STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST WILLISTON, ND 58801**

(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 October 30, 2017 and completed on November 02, 2017, the sample included five (5) residents for complete review, 16 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F 225		12/15/17

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

Electronically Signed | 12/09/2017

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F 225	Continued From page 1 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy,	F 225	1. Investigation was completed of	

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F 225	Continued From page 2 and staff interview, the facility failed to investigate injuries of unknown origin for 1 of 1 resident (Resident #3) identified as having bruises. Failure to thoroughly investigate injuries of unknown origin placed Resident #3, as well as other residents in the facility, at risk for further injury and/or potential abuse, and did not enable the facility to determine the causative factors for the bruises and/or implement corrective actions. Findings include: Review of the facility policy titled "Investigation of Injury of Unknown Origin" occurred on 11/02/2017. This policy, revised July 2017, stated, ". . . An injury of unknown source is defined when . . . the following conditions are met . . . The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and . . . The injury is suspicious because . . . the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time . . ." Review of Resident #3's medical record occurred on October 30-November 2, 2017. Diagnoses included dementia and cognitive/communication deficits. The quarterly Minimum Data Set (MDS), dated 08/21/17, identified severely impaired cognition and supervision required for transfers and locomotion. The progress note, dated 10/03/17 at 10:36 p.m., stated, ". . . CNA [certified nursing assistant) reported to writer that the resident had a bruise on the back. Upon assessment, there are 3 bruises noted to her right upper back. . . . The 1st	F 225	identified bruises for Resident #3 and potential causative factor identified for bar on commode and plumbing on back of toilet. Bolstered pad (infection control compliant) for commode and plumbing bar was placed. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. All staff were re-educated on abuse & neglect (signs/symptoms, definitions, how to report, investigation process, and Elder Justice Act) at the "All Staff" meeting on 11/13/2017. Nursing staff were re-educated on the process of investigating an injury of unknown origin on 11/21/2017 & 11/22/2017. Policy and procedure on Investigation of Injury of Unknown Origin was reviewed. A bruise/injury of unknown origin will be reviewed at morning report Monday-Friday and on Saturday/Sunday the House Supervisor will review and if required notify DON/Administrator. Injury/Bruise Checklist was reviewed and updated. 4. The Director of Nursing Services (or designee) will monitor bruise/injury of unknown origin daily. Monitoring will be reported to the QAA committee monthly for 12 months by the Director of Nursing (or designee). 5. December 15, 2017.	

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F 225	Continued From page 3 bruise to the right upper back is 10 cm (centimeters) x 3 cm. The 2nd bruise is 9 cm x 2 cm. The 3rd bruise is 11 cm x 3 cm. . . ." The Injury/Bruise Checklist, dated 10/03/17, further identified Resident #3 "ambulates [with] walker . . . tends to make [and] unmake bed. packs [and] unpacks clothing wanders . . ." The facility was unable to provide evidence of a thorough investigation including the possible causative factors for the three bruises to Resident #3's back and implement corrective actions the facility to prevent further injury/bruising from occurring. During an interview on 11/02/17 at 8:50 a.m., an administrative nurse (#6) confirmed staff should have attempted to identify the cause of Resident #3's bruises and any new interventions (if any) implemented to prevent further injury/bruising from occurring.	F 225		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to provide care for 4 of 21 sampled residents (Resident #1, #2, #9, and #14) and 1 supplemental resident (Resident #25) in a	F 241	F241 A: 1. Staff caring for resident #14 were re-educated on the policy and procedure for English Language Only. 2. Any resident in the skilled nursing	12/15/17

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F 241	Continued From page 4 manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to provide privacy when bathing and speak in a language familiar to the resident (Resident #14); failure to knock on doors and wait for a reply before entering (Resident #1, #2, and #25); and failure to reposition a resident in a dignified manner (Resident #9) does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment or emotional harm. Findings include: Review of the facility policy titled "English Language Only" occurred on 11/02/17. This policy, dated November 2014, stated, ". . . Employees are required to speak English at all times while on duty including within resident rooms while providing cares." - An interview occurred on 10/31/17 at 2:00 p.m. with Resident #14. When asked if she had any concerns related to privacy and dignity, the resident admitted to being a "very private" person and bath days are uncomfortable. The resident stated staff members "come and go" in the tub room while she is in the tub and left exposed. Resident #14 also stated staff members talk to each other in another language and laugh, and he/she does not know if they are talking about her. During an interview on 11/02/17 at 9:30 a.m., an administrative nurse (#1) stated she expected facility staff to speak English when caring for residents.	F 241	facility has the potential to be affected. 3. All staff were re-educated at the "All Staff" meeting on 11/13/2017 on the "English Language Only" policy. Nursing staff were re-educated on the "English Language Only" policy at nursing meetings held 11/21/2017 and 11/22/2017. After education was provided each employee□s at BLNRC signed the policy. Upon hire and annually employees will review and sign the "English Language Only" policy. 4. The Social Service Director (or designee) will interview residents weekly x 2 months, then monthly x 10 months for concerns voiced by residents of staff not speaking in the English language. Results of the monitoring will be reported to the QAA committee monthly by the Social Service Director. Human Resource Director (or designee) will monitor 10% of new hire and annual employee personal files to verify "English Language Only" policy has been signed by employee. Monitoring will be conducted weekly x 1 month, then monthly x 11 months. Results of the monitoring will be reported to the QAA committee monthly. 5. December 15, 2017. F241 B: 1. Staff caring for resident #1, #2, #9, #14, and #25 were re-educated to knock on resident room/bathroom door, pause, and ask for permission prior to entering room. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. All staff were re-educated at the "All	

