STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	400 S 4TH ST WISHEK, ND 58495

(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 January 31, 2016 and completed on February 02, 2016, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		2/29/16

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

Electronically Signed | 02/17/2016

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure timely physician notification for 1 of 1 sampled resident (Resident #2) who sustained a fall with a head injury. Failure to promptly notify Resident #2's physician of a fall with a head injury may have resulted in delayed treatment. Findings include: Review of the facility policy titled "Physician Notification of Changes" occurred on 02/02/2016. This policy, dated 2008, stated, "Policy Statement: It is the policy of this facility, . . . consult with the residents [sic] physician . . . when the following changes occur: a. The resident is involved in any incident or accident, which results in injury and had the potential for requiring physician interventions. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and atrial fibrillation. Medications at the time of the fall included Coumadin (blood thinner) 2 mg (milligrams) five days a week and 3 mg two days a week and Aspirin 81 mg daily. The care plan identified Resident #2 as a risk for falls. A nursing progress note dated, 08/11/2015 at 11:30 p.m., stated, "Resident found on the floor	F 157	Correction Response to F-157-Physician Notification: 1).Regarding resident number 2, resident was assessed by FNP the following day after the incident. A CT was completed and was negative. Staff completed neuro checks and post fall monitoring according to the facility policies. 2). Residents who have a change in condition, accident with injury or change in treatment, have a potential to be affected. 3). The following measures were put into place as outlined below: In response to the noted deficiency for resident number 2 and all other residents who have the potential to be affected, the Wishek Living Center has revised the facility policy for Physician Notification to include: The physician and family/resident contact will be notified immediately when a resident has a fall that results in hitting their head (head injury). In addition, all nurse staff will be educated on the new policy. 4). Staff education for all nurses will be completed by the QA nurse/DON on 2/22/16. Education for newly hired nurses after that date will occur during their	

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F 157	Continued From page 2 by [staff name] when answering call light. . . . Resident was getting night gown out of closet when she lost her balance and fell backwards hitting head on bench to the table. Resident also hit back of left hand causing skin tear. At that time resident denies hitting head but inspection reveals bump to the left side of the back of the head approx [approximately] 3 cm [centimeters] round. Resident had jerky movement and eyes glaced [sic] over for approx 15-30 seconds. Tapped her right cheek and she slightly shook head and was alert and denied pain. Resident skin tear to the back of the left hand is 5 cm in a smile shape. . . . Vitals are 99.0 [temp] 142/93 [blood pressure] 125 [heart rate] and resps [respirations] 28. . . . Neuro checks were annitiated [sic]. A hand written fax, dated 08/11/15 at 10:30 p.m., identified Resident #2 sustained a fall with a skin tear to the back of the left hand. A physician's progress note, dated 08/12/15, stated, "[Resident name] has shown increased confusion as of late as well as she has had a couple of falls. . . . Unfortunately, she did have a fall again last night where she did hit her head but patient was showing confusion even before the fall last evening. She just seemed out of sorts. Her memory was worse. . . . The patient is seen today. . . . The patient is on Coumadin therapy for her atrial fibrillation. I am recommending a head CT [cat scan] . . . . " Nursing progress notes, dated 08/12/15, stated the following: 4:01 p.m. - "[Family Nurse Practitioner Name] called with report from head CT which is normal."	F 157	orientation process. 5).Monitoring of all falls with head injury will occur through review of incident reports and documentation by the QA nurse or DON. The monitoring will also include review of appropriate notifications to be sure they follow the facility policy. Monitoring will begin on 2/23/16 and will be completed weekly x4, monthly x2 and then quarterly x3. If QA findings are out of compliance, the DON will be notified and staff re-education will occur on a 1:1 basis (by DON or QA nurse)immediately with all staff involved. QA results will be reviewed quarterly by the QA committee.	

