaningful activities to promote optimal quality of life. 5. ~~1/31/11~~ 01/11/11 phone call w/ Deb Traen 01/04/11 KH	

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F 248	Continued From page 4	F 248		

one/one activities per week, as resident tolerates. Staff will read to her from magazines and newspapers. Will encourage resident to look at pictures and staff will talk about her living on the farm. Staff will offer music to listen to, lotion hands and feet and give her manicures as she tolerates. . . . Assist with opening/reading her mail as needed.

Review of Resident #4's Activity Progress Note, dated 11/04/10, stated, "Discussed [resident name] quarterly activity progress note with her today. . . . [resident name] has a posted activity calender [sic] in her room and by staff verbal cueing is aware of what is going on. Staff will do three 1:1 visits per week, will do manicures, lotion hands, arms, read to, look at pictures, turn music on. Staff will deliver all mail, help open, read to, if requested. [Resident name] has own TV in room and staff will offer to turn on to channel of her request. . . ."

An interview with a nursing staff member (#8) occurred on 11/30/10 at 9:10 a.m. This staff member stated Resident #4 never leaves her room anymore. She stated due to the nausea she often experiences with a lot of movement, her husband has requested she remain in her room. She stated the resident has remained in her room for "quite some time now" only getting out of bed for bathing and short periods spent in the recliner chair in her room.

Review of Resident #4's Individual Activity Record indicated the following:
August 2010
* Beauty Shop/Manicure - 3 times
* Visit - 1 time
September 2010

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F 248	Continued From page 5 * Visit - 1 time October 2010 * Visit - 2 times November 2010 * Visit - 1 time Review of the above activity participation records for Resident #4 show facility staff failed to provide a meaningful individualized activity program as specified in the plan of care for this resident. A lack of meaningful activities may have contributed to Resident #4's depression. - Review of Resident #1's medical record occurred on all days of survey. The resident's diagnoses included Alzheimer's disease with severe end stage dementia and paranoid explosive behavior, psychoses, agitation, depression, anxiety, and generalized pain. The MDS, dated 09/07/10, indicated Resident #1 rarely understands others or makes himself understood and required extensive assistance with transfers. Resident #1's current care plan, dated 09/14/10, stated, "PROBLEM: Cognition: unable to assess long and short-term memory due to resident condition and diagnosis. Rarely/never makes decisions. Confused at all times. Does not know season or location of room. Periods of restlessness. APPROACHES: Provide regular, consistent routine. Reorientate and cue daily as needed. Repeat and rephrase as needed. . . . PROBLEM: Communication: mumbles - speech is unclear. Is difficult to understand. Easily distracted. Short attention span. At times speech is clear. Minimal difficulty hearing. Rarely understands others. Rarely makes self understood. APPROACHES: Staff will speak in	F 248		

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short, concise sentences . . . and allow time for resident to respond. . . . Activities: . . . Strengths - holds eye contact, very strong family ties . . . GOAL: He will be involved with 3 one/one activities per week and be active with a variety of hands on items for 10 minutes or as tolerated through next review. Staff will look at pictures, read to him, tinker with toys with him. APPROACHES: Post an activity calendar in room. Invite resident out to all activities and assist to activities of resident's choice. . . . encourage attendance . . . Assist with opening and reading mail . . . One/one activities - 3 per a week for 5-10 minutes or as tolerated. PROBLEM: Activities - APPROACHES: busy box activity, bean bags, picking up postcards, looking at pictures of cats, looking at family photo album. Have magazines handy for resident . . ."

Resident #1's Activity Progress Note, dated 09/06/10, stated, "Discussed [resident name] quarterly activity progress note with him today. . . . [resident name] has a posted activity calender [sic] in his room and by staff verbal cueing is aware of what is going on. Staff will do at least three 1:1 visits per week with him. Staff will read to him from newspapers magazines - show him pictures and talk to him. . . . Staff will deliver all mail, help open, and read to. [Resident name] reactions vary throughout the day, is active with hands on objects for as long as he can tolerate. . . "

Resident #1's Individual Activity Record from September 2010 through November 2010 identified the following:
September:
* Beauty Shop/Manicure/Shave - 1 time
* Visit - 2 times