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F 241	Continued From page 5 - Observations on 10/31/17 showed the following: * At 8:55 a.m., a certified nursing assistant (CNA) (#15) knocked softly on Resident #1's bathroom door as she entered the room uninvited. The CNA proceeded to wash her hands in the sink, despite the fact Resident #25 from the adjoining room was already in the bathroom. * At 12:20 p.m., an unidentified nurse carrying a supplement, knocked, and entered Resident #2's room uninvited. * At 2:07 p.m., a CNA (#7) entered Resident #2's room without knocking or announcing himself. - Review of Resident #9's medical record occurred on all day of survey. The current care plan stated, ". . . BED MOBILITY: I require extensive staff participation to reposition and turn in bed. . . . TRANSFER: I require Mechanical Aid full assist lift of 2 for transfers. . . ." Observation on 10/30/17 at 5:15 p.m. showed two CNAs (#11 and #16) transferred Resident #9 into his wheelchair with a full body mechanical lift. A CNA (#11) used the resident's pants to lift and pull the resident further back in the wheelchair. Observation on 10/31/17 at 11:16 a.m. showed two CNAs (#17 and #18) transferred Resident #9 into his wheelchair with a full body mechanical lift. A CNA (#17) used the resident's pants to lift and pull the resident further back in the wheelchair.	F 241	Staff" meeting on 11/13/2017 to knock on resident room/bathroom doors, pause, and permission to enter room. Nursing staff were re-educated on 11/21/2017 & 11/22/2017 to knock on resident room/bathroom doors, pause, and ask for permission prior to entering room. 4. The Director of Nursing Services (or designee) will monitor for knocking on resident room/bathroom doors weekly x 2 months, then monthly for 10 months. Results of the monitoring will be reported to the QAA committee meeting monthly by the Director of Nursing Service (or designee). 5. December 15, 2017. F241 C: 1. Staff members caring for resident #9 were re-educated to utilize gait belt to reposition resident. 2. Any resident in the skilled nursing facility who requires assistance with positioning/transferring have the potential to be affected. 3. All staff were re-educated at the all staff meeting on 11/13/2017 and nursing staff were re-educated on 11/21/2017 & 11/22/2017 to utilize a gait belt to reposition residents who require assistance with positioning/transfers. 4. The Director of Nursing Services (or designee) will monitor for utilization of gait belt for transfers/repositioning in a chair weekly for 2 months, then monthly for 10 months. Results of the monitoring will be reported to the QAA committee meeting monthly by the Director of Nursing (or designee).	

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F 241	Continued From page 6	F 241	5. December 15, 2017.	
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		12/15/17

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F 309	Continued From page 7 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/22/16 Based on record review, review of facility protocol, and staff interview, the facility staff failed to follow their bowel protocol to promote regular bowel elimination for 1 of 1 sampled resident (Resident #7) who received a suppository before attempting a less invasive intervention for bowel elimination. Failure to follow the bowel protocol may result in residents experiencing constipation and discomfort due to delayed bowel elimination. Findings include: Review of the facility protocol titled "ROUTINE BOWEL PROTOCOL" occurred on 11/02/17. This protocol, dated September 2017, stated, "Purpose: Promote early recognition of constipation and to reduce episodes of constipation. . . . 4. Approaches through the use of medications: a. Frequency of bowel movements less than 3 times per week, normal size and consistency. Implement a bulk or stimulant: . . . Laxative - if no BM [bowel movement] on 3rd day may administer Milk of Magnesia 30 ml [milliliters] orally as needed . . . b. Stools hard to pass or required straining to expel. Implement stool softener or stimulant . . . 3. If no BM on 3rd day may administer Milk of Magnesia. . . c. If no bowel movement is noted initiate the following as needed: 1. Bisacodyl (Dulcolax) 10 mg [milligrams] suppository one	F 309	1. Bowel regimen for resident #7 was reviewed and revised. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. All staff were re-educated at the "All Staff" meeting held on 11/13/2017 and nursing staff at nursing meetings held on 11/21/2017 & 11/22/2017 on the "Routine Bowel Protocol." Upon admission, adjustment in medication regimen, and change of condition residents will be reviewed for appropriate bowel regimen. The Director of Nursing (or designee) will monitor daily alerts for residents who have not had a bowel movement in three days from electronic medical record. These residents will be discussed by interdisciplinary team for adjustments in resident plan of care. 4. The Director of Nursing (or designee) will monitor daily alerts for residents who have not had a bowel movement in three days and notify the charge nurse/interdisciplinary team and discuss present intervention and/or additional interventions (starting with least invasive intervention). Results of the monitoring will be reported to the QAA committee monthly by the Director of Nursing (or designee). The Director of Nursing (or designee) will review ten percent of admission, significant change, and/or medication change resident records weekly for 2 months, then monthly	

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F 309	Continued From page 8 rectally on day #4 if no results from the Milk of Magnesia. . . ." Review of Resident #7's medical record occurred on all days of survey. Medications included Senna S (laxative and stool softener) twice a day (initiated 10/16/17), and a Dulcolax suppository every 72 hours as needed. Review of Resident #7's bowel elimination records and medication administration records (MARs), dated September 01 through October 31, 2017, showed the following: * No BM September 28, 29, 30, and October 01 (4 days). Nursing staff administered a Dulcolax suppository on October 02 (with results) but failed to administer a less invasive intervention prior to the suppository. * No BM October 13, 14, 15, and 16 (4 days). Nursing staff administered a Dulcolax suppository on October 17 (with results) but failed to administer a less invasive intervention prior to the suppository. During an interview on 11/02/17 at 9:30 a.m., an administrative nurse (#1) stated she expected nursing staff to follow the facility's bowel protocol for all residents, including Resident #7.	F 309	thereafter. Results of the monitoring will be reported to the QAA committee monthly by the Director of Nursing (or designee). 5. December 15, 2017.	
F 312 SS=E	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		12/15/17

