| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355124 | A. BUILDING _____ B. WING _____ | 03/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SHEYENNE CROSSINGS CARE CENTER/TCU | 125 13TH AVENUE WEST WEST FARGO, ND 58078 |

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| F 000 | INITIAL COMMENTS<br><br>For the MDS 3.0 Focused Survey started on 03/27/17 and completed on 03/28/17, the sample included 12 residents for focused review. | F 000 | | |
| F 278 SS=E | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. | F 278 | | 5/2/17 |

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

Electronically Signed | 04/14/2017

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| F 278 | Continued From page 1<br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>CODING ACCURACY<br><br>1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 4 of 12 sampled residents (Resident #1, #4, #5, and #10). Failure to accurately complete Section M (skin conditions) (Resident #4, #5, and #10), Section N (medications) (Resident #4 and #5), and Section O (special treatments, procedures, and programs) (Resident #1) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>SKIN CONDITIONS<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 pages M-1, M-2, M-3, M-37, M-39, and M-40 stated, "SECTION M: SKIN CONDITIONS . . . M0100: Determination of Pressure Ulcer Risk . . . Coding Instructions . . . Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the Braden Scale for Predicting Pressure Sore Risk. Other tools may be used. . . . M0150: Risk of Pressure Ulcers . . . Steps for Assessment . . . 3. Review | F 278 | F 278<br>1. Coding Accuracy<br>a. For Residents #1 and #5, MDS corrections will be completed by 5/2/17. Residents #4 and #10 have discharged and are closed records<br>Discharge and Admission Assessments<br>b. Resident #3□s MDS will be corrected by 5/2/17. Residents #4 and #7 have discharged and are closed records.<br>Completion of Discharge Assessments<br>c. Residents #18 and #19, discharge MDSs will be resent and confirmed acceptance with Federal CMS Validation Reports by 5/2/17. Resident #20□s MDS cannot be changed.<br>Attestation Statement<br>d. Residents #9 and #12 MDSs cannot be changed.<br>2. All residents have the potential to be affected<br>3. Coding Accuracy<br>a. The facility will ensure Sections M, N, and O of the MDS is coded accurately.<br>b. Residents will be determined at risk for pressure ulcers if identified as such by Braden assessment. Facility policy and procedure for determining if residents are at risk for pressure ulcers is being reviewed.<br>Discharge and Admission Assessments<br>c. All residents who are admitted within 30 days of discharge will have a Significant Change MDS completed. | |

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| F 278 | Continued From page 2<br>formal risk assessment tools to determine the resident's 'risk score.' . . . Coding Instructions . . . Code 1, yes: if the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100. . . . M1200: Skin and Ulcer Treatments . . . Coding Instructions: Check all that apply in the last 7 days. . . . M1200F Surgical Wound Care . . . Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. . . . M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet . . . M1200H Application of Ointments/Medications Other than to Feet . . . This category may include ointments or medications used to treat a skin condition . . . Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. . . . M1200I Application of Dressings to the Feet (with or without Topical Medications): Includes interventions to treat any foot wound or ulcer other than a pressure ulcer. . . ."<br><br>- Review of Resident #4's medical record occurred on all days of survey. The March 2017 Treatment Administration Record (TAR) identified staff completed a daily dressing change to Resident #4's left foot from March 01-06, 2017. An admission MDS, dated 03/06/17, identified a nonsurgical dressing other than to feet.<br><br>During an interview on the morning of 03/28/17, an administrative nurse (#1) confirmed Resident | F 278 | Completion of Discharge Assessments<br>d. Federal CMS Validation reports will be run at least weekly to verify that MDSs have been accepted by CMS system.<br>Attestation Statement<br>e. Education with MDS team was completed 3/28/17 regarding correct timing of coding with the look-back period.<br>4. May 2, 2017<br>5. Coding Accuracy<br>a. DON or designee will complete random audits of MDS Sections M, N, and O.<br>Discharge and Admission Assessments<br>b. DON or Designee will complete random audits to ensure residents admitted within 30 days of discharge will have a Significant Change MDS completed if unable to initially complete a MDS admission with CAAs.<br>Completion of Discharge Assessments<br>c. DON or Designee will complete random audits to ensure MDSs have been accepted by CMS system.<br>Attestation Statement<br>d. DON or Designee will complete random audits to ensure correct timing of coding with the look-back period.<br>Audit Schedule to be completed as follows: x1/weekly for 4 weeks, x1 monthly for 4 months and prn.<br>QAPI process followed to include improvements effective sustained and continued trial of necessary changes.<br>Quality Committee to review and provide recommendations prn. | |