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F 248	Continued From page 7 * View pictures/photos - 1 * Coffee - 1 time * Religion - 1 time * Group - (passively) 4 times October: * Manicure - 1 time * Touch (lotion-backrub) - 1 time * Mail/Visit - 3 times * Reminiscing - (passively) 1 time * Coffee - 3 times * Games - (passively) 1 time * Group activity - (passively) 2 times November: * Manicure - 1 time * Mail/Visit - 2 times * Touch (lotion-backrub) - 1 time * Sing Along - 1 time * Religion - 1 time Review of the above activity participation records for Resident #1 show facility staff failed to provide a meaningful individualized activity program and failed to provide one on one activities as specified in the interdisciplinary plan of care for this resident. A lack of meaningful activities may have contributed to Resident #1's depression. - Review of Resident #9's medical record occurred on November 30-December 1, 2010. Diagnoses included depression, arthritis, and a cerebrovascular accident (stroke). Review of Resident #9's Minimum Data Set (MDS), dated 10/17/10, identified the following signs and symptoms of depression 12 to 14 days in a two week period: little interest or pleasure in doing things; feeling down, depressed or hopeless; feeling tired or having little energy; feeling bad about yourself - or that you are a failure or have let yourself or your family down. The MDS also	F 248		

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F 248	Continued From page 8 identified Resident #9 as totally dependent on staff for all activities of daily living except eating. Review of Resident #9's current care plan, dated 10/19/10, stated, "PROBLEM - Activities: GOALS - Resident will participate in three one on one activities per week as tolerated. Staff will read to, lotion hands, do a manicure, turn music on, talk to her about her recipe book, baking. APPROACHES - *Post an activity calendar in her room. *Invite her out to all activities . . . *Staff will do three one/one visits per week. *Resident enjoys going to Mass - staff to assist resident to Mass as she wishes . . ." Review of the Activity Progress Notes, dated 10/17/10, stated, "Discussed [resident name] annual activity progress note with her today. Dx [diagnoses]: pneumonia, CVA, influenza, atrial fibrillation, DM Type II [diabetes mellitus]. [Resident name] has a posted activity calendar in her room and by staff verbal cueing's is aware of what is going on. Staff will do at least three 1:1 [one to one] visits per week. Staff will deliver all mail, help open, read to any mail [sic]. Staff has offered to get talking book machine but has declined again at this time. [Resident name] is able to communicate and make her wants and needs known. Very supportive family." Review of Resident #9's Individual Activity Records from August 2010 through November 30, 2010 identified the following: August: * Music on - 1 day * TV on - 1 day * Visits with others (family) - 2 days September: * Mail - 2 days	F 248		

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F 248	Continued From page 9 * Pictures/Reminiscing - 1 day * TV/Movie/Video - 3 days * Visit with others (daughter) - 1 day October: * Visit/Reminiscing - 2 days * TV/Movie/Video - 4 days * Visits with others (family) - 2 days November: * Touch (lotion/backrub) - 1 day * Mail - 2 days * TV/Movie/Video - 6 days * Visits with others (daughter) - 3 days Review of the above activity participation records for Resident #9 show facility staff failed to provide a meaningful individualized activity program and failed to provide one on one activities for this resident three times per week. A lack of meaningful activities may have contributed to Resident #9's depression. An interview with Resident #9's family member (#1) occurred on 12/01/10 at 10:30 a.m. This family member stated Resident #9 is more depressed since her stroke and spends most of the day in bed. - Review of Resident #7's medical record occurred on November 30-December 1, 2010. Diagnoses included dementia, anxiety, osteoarthritis, and left wrist fracture. Review of Resident #7's admission Minimum Data Set (MDS), dated 10/31/10, identified the following signs and symptoms of depression 12 to 14 days in a two week period: little interest or pleasure in doing things; feeling down, depressed or hopeless; feeling tired or having little energy; feeling bad about yourself - or that you are a failure or have let yourself or your family down,	F 248		

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F 248	Continued From page 10 and moving or speaking so slowly that other people could have noticed. The MDS also identified Resident #7 required extensive to total assistance of staff for all activities of daily living. Review of Resident #7's current care plan, dated 11/23/10, stated, "PROBLEM - Activities: GOALS - Resident will attend at least 1-3 activities per day to either participate or observe. APPROACHES - *Post an activity calendar in her room. *Invite her out to all activities . . . *Introduce to staff and other residents. *Encourage attendance. *Help with set up while in activities prn . . . ." Review of Resident #7's Individual Activity Records from November 1-30, 2010 identified the following: November: * Coffee - 5 days * Manicure/Beauty Shop - 5 days * Mass - 1 day * TV/Movie/Video - 1 days Review of the above activity log identified 21 days (November 02-04, 06-11, 14-15, 17-22, 24-25, 28-29) facility staff failed to invite or involve Resident #7 in activities in the facility. The facility failed to develop and implement an individualized and ongoing program of activities for Residents #1, #4, #7 and #9 which has the potential to affect physical, cognitive and emotional health.	F 248		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 11 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 hot water temperature readings, review of professional literature, and staff interview, the facility failed to ensure the environment remained as free of accident hazards as possible in regards to safe water temperatures in 2 of 2 long term care wings of the facility. Very hot water places residents at risk for injury. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding hot water temperatures which states water may reach hazardous temperatures in hand sinks, showers, and tubs. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Third degree burns can occur after five minutes of exposure to water at 120 degrees F.(Fahrenheit), three minutes exposure at 124 degrees F., and one minute exposure at 127 degrees F. - Observation of personal cares for Resident #1	F 323	1. The maintenance man turned the temperature at the mixing valve to 118° during the survey. 2. The temperature at the mixing valve will remain at 118° or below ensuring the temperatures throughout the building are at safe temperatures below 118°. 3. Water temperatures will be checked by the maintenance man weekly. Two resident rooms per week/per hall will be tested. One at the beginning of the hall and one room at the end, changing rooms and resident areas weekly. A log will be kept for review. 4. All water temperature logs/Safety will be reviewed at our monthly ~~QI~~ meeting to ensure the water temperatures in the environment remain safe. 5. ~~1/31/11~~ 01/11/11 Phone Call w/ Deb Fraser 01/04/11 KS	