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F 312	Continued From page 9 Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents received the necessary services required to maintain good nutrition for 4 of 10 sampled residents (Resident #1, #2, #3, and #8) observed during meals. Staff's failure to provide cues and/or assistance during meals has the potential to affect the residents' ability to maintain their caloric intake and/or nutritional status. Findings include: Review of the facility policy titled "Assistance with Meals" occurred on 11/02/17. This policy, dated December 2008, stated, ". . . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. . . ." - Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/10/17, identified severely impaired cognition, required supervision and assistance during meals, and receives a mechanically altered, therapeutic diet. The current care plan stated, ". . . Assist me with meals PRN [as needed]. If I won't drink my fluids, spoon feed them to me. . . ." On 10/31/17 at 8:05 a.m., observation showed Resident #1 rocking back and forth in her wheelchair next to an assisted table in the dining room. Staff had placed her breakfast on the table in front of her. At approximately 8:10 a.m., an unidentified certified nursing assistant (CNA) observed Resident #1 staring into space, and told her to "eat." At 8:48 a.m., Resident #1 was still seated in the same location chewing on a	F 312	F312 A: 1. Staff caring for residents #1, #2, #3, were re-educated on cueing and required assistance during meals. Individualized care plan for identified resident's were reviewed and Point of Care tasks (electronic medical record) were updated to include individualized meal assistant needs. 2. Any resident in the skilled nursing facility who requires assistance with meals has the potential to be affected. 3. Nursing staff were re-educated during nursing meetings held on 11/21/2017 and 11/22/2017 and again at shift to shift huddles held on 12/06/2017 on cueing and required assistance during meals as identified on the individualized care plans. 4. The Director of Nursing (or designee) will monitor for cueing and required meals assistance as identified in the individualized care plans weekly x 2 months, then monthly x 10 months. Results of monitoring will be reported to the QAA committee monthly by the Director of Nursing Services. 5. December 15, 2017. F312 B: 1. Staff caring for resident #2 & #3 were re-educated on positioning/placement. Individualized care plans for resident #2 & #3 were reviewed by the interdisciplinary team. No changes were required. 2. Any resident in the skilled nursing facility who requires assistance with meal service has the potential to be affected. 3. Education on positioning/placement	

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F 312	Continued From page 10 plastic lid (from one of the glasses on her tray). An unidentified nurse observed the surveyor watching Resident #1, approached the table, and removed the lid from her reach. At 8:55 a.m. two CNAs (#14 and #15) removed Resident #1 from the dining room. Resident #1 took two-to-three small bites of toast and drank a small glass of juice and water during the fifty minutes she sat in the dining room. Her sausage and cereal remained untouched. Facility staff failed to reheat the hot food items on Resident #1's tray and failed to cue/assist her during the meal. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 09/24/17, identified severely impaired cognition and required supervision and assistance during meals. The current care plan stated, ". . . Assist me with meals as needed. . . ." Observations showed the following: * On 10/31/17 at 8:40 a.m., Resident #2 lay in bed, with the head of her bed reclined to an approximate 65 degree angle. An unidentified CNA delivered Resident #2's room tray and placed it on the bedside table before exiting the room. At 9:25 a.m., a CNA (#13) reported Resident #2 drank her water. Her sausage, toast, cereal, coffee, and juice, remained untouched. Facility staff failed to reposition Resident #2 prior to and cue/assist her during the meal. * On 10/31/17 at 12:20 p.m., Resident #2 lay in bed, with the head of her bed reclined to an approximate 65 degree angle. An unidentified CNA delivered Resident #2's room tray and placed it on the bedside table before exiting the room. Resident #2 took one bite of her pulled-pork sandwich and drank 50% of her	F 312	was completed during nursing staff meetings held on 11/21/2017 & 11/22/2017 and on 12/05/2017 & 12/6/2017 during shift to shift huddles. Competency checklist for nursing updated to include positioning/placement of residents for meals. 4. The Director of Nursing (or designee) will monitor for positioning/placement of residents during meal service weekly for 2 months, then monthly for 10 months. Results of the monitoring will be reported to the QAA committee monthly by the Director of Nursing (or designee). 5. December 15, 2017. F312 C: 1. Staff caring for resident #8 were re-educated on required individualized adaptive devices during meals. 2. Any resident in the skilled nursing facility who requires adaptive devices during meals has the potential to be affected. 3. Nursing staff were re-educated in regards to identification of adaptive devices on tray card and documentation of tasks in Point of Care (electronic medical record) during mandatory nursing meetings held on 11/21/2017 & 11/22/2017 and during shift to shift huddles on 12/05/2017 & 12/06/2017. Dietary staff have been re-educated on setting tables with adaptive devices as identified on individualized tray cards. Competency checklist for nursing and dietary updated to include identified adaptive devices and location on tray	

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F 312	Continued From page 11 supplement. Her soup and fruit remained untouched. Facility staff failed to reposition Resident #2 prior to and cue/assist her during the meal. - Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 08/21/17, identified severely impaired cognition, required supervision and set-up assistance during meals, and received a mechanically altered diet. The current care plan stated, ". . . Assist me with meals as needed. . . . I need a calm, quiet setting at meal times with adequate eating time. I prefer to sit with one person. . . ." On 10/31/17 at 12:10 p.m., observation showed Resident #3 seated with two other residents next to an independent table in the dining room. Resident #3 fixated on her tablemate's tray, talking about the various food items on her tray and pulling the dishes away from and/or pushing them towards her. Resident #3 took two-to-three teaspoons of soup and two-to-three small bites of fruit. Her sandwich, coffee, milk, cranberry juice, and water remained untouched. Facility staff failed to seat Resident #3 at a table with only one other resident and failed to cue/assist her during the meal. During an interview on 11/02/17 at 8:50 a.m., an administrative nurse (#6) confirmed staff should have positioned Resident #2 as close to 90 degrees as possible, seated Resident #3 at a table with other resident, and cued/assisted Resident #1, #2, and #3 during meals. - Review of Resident #8's medical record occurred on all days of survey. The quarterly	F 312	card. 4. The Director of Food Service (or designee) will monitor for individualized adaptive devices during meal service weekly x 2 months, then monthly for 10 months. Results of monitoring will be reported to the QAA committee meeting monthly by the Director of Food Service (or designee). 5. December 15, 2017	