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| F 278 | Continued From page 3<br>#4's left foot dressing should have been coded as 'dressings to feet.'<br><br>- Review of Resident #10's medical record occurred on all days of survey. A Medicare 14 day MDS, dated 03/13/17, identified surgical wound care. The medical record lacked evidence staff completed surgical wound care during the look-back period.<br><br>During an interview on 03/28/17 at 11:52 a.m., an administrative nurse (#1) confirmed Resident #10's surgical wound care should not have been coded.<br><br>- Review of Resident #5's medical record occurred on all days of survey. A Medicare 30 day MDS, dated 03/11/17, identified Section M0100 "Determination of Pressure Ulcer Risk," coded as "None of the above," and Section M0150 "Risk of Pressure Ulcers" coded as "No." The medical record showed a Braden assessment completed on 03/06/17 identifying the resident "At Risk" for pressure ulcers. The facility failed to properly code the MDS for the formal assessment (Braden) identifying a risk for pressure ulcers.<br><br>Review of Resident #5's March 2017 Medication Administration Record (MAR) identified Mupirocin 2% ointment applied twice daily to nares. A Medicare 30 day MDS, dated 03/11/17, failed to code M1200 H for "Applications of ointment/medications other than to feet" for the ointment.<br><br>MEDICATIONS | F 278 | | |

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| F 278 | Continued From page 4<br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 pages N-5 and N-6, stated, "N0410: Medications Received . . . Coding Instructions . . . N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period . . . N0410E, Anticoagulant (e.g. [example given], warfarin . . . ): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . . N0410G, Diuretic: Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period . . ."<br><br>- Review of Resident #4's medical record occurred on all days of survey. The February 08-14, 2017 MAR identified Resident #4 received furosemide (a diuretic medication) on two days, Venlafaxine (an antidepressant medication) on six days, and Lovenox (an anticoagulant medication) on three days. An admission MDS, dated 02/14/17, identified Resident #4 received a diuretic medication three days, an antidepressant medication five days, and did not receive an anticoagulant medication.<br><br>- Review of Resident #5's medical record occurred on all days of survey. The February 19-25, 2017 MAR identified the resident received Coumadin (an anticoagulant medication) on six days. A Medicare 14 day MDS, dated 02/25/17, identified Resident #5 received Coumadin on seven days.<br><br>During an interview on the morning of 03/28/17, an administrative nurse (#1) confirmed Resident | F 278 | | |

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| F 278 | Continued From page 5<br>#4 and #5's medications were coded incorrectly.<br><br>RESTORATIVE NURSING PROGRAM<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 page O-38, stated, "O0500: Restorative Nursing Programs . . . Activities provided by restorative nursing staff. O0500A, Range of Motion (Passive) . . . These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record. . . ."<br><br>- Review of Resident #1's medical record occurred on all days of survey. A quarterly MDS, dated 12/16/16, identified Resident #1 received one day of passive range of motion restorative nursing program. The medical record lacked evidence of the restorative nursing program.<br><br>During an interview on 03/27/17 at 4:40 p.m., an administrative nurse (#1) stated the facility does not have a formal restorative nursing program.<br><br>DISCHARGE AND ADMISSION ASSESSMENTS<br><br>2. Based on record review, review of the federal database for Long-Term Care surveys, review of the Long-Term Care Facility RAI User's Manual (Version 1.14), the facility failed to complete the correct MDSs for 3 of 12 sampled residents (Resident #3, #4, and #7) and 3 supplemental residents (Resident #13, #14, and #15). Failure to complete the correct MDSs after being discharged from the facility with return anticipated does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate | F 278 | | |

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| F 278 | Continued From page 6<br>development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 2 page 2-8, stated, ". . . Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations:<br>* when the resident has never been admitted to this facility before; OR<br>* when the resident has been in this facility previously and was discharged return not anticipated; OR<br>* when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge . . ."<br><br>- Review of Resident #3's medical record occurred on all days of survey. Resident #3's record identified a hospital stay from 01/31/17 through 02/03/2017. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.<br><br>- Review of Resident #4's medical record occurred on all days of survey. Resident #4's record identified a hospital stay from February 14-27, 2017. The facility completed a discharge assessment return anticipated MDS on 02/14/17. | F 278 | | |