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F 157	Continued From page 3 4:07 p.m. - [Family Nurse Practitioner Name] called back and stated INR [blood test to monitor the effect of Coumadin] . . . elevated. New orders received for 2 mg of coumadin daily . . ." During an interview on 02/02/16 at 12:52 p.m., an administrative nurse (#2) confirmed her expectation for this fall would have been to inform the physician the night the fall occurred. She also stated from the documentation she believed the fall occurred at 10:30 p.m. and the nurse documented the fall in the nursing progress notes at 11:30 p.m.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide care for 3 of 11 sampled residents (Resident #7, #8, and #12) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality resident. Failure to knock on doors or wait for a reply before entering a resident's room does not promote residents' dignity or enhance their quality of life. Findings include: - Observation on 01/31/16 at 3:00 p.m. showed	F 241	Correction Response to F-241-Dignity and Respect of Individuals: 1). Residents number 7,8 and 12 were effected by the deficient practice of failure to knock on doors and wait for a response before entering. These residents were informed that staff education will begin to correct the deficient practice. The residents were informed to let the Administrator, DON or QA nurse know if failure to comply continues. 2). All residents have the potential to be affected by the deficient practice which could result in lack of respect and dignity	2/29/16

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F 241	Continued From page 4 Resident #7 in the bathroom and the certified nursing assistant (CNA) (#11) providing personal cares. An unidentified staff member knocked on the resident's room door and then knocked on the bathroom room door and entered. The unidentified staff member failed to wait for a reply from Resident #7 or from the CNA (#11) before entering the room and bathroom. - Observation on 02/01/16 at 10:00 a.m. showed two CNAs (#8 and #9) providing personal cares for Resident #8. A staff member (#5) knocked on the door and immediately entered without waiting for permission. During an interview on 02/01/16 at 2:10 p.m., Resident #8 stated the facility staff often forget to knock before entering his room and he has asked them to knock.The resident stated, "It gets good for about a week and then they are back at it [not knocking]." - Observation on 02/02/16 at 9:15 a.m. showed Resident #12 in her room and a CNA (#12) providing cares. The CNA had just positioned the resident in her chair when an unidentified staff member entered the room. The unidentified staff member failed to knock before entering the room. During an interview on the afternoon of 02/02/15, two administrative staff nurses (#1 and #2) stated staff members are expected to knock and wait for permission before entering a resident's room.	F 241	and lack of recognition for their individuality. 3).In response to the stated deficiency pertaining to knocking on a residents door (number 7,8, and 12) and all other residents doors (and waiting for a response before entering), education, will occur for all staff and will be completed by the QA nurse/Administrator. The education will include review of knocking on resident's doors and waiting for a reply before entering (Dignity and Respect of Individuality). 4).Education will begin on 2/9/16 and will be completed by 2/22/16. 5). Monitoring of compliance will occur by QA nurse/DON or Administrator observation. Monitoring will occur weekly x4, monthly x2 and quarterly x3. Additional monitoring will occur by the QA nurse/DON or Administrator through resident interviews weekly x4, monthly x2 and quarterly x3. Staff re-education will take place for any subsequent instances of non-compliance through 1:1 education by the administrator, DON or QA nurse. QA findings will be reviewed quarterly by the QA committee.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		2/29/16

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and review of manufacturer's instructions, the facility failed to follow professional standards of practice for 2 of 3 sampled residents (Resident #6 and #10) and 1 supplemental resident (Resident #15) observed during medication administration. Failure to follow the rights of medication administration (Resident #6) may result in a negative outcome and failure to correctly prime insulin pens (Resident #10 and #15) may result in an incorrect dose of insulin. These practices may negatively impact all residents residing in the facility. Findings include: Berman, Snyder, Frandsen, "Kozier & Erb's Fundamentals of Nursing Concepts, Process and Practice," 10th Edition, Pearson Education, New Jersey, page 773 states, ". . . Ten 'Rights' of Medication Administration . . . RIGHT TIME: Give the medication at the right frequency and at the time ordered . . . RIGHT DOCUMENTATION: Document medication administration after giving it, not before. If time of administration differs from prescribed time, note the time on the MAR [medication administration record] and explain the reason and follow-through activities . . . in nursing notes. . . ." Review of the manufacturer's instructions for NovoLog FlexPen occurred on 02/02/16. This insert stated, ". . . Small amounts of air may collect in the cartridge during normal use. To	F 281	Correction Response-F-281-Services Provided Meet Professional Standards: 1). Corrective action for residents number 10 and 15 regarding improper priming of the insulin pen before administration includes: On 2/2/16 DON/QA nurse were made aware of the deficient practice which resulted in 1:1 education to the nurses/CMA's involved resulting in further insulin pen priming being done correctly (holding the pen in the upright position)according to the manufacturers recommendation. 2).All other residents who receive insulin via pen administration have the potential to be affected by the deficient practice. 3).In response to the stated deficient practice of improper priming of Insulin pens for residents number 10 and 15 and all other residents who receive insulin pen injections, education was completed to the individuals (via 1:1)involved in the deficiency on 2/2/16 by the QA nurse. Additional education will be completed to all nurse and CMA staff on 2/22/16. The education will be done by the consulting pharmacist and will include review of the manufacturers recommendation for Insulin pen use followed by a demonstration. 4). Education will be completed to all nurse and CMA staff on 2/22/16.	