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F 312	Continued From page 12 MDS, dated 10/09/17, identified severely impaired cognition, required extensive assistance of one person for eating, and received a mechanically altered and therapeutic diet. The current care plan stated, ". . . pedestal cups w/ [with] lids/hole/straws for all beverages as needed. . . ." The diet card, dated 11/02/17, stated, ". . . PestalCp [pedestal cup]+Lid+Stw [straw] . . ." A nutrition review, dated 10/09/17, stated, ". . . Adaptive equipment provided . . . Pedestal Cups (Lids & Straws) . . ." Observation of breakfast and lunch on 10/31/17 at 8:00 a.m. and 12:05 p.m. showed her fluids in regular cups. Facility staff failed to provide Resident #8 with pedestal cups with lids and straws.	F 312		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		12/15/17

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F 323	Continued From page 13 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 2 of 8 sampled residents (Resident #10 and #13) who required assistance with transfers using a gait belt. Failure to utilize gait belts for assisted transfers, placed the residents at risk of accidents and injury. Findings include: Review of the "Transfer/Gait Belts, Use Of" policy and procedure occurred on 11/02/17. The policy and procedure stated, "PURPOSE: Ensure safety for residents and staff. PROCEDURE: . . . Staff transferring residents will properly apply and use a transfer/gait belt as appropriate when ambulating or transferring residents whose: . . . Balance is impaired . . . Muscle tone and/or strength is decreased . . . Care plan identifies use of the transfer/gait belt with special care instructions. . . . Residents requesting transfer/gait belt on their person, when up, will have one issued. . . ."	F 323	F323 A 1. Staff providing care to resident #10 and #13 were re-educated on utilization of a gait belt with residents who require assistance with transfers. Care plans for resident #10 and #13 were reviewed and updated to include use of a gait belt. 2. Any resident in the skilled nursing facility who requires assistance with transfers have the potential to be affected. 3. Staff were re-educated at the "All Staff" meeting held on 11/13/2017 and nursing staff meetings held on 11/21/2017 and 11/22/2017 for use of gait belts during transfers on residents who require assistance with transfers. Nursing staff have been re-educated on the use of a gait belt. Policy and Procedure for Transfer/Gait Belts, Use of was reviewed. 4. The Director of Nursing (or designee) will monitor 10 percent of residents who require assistance with transfer weekly for two months, then monthly for 10 months. Results of monitoring will be reported to the QAA committee monthly by the Director of Nursing (or designee). 5. December 15, 2017.	

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F 323	Continued From page 14 - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia with behaviors and Alzheimer's disease. The current care plan stated, ". . . TRANSFER: I require 1 assistance with gait belt and FWW [four wheeled walker] with transferring. . . ." Observation on 10/31/17 at 5:35 p.m. showed a certified nursing assistant (CNA) (#19) transferred Resident #10 from his wheelchair to the bathroom and back to his wheelchair. The CNA (#19) held onto the resident's pants to transfer him back into the wheelchair. The CNA (#19) failed to utilize a gait belt to transfer Resident #10. - Review of Resident #13's record occurred on all days of survey. Diagnoses included generalized muscle weakness, difficulty walking, weakness, fatigue, Parkinson's disease, and dementia. Resident #13's current care plan stated, "Transfer: I use a Lumex (a non- mechanical transfer device) and assist x 1 (of one) to transfer." During all observations on 10/30/17 at 5:14 p.m., 10/31/17 at 9:00 a.m. and 10:35 a.m. of transfers, two CNAs used the Lumex lift and a gait belt to transfer Resident #13. During an observation on 10/31/17 at 2:44 p.m., two certified nursing assistants (CNAs #11 and #12) transferred Resident #13 from his wheelchair to his recliner using a Lumex without a gait belt. To assist Resident #13 to stand up from the wheelchair, one CNA (#12) pulled up on the resident's arm and the other CNA (#11)	F 323	F323 B: 1. Investigation was completed for the elopement that occurred with resident #10. All door alarms in facility were checked. Care plan for resident #10 was reviewed. 2. Any resident in the skilled nursing facility who has a cognitive deficit has the potential to be affected. 3. All staff were re-educated at the "All Staff" meeting on 11/13/2017 and nursing staff were re-educated on 11/21/2017 & 11/22/2017 on the elopement procedure and door alarms. Elopement Procedure was reviewed. Door alarms will be checked by nursing staff twice per day. Batteries in door alarms will be changed every three months by maintenance. Door alarms will be added to new employee orientation checklist for nursing staff and maintenance staff. 4. The Director of Nursing (or designee) will monitor the checking of the door alarms weekly for 2 months, then monthly for 10 months. Results of the monitoring will be reported to the QAA committee monthly. The Maintenance Supervisor will monitor the changing of door alarm batteries quarterly. Results of monitoring will be reported to the QAA committee monthly by the Maintenance Supervisor. 5. December 15, 2017.	