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| F 278 | Continued From page 7<br>The facility then completed a discharge assessment return not anticipated MDS on 02/20/17, due to the resident/family not holding the bed after she went to the hospital. Upon return from the hospital, the facility incorrectly completed an admission MDS.<br><br>- Review of Resident #7's medical record occurred on all days of survey. Resident #7's record identified a hospital stay from March 05-10, 2017. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.<br><br>- Review of Resident #13's MDSs in the federal database occurred on 03/28/17 and showed the facility completed a discharge assessment return anticipated MDS on 05/27/16 and 06/09/16. Upon return to the facility, the facility incorrectly completed admission MDSs.<br><br>- Review of Resident #14's MDSs in the federal database occurred on 03/28/17 and showed the facility completed a discharge assessment return anticipated MDS on 09/24/16. Upon return to the facility, the facility incorrectly completed an admission MDS.<br><br>- Review of Resident #15's MDSs in the federal database occurred on 03/28/17 and showed the facility completed a discharge assessment return anticipated MDS on 04/25/16. Upon return to the facility, the facility incorrectly completed an admission MDS.<br><br>Resident #3, #4, #7, #13, #14, and #15 all returned to the facility within 30 days of | F 278 | | |

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| F 278 | Continued From page 8<br>discharge.<br><br>COMPLETION OF DISCHARGE ASSESSMENTS<br><br>3. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), the facility failed to complete discharge Minimum Data Sets (MDSs) for 3 supplemental residents (Resident #18, #19, and #20) who discharged from the facility.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 2 page 2-34, stated, ". . . Tracking Records and Discharge Assessments . . . OBRA [Omnibus Budget Reconciliation Act] - required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. . . . The Discharge assessments include items for quality monitoring. . . ."<br><br>- Review of Resident #18's medical record showed the resident discharged from the facility on 07/15/16. The facility failed to complete a discharge MDS.<br><br>- Review of Resident #19's medical record showed the resident discharged from the facility on 07/23/16. The facility failed to complete a discharge MDS. | F 278 | | |

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| F 278 | Continued From page 9<br>- Review of Resident #20's medical record showed the resident discharged from the facility on 11/9/12. The facility failed to complete a discharge MDS.<br><br>ATTESTATION STATEMENT<br><br>4. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) items on 2 of 12 sampled residents (Resident #9 and #12). Failure to include all the days of the look back period when completing the MDS has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . ." Therefore, the earliest you can code items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD.<br><br>Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that | F 278 | | |

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| F 278 | Continued From page 10<br>the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed . . . and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.<br><br>- Review of Resident #9's medical record occurred on all days of survey. A Medicare 30 day MDS with an ARD of 03/13/17 identified the following:<br>*Section C1310 (Delirium) completed with a Z0400 date of 03/13/17.<br><br>- Review of Resident #12's medical record occurred on all days of survey. An annual MDS with an ARD of 01/03/17 identified the following:<br>*Section C (Delirium) and Section D0200 A-I, D0300, D0500 A-J, and D0600 (Mood and Behaviors) completed with a Z0400 date of 11/28/16 (more than 30 days prior to the ARD). | F 278 | | |
| F 287 SS=D | 483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT<br><br>(f) Automated Data Processing Requirement<br><br>(1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br><br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, | F 287 | | 5/2/17 |

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| F 287 | Continued From page 11 | F 287 | | |

reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that
does not have an admission assessment.

(4) Data Format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

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| F 287 | Continued From page 12<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the federal database for Long-Term Care Surveys, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 1.14), the facility incorrectly submitted a discharge assessment return not anticipated MDS to the CMS Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for 1 of 3 sampled residents (Resident #4) transferred to the hospital, incorrectly submitted an End of Therapy (EOT) OMRAs (Other Medicare-required Assessments) to the CMS QIES ASAP system for 1 supplemental resident (Resident #16), and failed to electronically transmit encoded and completed Minimum Data Sets (MDSs) to the CMS QIES ASAP system within the proper time frame for 1 supplemental resident (Resident #17). Failure to transmit the MDSs within the required time frame may result in inaccuracy of the facility's Resident Level Quality Measure Reports.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, page 5-1, stated, ". . . Transmitting MDS Data . . . Assessments that are completed for purposes other than OBRA [Omnibus Budget Reconciliation Act] and SNF PPS [Prospective Payment System] reasons are not to be submitted, e.g. [example given], private insurance, including but not limited to Medicare Advantage Plans. . . ."<br><br>The Long-Term Care Facility RAI User's Manual, | F 287 | F 287<br>1. Resident #4<br>a. MDS assessments required with the state of ND system, but not Federal CMS system will only be sent to the ND system.<br>Resident # 16 and #17<br>b. MDSs that were not submitted to the CMS QIES ASAP will be submitted.<br>2. All residents have the potential to be affected.<br>3. Facility will ensure deficient practice will not recur.<br>a. MDS assessments required with the state of ND system, but not Federal CMS system will only be sent to the ND system.<br>b. CMS Validation reports will be run basis to ensure compliance with all CMS requirements. Education has been completed to ensure understanding of requirements.<br>4. May 2, 2017<br>5. DON or Designee will complete audits to ensure MDS assessments required with the state of ND system, but not Federal CMS system are only sent to the ND system.<br>DON or Designee will complete audits to ensure MDSs are completed and submitted as per the CMS MDS requirements.<br>Audit Schedule to be completed as follows: x1/weekly for 4 weeks, x1 monthly for 4 months and prn.<br>QAPI process followed to include | |