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F 281	Continued From page 6 avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . ." - Observation on 01/31/16 at 2:24 p.m. showed a nurse (#5) administered Resident #6's Preservative Free Tears eye drops. The physician's orders identified Preservative Free Tears scheduled three times a day at 9:00 a.m., 1:00 p.m., and 8:00 p.m. The MAR showed the nurse (#5) documented she administered Resident #6's eye drops at 1:17 p.m. The nurse (#5) failed to administer Resident #6's eye drops at the time ordered and failed to document the reason for the late administration of the medication. - Observation on 02/01/16 at 11:42 a.m. showed a nurse (#5) obtained Resident #15's NovoLog FlexPen, dialed the FlexPen to 2 units, pointed the FlexPen downward, and performed the airshot. The nurse failed to perform the airshot while holding the pen in an upright position. - Observation on 02/01/16 at 11:50 a.m. showed a nurse (#10) obtained Resident #10's NovoLog FlexPen, dialed the FlexPen to 2 units, held the FlexPen horizontally, and performed the airshot. The nurse failed to perform the airshot while holding the pen in an upright position.	F 281	5). Monitoring will be completed by the QA nurse or DON through observation of staff preparing the Insulin pen for administration. Monitoring will occur by random observation of three residents weekly x4, monthly x2 and quarterly x3. Staff re-education will be completed by the QA nurse or DON 1:1 at the time of witnessed noncompliance. QA findings will be reviewed quarterly by the QA committee. 1). Corrective action for resident number 6 regarding improper documentation, all medication documentation shall be completed after the medication is administered. The education included immediate 1:1 education to the nurse involved in the deficient practice on 1/31/16 by the QA nurse. Education included all medication documentation shall be done immediately after medication administration and not before it is administered. 2) All other residents who receive medications of any kind, have the potential to be affected by the deficient practice. 3). In response to the stated deficiency of failure to follow the professional standards of practice for medication administration/documentation for resident number 6 and all other residents who could be affected, education to all nurse and CMA staff on the "Ten Rights of Medication Administration", will be	

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F 281	Continued From page 7	F 281	completed by the QA nurse/DON on 2/22/16. 4).Education to all nurse and CMA staff will be completed on 2/22/16. 5).Monitoring will be completed by the QA nurse or DON, through random observation of three medication administrations and documentation of medication administration weekly x4, monthly x2 and quarterly x3. Staff re-education will be completed by the QA nurse or DON 1:1 at the time of witnessed noncompliance. The QA findings will be reviewed quarterly by the QA committee.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		2/29/16

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F 441	Continued From page 8 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2 of 4 sampled residents (Resident #6 and #7) observed during cares following a bowel movement, 1 of 1 sampled resident (Resident #8) observed during a dressing change, 1 of 2 sampled residents (Resident #8) with an indwelling catheter, and 1 of 1 random observation of food handling (Resident #10). Failure to follow infection control practices has the potential to cause or spread infection within the facility. Findings include:	F 441	Correction Response-F-441-Infection Control, Prevent Spread, Linens: 1). Corrective action for deficient practice of improper equipment cleaning for resident number 6, included immediate 1:1 education to CNA involved by the QA nurse when the deficient practice was made known education included proper infection control standards of practice. 2). All residents who resident in the facility have the potential to be affected by the deficient practice of improper equipment cleaning. 3).In review of the deficient practice of failure to follow infection control practices when cleaning equipment for resident	