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F 323	Continued From page 15 pushed up on the resident's hips. By pulling and pushing in this manner, the CNAs (#11 and #12) assisted Resident #13 to stand straight enough to fold down the seat of the Lumex lift. The CNA's (#11 and #12) positioned Resident #13 over his lift recliner elevated to its full lift height. The CNA's cued the resident to stand up tall, as one CNA (#11) pulled up on the resident's arms, the other CNA (#12) pushed up on his hip/buttock area. One CNA commented to the other that Resident #13 is weaker in the afternoon. When the CNAs (#11 and #12) assisted the resident to stand up straight enough, CNA (#11) folded the seat of the Lumex out of the way and Resident #13 sat on the recliner. With the recliner elevated, the CNAs (#11 and #12) pulled the Lumex away from the recliner while Resident #13's feet remained braced on the foot plate of the lift. Resident #13 slid down in the recliner. The CNAs (#11 and #12) stood on each side of Resident #13 and positioned him, lifting on his axilla and leg to move him back in his recliner. During interview on 11/01/17 at 3:00 p.m., an administrative nurse (#10) identified staff should have used a gait belt with Resident #13's Lumex transfer. ELOPEMENT 2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure the safety for 1 of 1 sampled resident (Resident #10) who eloped. Failure to thoroughly investigate an elopement could result in the resident leaving the facility unsupervised. Findings:	F 323		

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F 323	Continued From page 16 Review of the facility procedure titled, "Elopement Procedures" occurred on 11/02/17. This policy, revised May 2016, stated, ". . . If the resident is not located during the initial search . . . 8. The Elopement Alert Notice will be filled out by the charge nurse and an Elopement Incident Report Form will be started. . . . The nurse in charge shall complete the Elopement Incident Report Form . . ." Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia with behaviors and Alzheimer's disease. The current care plan stated, ". . . I am at moderate risk for elopement. . . . 15 minute monitoring for impulsiveness and fall risk. . . ." The nurse's progress notes identified the following: * 10/07/17 at 6:13 a.m.: "During rounds resident noted to [sic] standing outside of exit door near unit kitchenette. Resident assisted back inside the facility. Complete head to toe body assessment done with abrasion noted on front right knee. No bleeding noted. ROM [range of motion] WNL [within normal limits] for this resident. No complaints of pain/discomfort noted. T [temperature] 98.1 P [pulse] 72 R [respirations] 20 B/P [blood pressure] 134/63 SPO2 [oxygen saturations] 96% RA [room air]." * 10/07/17 at 7:55 a.m.: "Updated his daughter . . . of resident being outside during the night hours. Resident has been quite active thus far today. Staff took him for a wheel chair [sic], walking with staff, providing 1-1 [one on one] and music therapy. Had a fair appetite for breakfast."	F 323		

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F 323	Continued From page 17 An incident report, dated 10/07/17 at 5:53 a.m. stated, "Resident was found standing outside the exit door near unit kitchenette. Resident assisted back inside the facility and assessed. Complete head to toe assessment done and resident noted to have abrasion on right knee. No bleeding noted. No c/o [complaints of] pain noted when area assessed. ROM WNL for this resident. Gait is unsteady." During an interview on 10/31/17 at 5:50 p.m., an administrative nurse (#10) stated administration reviewed cameras and verified Resident #10 was outside for three minutes before facility staff brought him back inside the building. During an interview on 10/31/17 at 6:00 p.m., an administrative nurse (#6) stated she was not sure if the door alarmed. A progress note dated, 11/01/17 at 7:30 a.m., stated, "Verified by camera that resident was outside for 3 minutes and returned to family lounge on Wheatland by staff." Facility staff failed to thoroughly investigate Resident #10's elopement, including contributing factors. This failure limited the facility's ability to implement the necessary measures to prevent further elopements.	F 323		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		12/15/17

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F 329	Continued From page 18 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure a	F 329	F329 A: 1. Staff caring for residents #7, #19,	

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F 329	Continued From page 19 medication regimen free from unnecessary drugs for 4 of 4 sampled residents (Resident #7, #19, #20, and #21) who received as needed (PRN) antianxiety medications. Failure to attempt non-pharmacological interventions prior to administering an antianxiety medication and failure to conduct a follow up assessment placed residents at risk for receiving unnecessary medications and experiencing adverse consequences related to the medications. Findings include: Review of the facility policy, "Resident Behavior" occurred on 11/02/17. This policy, dated August 2013, stated, ". . . All residents shall be observed for mental, emotional and behavioral changes as well as physical condition and initiate appropriate interventions. Staff actions will be directed toward problem awareness, problem description and observation in order to identify goals, interventions, and approaches. . . . Behavioral interventions - all planned actions by the interdisciplinary team, physician, or outside mental health professional; must be incorporated in the overall plan of care and directed toward prevention or changing inappropriate behaviors; interventions may include structuring of the environment and consider consistency of approaches. . . . Interdisciplinary progress notes shall reflect the success of intervention and change in inappropriate behaviors. . . ." Review of the facility policy, "Nursing Practice Guidelines - Nursing Service Department" occurred on 11/02/17. This policy, dated July 2017, stated, ". . . Psycho-Social Needs will be met by: . . . Initiating appropriate nursing	F 329	#20, #21 were re-educated on the need for documenting non-pharmacological interventions prior to the use of anti-anxiety medications. New documentation records were added to charts for each as needed anti-anxiety medication. 2. Any resident in the skilled nursing facility receiving as needed anti-anxiety medications has the potential to be affected. 3. Nursing staff were re-educated during nursing meetings on 11/21/2017 and 11/22/2017 on documenting non-pharmacological interventions on new documentation sheets prior to administration of as needed medications. Reviewed policy and procedure "Resident Behaviors" and "Nursing Practice Guidelines - Nursing Service Department" were reviewed. 4. The Director of Nursing (or designee) will monitor for the use of non-pharmacological interventions prior to the administration of as needed anti-anxiety medications daily x 4 weeks, then weekly, x 2 months, then monthly x 9 months. Results of the monitoring will be reported to the QAA committee monthly by the Director of Nursing Services. 5. December 15, 2017. F329B: 1. Staff caring for residents #7, #21, #20 were re-educated on documentation of effectiveness of as needed medications. 2. Any resident in the skilled nursing facility who are receiving as needed	