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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 323	Continued From page 12 occurred on 11/30/10 at 8:54 a.m. A certified nursing assistant (CNA) (#6) washed her hands in the resident's bathroom and stated, "Wow. The water is different. It's really warm." - On 11/30/10 at 3:30 p.m., water temperatures taken in four random resident rooms revealed the following hot water temperatures: * Room 31/32 (shared bathroom) - 127.1 degrees F * Room 37 - 127 degrees F * Room 45 - 122.6 degrees F * Room 44 - 123.2 degrees F - On 12/01/10 at 9:30 a.m., two CNAs (#5 and #11) provided personal cares for Resident #7. At the completion of cares, the CNA (#11) pushed the resident up to the sink in her room and turned on the hot water. Resident #7 placed her hand under the water and immediately pulled it back and stated "pretty hot." At that moment, the temperature of the hot water revealed 123.8 degrees F. The CNA (#11) turned on the cold water to cool down the hot water before she allowed Resident #7 to finish washing her hands. - The environmental tour of the facility with an administrative maintenance staff member (#10) occurred on 12/01/10 at 9:45 a.m. Water temperatures taken in three random resident rooms revealed the following hot water temperatures: * Room 28/29 (shared bathroom) - 122.3 degrees F * Room 36 - 119.5 degrees F * Room 49 - 123 degrees F * The temperature at the mixing valve (hot and cold water mixed) in the boiler room - 124 degrees F	F 323		

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	355057	A. BUILDING _____ B. WING _____	12/01/2010

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F 323	Continued From page 13 During an interview with the maintenance staff member (#10) on 12/01/10 at 10:15 a.m., he stated the temperature of the hot water in the resident rooms should not exceed 118 degrees F. He stated the facility installed a new mixing valve about three weeks ago because the temperatures were too cool. He proceeded to turn the temperature down at the mixing valve area. 2. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/18/09. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility staff failed to ensure 2 of 3 sampled residents (Resident #1 and #7), transferred with a stand up lift (a type of mechanical lift used by staff to transfer residents), received adequate supervision and proper use of assistive devices to prevent accidents. Failure to safely use stand up lifts placed Resident #1 and #7 at risk of falls, injury and pain. Findings include: Review of the facility policy titled ". . . E - Z Stand Aide Policy" occurred on 12/01/10. This undated policy stated, "Purpose: To provide safe, comfortable transfers to residents. . . ." - Review of Resident #7's medical record occurred on all days of survey. The resident's diagnoses included dementia, anxiety, osteoarthritis, and left wrist fracture. Review of Resident #7's admission Minimum Data Set (MDS), dated 10/31/10, indicated requires extensive one person physical assistance with transfers and has functional limitations and impairment on one side of her upper extremity.	F 323	1. Residents #1 and #7 will have therapy evaluations on transferring techniques and appropriateness of their usage, and will be care planned by the interdisciplinary team. 2. All residents in the facility who are transferred with assistive devices will be assessed on transferring techniques by the interdisciplinary team and care plans will reflect transferring if necessary. 3. The Director of Nursing and the Therapy Staff will provide in-service training on 1/10/11 for all nursing staff on proper transferring with the use of lifts. 4. A QA study will be done monthly for six months on all residents using standing lifts on appropriate use. This monthly study will also be reviewed monthly with the Safe Lift Committee. All results of these audits will be reviewed at the QA/Safety meeting. 5. ~~1/31/11~~ 01/11/11 Phone call w/ A. Fraser 01/04/11 KSL	