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F 441	Continued From page 9 Review of the facility policy titled "Toileting" occurred on 02/02/16. This policy, revised in 2013, stated, ". . . PURPOSE: . . . To provide perineal cleansing to prevent infection and skin breakdown. PROCEDURE: . . . Peri-care is completed by using wet wipes and wash product . . . Always wash from front to back. . . ." Review of the facility policy titled "Nephrostomy Tube Irrigation and Dressing Change" occurred on 02/02/16. This policy, dated January 2016, stated, "POLICY: To safely and aseptically irrigate and perform a dressing change of an implanted nephrostomy tube implanted into the kidney for the drainage of patient's urine. . . . PROCEDURE: . . . Dressing Change: 1. Don gloves and carefully remove current dressings . . . 2. Assess site . . . 3. Discard dressing, tape and gloves. 4. Don sterile gloves. . . ." This policy failed to address when nursing staff are expected to wash their hands. Review of the facility policy titled "Gloves" occurred on 02/02/16. This policy, dated 2010, stated, "Purpose: . . . To prevent the spread of infection and disease to residents and employees. Procedure: . . . Sterile gloves should be worn when indication for sterile gloves are needed. . . . Wash hands when gloves are removed. Wash hands before and after using sterile gloves. . . ." Review of the facility policy titled "Hand Washing/Hand Hygiene" occurred on 02/02/16. This policy, dated 2011, stated, "Purpose: To provide guidelines . . . that will aid in the prevention of the transmission of infection. . . . When hand hygiene is required: . . . Before and	F 441	number 6 and all other residents who could potentially be affected, education to CNA staff will begin on 2/15/16 and be completed by the QA/Infection Control nurse and will include infection control practices for cleaning equipment. 4).Education to CNA staff will be completed on 2/16/16. 5).Monitoring will be completed by the QA/Infection Control nurse or DON through random observation of three CNA's weekly x4, monthly x2 and quarterly x3. The observation will include observation of equipment cleaning practices by three random CNA's. Re-education will occur by the QA nurse or DON immediately through 1:1 education when non-compliance is witnessed. QA findings will be reviewed quarterly by the QA committee. 1). Corrective action for improper hand sanitization between glove changes when doing a sterile dressing change and failure to use a sterile Q-tip when applying ointment for resident number 8 included immediate 1:1 education to the two nurses involved by the QA nurse on 2//16. 2). Any resident who received sterile dressing changes/sterile ointment application is at risk for the deficient practice.	

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F 441	Continued From page 10 after changing a dressing. . . . After contact with a resident's . . . body fluids or excretions. . . ." - On 02/01/16 at 9:50 a.m., a certified nursing assistant (CNA) (#3) assisted Resident #6 out of the bathroom after voiding. Observation showed stool on the inside of the toilet riser. The CNA (#3) used a Clorox wipe and cleaned the stool off the toilet riser and, with the same wipe, cleaned the hand bars of the toilet riser. The CNA (#3) failed to use a new Clorox wipe to clean the hand bars of the toilet riser. - Observation on 02/01/16 at 10:00 a.m. showed the nurse (#5) applied non-sterile gloves and removed a dressing from Resident #8's wound site. The nurse then removed these gloves, applied sterile gloves without washing her hands first as per facility policy, and cleansed the wound site with an antibacterial swab. Another nurse (#6) placed antibacterial ointment on the nurse's (#5) finger and the nurse (#5) wiped the ointment around the wound site and applied a new dressing. Both nurses washed their hands and exited the room. At approximately 10:15 a.m., two CNAs (#7 and #8) donned gloves and gowns and entered Resident #8's room. The CNA (#7) emptied the resident's catheter and nephrostomy (kidney) bags into a container and then dumped the urine into the toilet. Without changing gloves, the CNA (#7) assisted the other CNA (#8) to transfer Resident #7 from bed to a wheelchair. The CNA (#7) shaved the resident's face, combed his hair, applied his glasses, and opened the door to the room. The CNA (#7) then removed her gloves and gown, washed her hands, and exited the	F 441	3).In response to the stated deficient practices of failure to follow professional standards of Infection Control when doing a sterile dressing change (failure to sanitize hands between glove changes) and failure to use a sterile Q-tip when applying ointment during a sterile dressing change for resident number 8 and any other resident who could have a sterile dressing change and ointment applied using a sterile Q-tip,the policy titled "Nephrostomy Tube Irrigation and Dressing Change" was revised to include;staff must do hand washing/hygiene between glove changes when doing a sterile dressing change and using a sterile Q-tip when applying ointment during a sterile dressing change. The education will include a review of the revised policy for "Nephrostomy Tube Irrigation and Dressing Change". The education will also include infection control practices for hand washing/hygiene between glove changes when doing a sterile dressing change. 4).Education to nurses will begin on 2/22/16 and will be completed by the QA nurse and DON. 5).Monitoring will be completed by the Infection Control nurse or DON through random observation of two dressing changes weekly x4, monthly x2 and quarterly x3. The observation will include watching two sterile dressing changes and monitoring for hand sanitizing between gloves and proper application of ointment if applicable.	