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F 329	Continued From page 20 intervention in regard to resident's fears, anxieties and feelings. . . ." - Review of Resident #19's medical record occurred on November 01-02, 2017. Medication included alprazolam tablet 0.25 milligrams (mg) by mouth every 8 hours PRN for anxiety. Resident #19's current care plan stated, "Focus: I have an ADL [activity of daily living] self care performance deficit r/t [related to] confusion, dementia, I am dependent [sic] for ADLs. . . . Intervention: Provide for privacy, maintain warm environment during bathing. . . . Provide me with a sponge bath if a full bath or shower cannot be tolerated. . . . Focus: I have mood problem r/t diagnosis of anxiety disorder and recurrent depressive disorder. I holler at times during cares or when I am wanting something. . . . Interventions: Explain clearly what you are going to do before performing cares. I need time to talk. Encourage me to express feelings if I appear anxious or upset. If I am yelling, I calm easily if you hold my hand, reassure me and ask me what is wrong. . . ." Resident #19's Medication Administration Records (MARs), dated August 2017 through October 2017, showed the following: * August: Received PRN alprazolam eight times, with three of the eight times staff documented "prior to bath." * September: Received PRN alprazolam five times, with four of the five times staff documented "prior to bath." * October: Received PRN alprazolam four times, with all times staff documented as "prior to bath."	F 329	medications has the potential to be affected. 3. Nursing staff were re-educated during nursing meetings on 11/21/2017 and 11/22/2017 and on 12/6/2017 and 12/7/2017, regarding documentation of effectiveness of as needed medications. 4. The Director of Nursing (or designee) will monitor effectiveness of as needed medications daily x 4 weeks, then weekly x 2 months, then monthly x 9 months. Results of the monitoring will be reported to the QAA committee monthly by the Director of Nursing (or designee). 5. December 15, 2017.	

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F 329	Continued From page 21 The record lacked evidence staff attempted non-pharmacological interventions prior to administering alprazolam. During an interview on 11/02/17 at 10:19 a.m., an administrative nurse (#2) stated the resident's behavioral charting and progress notes lacked any interventions attempted before administering the PRN alprazolam. - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included Alzheimer's disease. Medications included lorazepam every 6 hours PRN for agitation related to dementia. Resident #7's care plan stated, "Focus: I have a mood disorder and delusional disorder dx [diagnosis]. can be irritable and/or physically and verbally abusive to staff and residents at times. . . . I will yell out when I have a new care-giver providing toileting assistance. . . . Interventions: *Music therapy. I enjoy playing Piano. One is located on my neighborhood. *30 minute monitoring. *Assess and anticipate resident's needs: food, thirst, toilet, comfort level, body positioning, and pain. *Assess resident's understanding of the situation and allow her time to express her feelings. . . . Pet therapy. I enjoy watching the bird in the Harmony lounge. *Use distraction when possible. I enjoy drinking coffee and I like sweets. *Utilize therapeutic fibbing PRN by calling my son [name]. *When I become agitated/verbally abusive; Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Make sure you explain	F 329		

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F 329	Continued From page 22 what you are going to do when providing cares." Review of Resident #7's MARs and nursing notes, dated September 01 through October 31, 2017, showed the following: * 09/03/17 - Received lorazepam at 3:46 a.m. for agitation. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of lorazepam and failed to assess the efficacy until 5:30 a.m. (one hour and 45 minutes later). * 09/04/17 - Received lorazepam at 2:40 a.m. for agitation. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of lorazepam and failed to assess the efficacy until 4:41 a.m. (two hours later). * 09/05/17 - Received lorazepam at 9:36 a.m. The staff failed to identify the resident's behavior, interventions attempted prior to the administration of lorazepam, and failed to assess the efficacy. * 09/08/17 - Received lorazepam at 6:07 a.m. for hitting, slapping, and scratching staff. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of lorazepam. * 09/08/17 - Received lorazepam at 5:02 p.m. for hitting, slapping, and scratching staff. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of lorazepam. * 09/13/17 - Resident #7 received lorazepam and morphine (pain medication) at 12:27 p.m. The staff failed to identify the resident's behavior and pain and interventions attempted prior to the administration of lorazepam and morphine. The nurse failed to assess the efficacy until 4:41 p.m.	F 329		

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F 329	Continued From page 23 (4 hours later). * 09/29/17 - Received lorazepam at 10:41 p.m. The staff failed to assess the efficacy until 2:24 a.m. (three and a half hours later). * 10/09/17 - Received lorazepam at 11:00 p.m. for wandering and shouting at staff. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of lorazepam and failed to assess the efficacy until 10/10/17 at 5:21 a.m. (over six hours later). During an interview on 11/02/17 at 9:30 a.m., an administrative nurse (#1) stated she expected nursing staff to attempt the non-pharmacological interventions identified in Resident #7's care plan before administering lorazepam and a follow up assessment should be conducted in one to one and a half hours. - Review of Resident #21's medical record occurred on November 01-02, 2017. Medications included, "Lorazepam Tablet 1 mg by mouth as needed for Restlessness/anxiety related to RESTLESSNESS AND AGITATION; GENERALIZED ANXIETY DISORDER Give 1 mg by mouth twice daily as needed in addition to scheduled doses." Resident #21's current care plan stated, "Focus: I have mood problem r/t dementia with behavioral disturbances, depression and anxiety. I am a moderate elopement risk and have been pacing the hallways at times and rummaging through things in my room moving things around. . . . Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Assist me in developing and me	F 329		