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| F 287 | Continued From page 13<br>revised October 2016, pages 2-50 and 2-51, stated, "There are several unscheduled assessment types that may be required to be completed during a resident's [Medicare] Part A SNF [Skilled Nursing Facility] covered stay. . . . End of Therapy (EOT) OMRA . . ."<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2016, pages 2-16 to 2-18 defines the submission deadline as 14 days after completion for all MDS types.<br><br>- Review of Resident #4's medical record occurred on all days of survey. Resident #4's record identified a discharge assessment return anticipated MDS dated 02/14/17; and a discharge assessment return not anticipated MDS dated 02/20/17. Review of the federal database identified both discharge assessments were submitted to the CMS QIES ASAP system. The discharge assessment return not anticipated MDS should not have been submitted to the CMS QIES ASAP system.<br><br>- Review of Resident #16's MDSs in the federal database occurred on 03/28/17 and showed a EOT MDS dated 05/27/16. The federal database showed Resident #16 did not receive Medicare Part A during that period of time, so the unscheduled assessment used for PPS (Prospective Payment System) should not have been submitted to the CMS QIES ASAP system.<br><br>- Review of Resident #17's MDSs in the federal database occurred on 03/28/17 and showed an Entry Tracking Record dated 06/03/11. The federal database did not show any other MDSs submitted for Resident #17. | F 287 | improvements effective sustained and continued trial of necessary changes. Quality Committee to review and provide recommendations prn. | |

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| F 287 | Continued From page 14<br><br>Review of Resident #17's medical record showed the following completed MDSs:<br>* ARD of 06/08/11: an MDS coded as an Admission, Medicare 5 day PPS, Start of Therapy, and a discharge return not anticipated<br>* ARD of 06/13/11: an Entry Tracking Record<br>* ARD of 06/18/11: an MDS coded as an Admission and a Medicare-Readmission<br>* ARD of 06/22/11: an MDS coded as a discharge return not anticipated<br><br>The facility failed to electronically transmit the above-stated entry tracking form and assessments completed on Resident #17. | F 287 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 441 | | 5/2/17 |

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| F 441 | Continued From page 15<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the | F 441 | | |

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| F 441 | Continued From page 16<br>spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility policy, the facility failed to follow standard infection control practices for 3 of 9 sampled residents (Resident #5, #8 and #11) observed during toileting/perineal cares. Failure to follow infection control practices while providing toileting/perineal cares has the potential to cause/spread infection.<br><br>Findings include:<br><br>Review of the facility policy titled "Hand Hygiene" occurred on 03/28/17. This policy, revised November 2013, stated, ". . . Hand hygiene will be done: a. Before and after resident contact (before you leave the room) b. before every clean procedure c. after every dirty procedure d. as needed. . . ."<br><br>Review of the facility policy titled "Perineal Care" occurred on 03/28/17. This policy, revised May 2013, stated, ". . . Staff must wash hands with soap and water after removing gloves following pericares . . ."<br><br>- Observation on 03/27/17 at 11:47 a.m. showed Resident #11 continent of bowel and a CNA (#4) performed perineal cares. The CNA removed her gloves and without performing hand hygiene assisted the resident into bed, removed the gaitbelt, placed a blanket on the resident and a | F 441 | F 441<br>1. Standard Infection Control Practices will be completed with Residents #5, #8, and #11<br>2. All residents needing assistance with perineal cares have the potential to be affected.<br>3. Education will be completed with Nurse and CNA staff on 4/26/17 regarding Standard Infection Control Practices including handwashing with perineal cares and glove usage.<br>4. May 2, 2017<br>5. DON or Designee will complete audits to ensure Standard Infection Control practices are followed with perineal cares.<br>Audit Schedule to be completed as follows: x3/weekly for 4 weeks, x1/weekly for 4 weeks, x1 monthly for 4 months and prn.<br>QAPI process followed to include improvements effective sustained and continued trial of necessary changes. Quality Committee to review and provide recommendations prn. | |