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	355066	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 11 room. The CNA (#7) failed to remove her gloves, sanitize her hands, and apply clean gloves after emptying the urine into the toilet and failed to remove her gloves before touching the door knob. - Observation on 02/01/16 at 11:55 a.m. showed two (CNAs) (#3 and #4) assisted Resident #7 into the bathroom and found the resident incontinent of stool. While Resident #7 stood, the CNA (#3) provided perineal cares. The CNA (#3) cleansed the resident's back peri-area, then using several wipes, cleansed the front peri-area, wiping from the back to the front, smearing stool to her front peri-area. During an interview of 02/01/16 at 12:20 p.m., an administrative nurse (#2) stated the CNA (#3) failed to follow infection control practices while providing perineal cares to Resident #7. During an interview on 02/02/16 at 11:05 a.m., an administrative nurse (#1) stated the staff did not follow the facility's infection control policies regarding glove use and hand hygiene. - Review of the facility policy titled "Food Handling/Restriction of removal from Dining Room" occurred on 02/02/16. This policy, dated February 2014, stated, ". . . Food that is contaminated by food employees, consumers, or other persons through contact with their hands . . . shall be discarded." Observation on 02/01/16 at 11:54 a.m. showed a CNA (#4) placed a piece of bread on Resident #10's meal tray bare handed.	F 441	Re-education will occur by the QA nurse or DON immediately through 1:1 education when non-compliance is witnessed. QA findings will be reviewed quarterly by the QA committee. 1). Corrective action for the deficient practice of improper perineal care after a bowel movement for resident number 7 included having another CNA perform perineal care correctly immediately follow knowledge of the deficient practice. Corrective action also included immediate 1:1 education to the two CNA's involved by the DON on 2/1/16. 2), All residents who are incontinent of bowel are at risk for the deficient practice. 3).In response to the stated deficient practices of failure to follow professional standards of infection control practices in doing perineal care after a bowel movement for resident number 7 and all other residents who are incontinent of bowel, includes education to CNA, CMA and nurse staff and will begin on 2/15/16 and will be completed by the Infection Control nurse. Education will include review of infection control practices in providing proper perineal care after a bowel movement. 4) All education on proper perineal care standards in infection control practice will be completed on 2/22/16. 5).Monitoring will be completed by the	

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F 441	Continued From page 12	F 441	Infection Control nurse or DON through random observation of three residents weekly x4, monthly x2 and quarterly x3. The observation will include watching perineal cares for three residents. Re-education will occur by the QA nurse or DON immediately through 1:1 education when non-compliance is witnessed. QA findings will be reviewed quarterly by the QA committee. 1).Corrective action for the deficient practice of improper glove use and improper hand hygiene for resident 7 and 8 included education to the CNA's involved by the QA nurse upon knowledge of the deficient practice on 2/3/16. 2). All residents in the facility have the potential to be affected by the deficient practice of improper glove use and hand hygiene. 3).In review of the deficient practice of improper glove use and hand hygiene, education to CNA, CMA and nurse staff will begin on 2/15/16 and will include infection control standards of practice for glove use and hand hygiene. 4). Education for glove use and hand hygiene will be completed on 2/22/16. 5). Monitoring will be completed by the Infection Control nurse or DON through	

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F 441	Continued From page 13	F 441	random observation of three random staff weekly x4, monthly x2 and quarterly x3. The observation will include observation of glove use and hand hygiene of three random staff. Re-education will occur by the QA nurse or DON immediately through 1:1 education when non-compliance is witnessed. QA findings will be reviewed quarterly by the QA committee. 1).Corrective action for the deficient practice of improper food handling (touching bread with bare hands while setting up a tray) for resident number 10 included immediate 1:1 education to all staff working and was completed by the QA/Infection Control nurse on 2/1/16. 2). All residents have the potential to be affected by the deficient practice of improper food handling. 3).In review of the deficient practice of improper food handling for resident number 10 and all other residents who could be affected, education to CNA, CMA, and nurses will begin on 2/15/16 and will be completed by the Infection Control nurse. Education will include proper handling of food when setting up trays and feeding. 4).Education will be completed by 2/22/16.	

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F 441	Continued From page 14	F 441	5).Monitoring of food handling practices will be completed by the QA nurse or DON through random observation of three staff weekly x4, monthly x2 and quarterly x3. Re-education will occur by the QA nurse or DON immediately through 1:1 education when non-compliance is witnessed. QA findings will be reviewed quarterly by the QA committee.	