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F 329	Continued From page 24 [sic] with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity and socialization. . . . Eyes on. . . . I need time to talk. Encourage me to express feelings. Stop by and visit with me when passing by. Monitor and record mood to determine if problems seem to be related to external causes, medications, treatments, etc. Monitor, record,report [sic] to MD [Medical Doctor] prn mood patterns s/sx [signs/symptoms] of depression, anxiety, sad mood as per facility behavior monitoring protocols. Monitor/record/report to MD prn risk for harming others; increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity." Resident #21's MAR for October 2017 showed the following: * 10/25/17 - Received PRN lorazepam at 7:59 p.m., for anxiousness due to a new place. The record failed to identify non-pharmacological interventions attempted prior to administration of the lorazepam. * 10/27/17 - Received PRN lorazepam at 1:41 p.m. The staff failed to assess the efficacy until 3:49 p.m. (over two hours later). * 10/28/17 - Received PRN lorazepam at 11:05 p.m. The staff failed to identify the non-pharmacological interventions attempted prior to the administration of the lorazepam and	F 329		

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F 329	Continued From page 25 failed to assess the efficacy until 10/29/17 at 2:06 a.m. (over two hours later). - Review of Resident #20's medical record occurred on November 01-02, 2017. Diagnoses included dementia with behaviors and Alzheimer's disease. Medications included lorazepam every 12 hours as needed for agitation related to dementia. The current care plan stated, ". . . I have mood problem r/t depression dx. I have a hx [history] of visual hallucinations. . . . Administer medications as ordered (Zoloft, Ativan). . . . I enjoy my books on tape. Offer for me to listen to them throughout the day. . . . Pet therapy. . . . Re-direct if agitated. Call my daughter . . . to help calm and re-direct me. Listen to my books on tapes, go for a w/c [wheelchair] ride, offer snack or coffee . . . Record any episodes of behaviors in the behavior log at the nurses station. . . ." Review of Resident #20's MARs and nurse's notes on administration of lorazepam, dated September 01 through October 31, 2017, showed following: * 09/09/17 at 10:21 p.m.: "Resident is restless and agitated." Facility staff failed to identify non-pharmacological interventions attempted prior to the administration of lorazepam and failed to assess the efficacy until 1:48 a.m. (three hours later). * 09/10/17 at 8:38 p.m.: "restless and agitated, redirected, offer some water" Facility staff failed to identify non-pharmacological interventions attempted prior to the administration of lorazepam. * 09/15/17 at 9:37 p.m.: "Lorazepam img [one	F 329		

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F 329	Continued From page 26 milligram] given for restlessness and agitation." Facility staff failed to identify non-pharmacological interventions attempted prior to the administration of lorazepam and failed to assess the efficacy until 11:54 p.m. (over two hours later). * 09/17/17 at 11:12 p.m.: "resident is restless and agitated" Facility staff failed to identify non-pharmacological interventions attempted prior to the administration of lorazepam. * 09/20/17 at 8:11 p.m.: The medical record lacked an indication for use. Facility staff failed to identify non-pharmacological interventions attempted prior to administration of lorazepam. * 10/24/17 at 9:21 p.m.: The medical record lacked an indication for use. Facility staff failed to identify non-pharmacological interventions attempted prior to administration of lorazepam. During interviews on 11/02/17 at 10:30 a.m. and 10:55 a.m., an administrative nurse (#10) stated nursing staff are to document three interventions tried and how they failed before administering prn antianxiety medication and follow up the administration of a prn medication within one hour.	F 329		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		12/15/17

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F 333	Continued From page 27 Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #2) with a significant medication error. Failure to administer the correct dosage of a medication may result in a negative outcome for the resident. Findings include: Review of the facility policy titled "Medication Administration" occurred on 11/02/2017. This policy, dated May 2013, stated, ". . . verifies medication and strength with eMAR/eTAR (electronic medical administration record/electronic treatment authorization request) and medication card label. Completes the six rights: Right resident, Right dose . . . checking each medication in order against the medication card . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. Physician's orders included Donepezil HCL (anti-Alzheimer medication) 10 milligrams (mg) by mouth two times a day, give 10 mg in the morning and 5 mg in the evening. The medication card, provided by the pharmacy on a monthly basis, stated, "give 10 mg A.M. and P.M." Review of Resident #2's October 2017 eMAR showed the facility administered 10 mg of Donepezil at 7:00 a.m. and 7:00 p.m. During a interview on 11/02/17 at 8:00 a.m., an	F 333	1. On 11/2/2017 Resident #2 electronic medication administration record the Donepezil HCl directions updated to 10 mg A.M. and P.M. per order. Resident was receiving medication as prescribed by physician. On 11/6/2017 Resident #2 Donepezil was discontinued per new physician orders. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Nursing staff were re-educated on the process of one Licensed Nurse entering order and a second Licensed Nurse verifying order entered correctly in the electronic medical record. Licensed Nursing staff were re-educated on the process of entering physician orders in the electronic medical record, during nursing meetings on 11/21/2017, 11/22/2017 and again 12/6/2017, and 12/7/2017. Health information management will continue to monitor for two licensed nurse signatures on physician orders. Nurse Managers (or designee) will review electronic medication administration records monthly. 4. The Director of Nursing (or designee) will monitor 10 percent of residents electronic medical record for accuracy of medication orders weekly for two months, then monthly for 10 months. Results of the monitoring will be reported to the QAA Committee monthly by the Director of Nursing (or designee). 5. December 15, 2017	

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F 333	Continued From page 28 administrative nurse (#1) agreed Resident #2's physician's order for Donepezil differed from the medication card. The facility failed to clarify Resident #2's physician's order for Donepezil which resulted in the resident receiving the wrong dosage of the medication.	F 333		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		12/15/17

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F 441	Continued From page 29 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced	F 441		