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| F 441 | Continued From page 17<br>pillow under the resident's right arm, gave the resident the call light, and then washed her hands. The CNA (#4) failed to perform hand hygiene after completing perineal cares and prior to completing other tasks.<br><br>- Observation on 03/27/17 at 3:39 p.m. showed Resident #8 incontinent of urine and a CNA (#3) performed perineal cares. Without removing his gloves, the CNA repositioned the resident in bed, placed a pillow under the resident's left side, elevated the head of the bed, and lowered the bed to the floor. The CNA then removed his gloves and washed his hands. The CNA (#3) failed to remove his gloves and perform hand hygiene prior to completing other tasks.<br><br>- Observation on 03/27/17 at 5:04 p.m. showed a certified nursing assistant (CNA) (#2) assisted Resident #5 with a urinal. The CNA failed to offer the resident hand hygiene. | F 441 | | |
| F 493 SS=E | 483.70(d)(1)(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN<br><br>(d) Governing body.<br><br>(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and<br><br>(2) The governing body appoints the administrator who is-<br><br>(i) Licensed by the State, where licensing is required; | F 493 | | 5/2/17 |

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| F 493 | Continued From page 18<br>(ii) Responsible for management of the facility; and<br><br>(iii) Reports to and is accountable to the governing body.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy and procedure and staff interview, the facility failed to implement policies regarding completing each section of the Minimum Data Set (MDS) for 7 of 12 sampled residents (Resident #2, #4, #6, #7, #8, #9, and #12). Failure to follow policies related to all aspects of the MDS may result in inaccurate resident assessments and incomplete care plans.<br><br>Findings include:<br><br>Review of the facility policy titled "RAI [Resident Assessment Instrument] Process - MDS 3.0" occurred on 03/28/17. This policy, revised September 2016, stated, ". . . * Section C - Social worker to do all * Section D - Social worker to do all . . . * Section K - Dietician . . . The RAI coordinator is responsible for reviewing the MDS, CAA's [Care Area Assessments] and care plans to assure it is completed, signed, and dated per RAI manual requirements. . . ."<br><br>Review of MDSs identified staff placed dashes, rather than completing the assessment, after items in Section C (Cognitive Patterns) and Section D (Mood) for the following:<br>* Resident #2's admission MDS, dated 01/16/17.<br>* Resident #4's admission MDS, dated 02/14/17.<br>* Resident #6's quarterly MDS, dated 01/27/17.<br>* Resident #7's admission MDS, dated 03/16/17. | F 493 | F 493<br>1. Assessments for MDS sections C, D, and K will be completed with no dashes within required timeframes.<br>2. All residents have the potential to be affected.<br>3. Education was completed with MDS team members completing Sections C, D, K and all other sections regarding required timeframe necessary to complete assessments on 3/28/17.<br>4. May 2, 2017<br>5. MDS Coordinator or designee will complete audits to ensure MDS sections are completed within required timeframes and do not require dashes.<br>Audit Schedule to be completed as follows: x3/weekly for 4 weeks, x1/weekly for 4 weeks, x1 monthly for 4 months and prn.<br>QAPI process followed to include improvements effective sustained and continued trial of necessary changes.<br>Quality Committee to review and provide recommendations prn. | |

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| F 493 | Continued From page 19<br>* Resident #8's quarterly MDS, dated 02/22/17.<br>* Resident #9's 30 day MDS, dated 01/09/17.<br>* Resident #12's annual MDS, dated 01/13/17.<br><br>Review of MDSs identified staff placed dashes, rather than completing the assessment, after items in Section K (Swallowing/Nutrition Status) for the following:<br>* Resident #4 admission MDS, dated 03/06/17.<br>* Resident #7's admission MDS, dated 03/16/17.<br>* Resident #12's annual MDS, dated 01/03/17.<br><br>During an interview on the afternoon of 03/27/17, an administrative nurse (#1) confirmed the facility lacked enough staff (specifically a licensed social worker) and time to complete certain MDS sections before MDS submission. | F 493 | | |