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F 323	Continued From page 14 Resident #7's care plan, dated 11/23/10, stated "ADLs [activities of daily living] fractured left wrist due to a fall and need [sic] much assist with ADLs" and "Approaches" of " . . . Transfers-extensive assistance. Stand aid as needed. II [two] person assist . . . ." Observation on 11/30/10 at 3:45 p.m., showed two certified nursing assistants (CNAs) (#12 and #13) transfer Resident #7 from her bed into the bathroom using a stand up lift. The CNAs placed the canvas harness around Resident #7's upper back rather than positioning the harness around the resident's lower back and waist area. Observation showed Resident #7 grabbed the right handlebar on the lift with her right arm. Her casted left arm dangled by her side. The CNA (#13) lifted Resident #7's feet and placed them on the foot platform of the stand up lift and failed to support Resident #7's casted left arm during the transfer. Resident #7 complained of pain to her bilateral toes and shoulders when the other CNA (#12) raised the arm of the stand up lift to raise the resident off the bed and transfer her into the bathroom. Failure of facility staff to properly place the canvas harness around Resident #7 lower back and failure to support the resident's left arm during the transfer may have contributed to Resident #7's verbal complaints of pain. - Review of Resident #1's medical record occurred on all days of survey. The resident's diagnoses included Alzheimer's disease with severe end stage dementia and paranoid explosive behavior, psychoses, agitation, depression, anxiety, and generalized pain. The MDS, dated 09/07/10, indicated the resident	F 323		

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F 323	Continued From page 15 rarely understands others or makes self understood, extensive assist with transfers and total assist with toileting. Resident #1's current care plan, dated 9/14/10, stated, ". . . Transfers - extensive assist of i - ii [1 - 2] assist to transfer. Use stand aid prn [as needed]. . . . Resistive to staff . . ." Observation on 11/30/10 at 11:05 a.m., showed a CNA (#4) transferred Resident #1 from a recliner to a bedside commode with a stand up lift. The CNA placed the harness around the resident's upper back and chest. The resident's hands were not placed on the gripper handles and the resident was not cued or assisted to do so. The harness slid up to the resident's arm pits and raised his elbows to above shoulder level during the transfer. This caused the resident's left arm to slip out of the harness. The CNA lowered the lift and placed the resident's left arm back into the harness. The CNA failed to reposition the harness around the resident's lower back and transferred Resident #1 to the commode with his elbows elevated at shoulder level. The Resident hollered and swore at the CNA during the transfer and told her to "get out of here." The CNA (#4) failed to transfer Resident #1 properly and caused Resident #1 unnecessary agitation and may have caused pain.	F 323		
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.	F 441	1. Residents #1 and #9 will be observed and care planned for proper dining techniques to include the use of gloves and hand hygiene. 2. All resident who eat in the Assisted Dining Room will be observed for proper technique (use of gloves and hand hygiene) and care planned as needed.	

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F 441	Continued From page 16 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, the facility failed to follow accepted infection control practices for food handling and personal hygiene during 1 of 3 meal observations. Failure to follow proper infection control procedures has the potential to	F 441	3. The interdisciplinary team will review the above findings and care plan as needed for all residents who are in the Assisted Dining Room. 4. The Director of Nursing will in-service all staff on hand hygiene and appropriate use of gloves regarding control measures related to feeding at the 1/10/11 meeting. A QA audit will be done monthly by the Director of Nursing for six months to ensure proper infection control measures are used in the dining area. All results of these audits will be reviewed quarterly at the QA meetings. 5.	~~1/31/11~~ 01/11/11 Phone Call w/ D. Fraser 01/04/11 KG

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F 441	Continued From page 17 adversely affect the health of all residents. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, & Practices" 8th edition, dated 2008, page 682 states, "Hand Hygiene . . . It is important that both the nurses' and the clients' hands be cleansed at the following times to prevent the spread of microorganisms: before eating, after using the bedpan or toilet, and after the hands have come in contact with any body substances, such as sputum or drainage . . ." - Observation on 11/30/10 at 11:45 showed a certified activity staff member (#9) touched Resident #11's bread with her bare hands as she buttered it and continued to feed the bread to the resident throughout the meal. The staff member (#9) failed to wear gloves when she touched the food. - Observation in the dining room on 11/30/10 at 12:05 p.m. showed a Certified Nursing Assistant (CNA) (#4) feeding Resident #1. The CNA wiped her nose on her forearm and ungloved hand and continued to feed Resident #1 without performing hand hygiene. During an interview on 12/01/10 at 10:15 a.m., two administrative staff members (#1 and #2) stated they expected facility staff to wear gloves when touching food and the CNA should have sanitized her hands after touching her nose.	F 441		