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F 441	Continued From page 30 by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 13 sampled residents (Resident #2, #9 and #12) observed during personal cares. Failure to follow infection control practices related to hand hygiene, glove use and equipment has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 11/02/17. This policy, revised August 2017, stated, "Hand hygiene shall be regarded by this organization as the single most important means of preventing the spread of infection. Hand hygiene can be done by washing hands with soap and water (hand washing) or alcohol foam/gel . . . 1. All personnel shall follow our established hand hygiene procedure to prevent the spread of infection and disease to other personnel, patients, and visitors. . . . 2. Hand hygiene is required in the below situations: . . . f. Before and after assisting a resident with meals (hand washing with soap and water). g. Before and after assisting a resident with personal care (oral care, bathing, etc.); . . . k. Upon and after coming in contact with a resident's intact skin (when taking a pulse or blood pressure, and lifting a resident); . . . m. Before and after assisting a resident with toileting (hand washing with soap and water); . . . t. After removing gloves or aprons; u. After completing duty . . . v. Whenever in doubt . . ." Review of the facility policy titled "Perineal Care" occurred on 11/02/17. This policy, revised April	F 441	F441 A 1. Staff caring for resident #2, #9, and #12 were re-educated on performance of hand hygiene after completing perineal cares. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Hand hygiene education was provided to all staff during the "All Staff" meeting held on 11/13/2017. Mandatory nursing meetings were conducted on 11/21/2017 & 11/22/2017 on proper hand hygiene. Infection Preventionist is completing hand hygiene education checklists with all nursing staff. 4. The Infection Preventionist (or designee) will complete monitoring of hand hygiene after perineal care weekly x 8 weeks, then monthly thereafter. Results of the monitoring will be reported to the QAA committee monthly by the Infection Preventionist. 5. December 15, 2017. F441 B 1. The staff member providing snack to resident #2 was re-educated to complete hand washing prior to distributing snacks to residents. 2. Any resident in the skilled nursing facility has the potential to be affected. 3. Mandatory nursing meetings were completed on 11/21/2017 & 11/22/2017 on hand hygiene. Hand hygiene education was provided to all staff during the "All Staff" meeting held on 11/13/2017. Hand hygiene policy and procedure was reviewed.	

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F 441	Continued From page 31 2017, stated, "Policy Statement: To promote proper hygiene and prevention of urinary tract infections [UTIs]. . . . 7. Remove soiled gloves before applying clean brief/clothes. 8. Washes hands with soap and water after the procedure is completed (and Resident is safe)." - Observation on 10/31/17 at 3:00 p.m. showed Resident #12 in bed. Two certified nursing assistants (CNAs) (#4 and #5) entered the resident's room and donned gloves. The CNA (#5) obtained a wash basin of water (used for morning cares and bed baths) and washcloths and provided incontinence cares (bowel movement) using three clean washcloths and toilet paper. Both CNAs (#4 and #5) removed their gloves and continued to provide cares for the resident which included transferring from the bed to a wheelchair with a full body lift, combing her hair, and applying her glasses. One CNA (#4) transported Resident #12 from her room to the TV lounge area. One CNA (#5) dumped the basin of water in the toilet, failed to rinse and/or sanitize the basin, bagged the soiled linen and garbage, and removed them from the room. The CNA (#5) failed to perform hand hygiene after providing incontinence cares and before continuing with other tasks and both CNAs failed to perform hand hygiene before leaving the resident's room. During an interview on 11/02/17 at 9:30 a.m., an administrative nurse (#1) stated she expected facility staff to perform hand hygiene after incontinence cares and before doing anything else for the resident. - Observation on 10/31/17 at 3:00 p.m., showed	F 441	4. The Infection Preventionist (or designee) will monitor hand washing prior to administering snacks to residents. This monitoring will be conducted weekly for 8 weeks, then monthly thereafter. The results of the monitoring will be reported to the QAA committee monthly by the Infection Preventionist. 5. December 15, 2017.	

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F 441	Continued From page 32 a CNA (#8) entered Resident #2's room carrying cranberry juice and a cookie. The CNA (#8) failed to perform hand hygiene prior to handling the food items. The CNA (#8) then assisted Resident #2 with her toileting cares. The CNA failed to perform hand hygiene after disposing of her gloves and prior to exiting the room. - Observation on 10/30/17 at 5:15 p.m. showed a CNA (#11) used a wash cloth and basin of water to perform perineal cares for Resident #9, who was incontinent of stool. The CNA (#11) performed perineal cares, changed her gloves, emptied the basin of water into the bathroom sink, transferred the resident from the bed to the wheelchair, washed Resident #9's hands, covered resident with blanket, opened blinds, unlocked the wheelchair brakes, and washed her hands. Facility staff failed to perform hand hygiene after performing perineal cares and prior to completing other tasks and failed to empty the basin of water into the toilet. Observation on 10/31/17 at 11:16 a.m. showed two CNAs (#14 and #18) used a wash cloth and basin of water to perform perineal cares for Resident #9, who was incontinent of stool. One CNA (#18) emptied the basin of water into the bathroom sink. Facility staff failed to empty the basin of water into the toilet. Observation on 10/31/17 at 3:17 p.m. showed two CNAs (#11 and #20) used a wash cloth and basin of water to perform perineal cares for Resident #9, who was incontinent of stool. With the same gloves on, the CNAs (#11 and #20) applied A&D ointment on Resident #9's buttocks,	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 441	Continued From page 33 put on the resident's pants and a blanket, gave the resident the call light, removed their gloves, and repositioned the resident. One CNA (#20) emptied the basin of water into the sink and both CNAs (#11 and #20) washed their hands. The CNAs (#11 and #20) failed to perform hand hygiene after performing perineal cares and prior to applying ointment and failed to empty the basin of water into the toilet. During an interview on 11/02/17 at 9:00 a.m., an administrative nurse (#10) stated she expected staff to empty basin water in the toilet when used for perineal cares and to clean the basin with soap and water.	F 441		