DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 11/07/2013

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey, started on 11/04/13 and completed on 11/07/13, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 residents added to verify specific concerns during the survey.	F 000	F 176 The facility encourages resident independence and assesses each resident to determine their ability to self-administer medication. To ensure safety of residents with medication administration, the facility follows the policy for self administration of medication.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the interdisciplinary team determined the resident could safely self-administer medications (SAM) for 1 of 1 sampled resident (Resident #5) observed self administering medications. Failure to assess the resident's ability to SAM could result inappropriate spacing and/or missed doses of medications. Findings include: Review of the facility policy "Protocol for Self-Administration Of Medications" occurred on 11/06/13. The undated policy stated, "Intent: It is the intent of Wishek Home for the Aged to allow residents to self-administer medications if the multidisciplinary team has determined this	F 176	Based on the findings from the annual survey which indicated a deficient practice regarding resident self - administration of medications (F-176), the current policy has been reviewed and enforced to assure resident safety. Resident #5, along with all residents of the Wishek Living Center, has been assessed for medication self-administration ability as outlined in the policy. All medication self-administration information has been updated on the eMAR and care plan. Residents have been assessed for ability and preference to self-administer medications on admission, with any change of status, and quarterly. Initial (including new admissions), determination is made through an assessment by the QR team. If it is determined that a resident may self-administer their own medication, it is added to the care plan and on the	

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

11-26-13
Revised 12-3-13

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F 176	Continued From page 1 practice to be safe. Protocol: . . . 2. Determine if the resident can safely take medications after they are prepared by the nurse or CMA [Certified Medication Assistant] and given to the resident to take on own during medication passes. If this is the request the multidisciplinary team shall determine if this practice is safe. The team will look at the physical and cognitive needs of the residents to determine their ability. . . ." Observation of medication administration for Resident #5 occurred on 11/05/13 at 8:50 a.m. in the dining room. A Certified Medication Assistant (CMA) placed aspirin (an analgesic), diltiazem (an antihypertensive [used to control blood pressure]), metoprolol (an antihypertensive), Cranberry tablets (used to prevent urinary tract infection), Aricept (Alzheimer's medication), potassium chloride (used to regulate potassium blood levels), and Colace (a stool softener) in a medication cup. The CMA then left the cup on the dining table beside Resident 5's breakfast and left the area. The CMA stated Resident #5 could self-administer her medications. Observation in the dining room on 11/05/13 at 12:23 p.m. showed Resident #5 at the dining table with a medication cup containing several tablets on the table beside her plate. Observation showed no nursing staff member in the immediate area. Review of Resident #5's medical record occurred on all days of survey. A Significant Change in Status Minimum Data Set, dated 10/07/13, identified the resident with moderately impaired cognitive status. The record lacked evidence the interdisciplinary team determined Resident #5 could safely self-administer her medications.	F 176	eMAR under the special needs tab so it is visible to nursing staff during medication administration. Resident's identified as not able to self-administer their own medications, will be given their medications by the nursing staff during medication pass and PRN as ordered. Medications will be given to the resident, and the nursing staff will stay with the resident until they have determined that the resident has taken the medications. Recording of the medication administration will be done by the nursing staff on the eMAR. Education to staff on self-administration practices will be done by the DON on November 18th, 2013 and the education will be reviewed quarterly at staff meetings x 4. One to one education will occur by the DON if a deficient medication self-Administration practice is identified through observation. QA monitoring has begun December, 1st, 2013. Three random observations of medication pass (with review of eMAR and care plan) will be conducted by the DON monthly x 3 months, then quarterly x3. The outcome of the observations are documented by the DON and reported at the quarterly QA meetings.	

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F 176	Continued From page 2 During an interview on 11/05/13 at 3:10 p.m. an administrative nurse (#4) confirmed the interdisciplinary team had not assessed Resident #5 as safe to self-administer medications.	F 176	F 309 The facility recognizes the resident's right to be free of pain to the degree possible and be provided an individualized pain management plan to address their pain.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and resident interview, the facility failed to provide necessary care and services to promote optimal well-being for 1 of 1 sampled resident (Resident #8) with complaints of pain. Failure to assess and evaluate Resident #8's reports of pain limited staff's ability to determine a causative factor for the pain and provide appropriate interventions, resulting in the resident experiencing unrelieved pain for over three and one-half hours. Findings include: Review of the facility policy titled "Pain Management" occurred on 11/07/13. This policy, dated March 2011, stated, "Policy: Each resident of the Wishek Home for the Aged who experiences pain is entitled to an assessment of the pain and will have an individualized treatment	F 309	Based on the findings from the annual survey; (F-309), which identified a resident (#8) with a pain score of 5/10 (and later 6-7/10) who did not receive pain medication in a timely manner, the facility has reviewed the current pain management policy and enforced (for resident # 8 and all residents of the facility), implementation of the policy by nursing staff. Monitoring of deficient practice for resident (#8, and all residents at random who receive prn pain medications), will be done through the QA process as outline below. Education on the pain management policy occurred to nursing staff (nurses and CMA's) on November 18th, 2013. Education was provided by the DON. The policy was reviewed in detail including timely management of pain interventions. All nursing staff will have quarterly education on pain management x2, then annually. All *new* nursing staff (nurses and CMA's) will be educated on pain management policies and procedures including timely administration of pain management	

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F 309	Continued From page 3 plan established to treat his or her pain . . . A licensed nurse must carry out pain assessments and all reassessments . . . Procedures: . . . d. Use medication for breakthrough pain . . . f. Use a pain scale when the resident describes his or her pain and the amount of relief . . . 2. Explain the specific pain rating scale (e.g., 0 to 10 where 0 = no pain and 10 = worst possible pain) . . . Documentation: . . . a . . . Any time a resident's pain measures a 5 or higher the result shall be immediately reported to the nurse. The nurse is then to approach the resident to assess and provide proper treatment to relieve the pain. . . ." Review of Resident #8's medical record occurred on all days of survey and diagnoses included history of compression fractures, osteoarthritis, and chronic low back pain. Current scheduled medications for pain included Vicodin 5-500 one tablet (combination of 5 milligrams hydrocodone and 500 milligrams Tylenol) twice daily, Fentanyl 50 microgram per hour patch changed every three days, and Lidoderm patch (on for twelve hours/off for twelve hours) daily. As needed medications included Extra Strength Tylenol 1,000 milligrams every four hours and Vicodin 5-500 one tablet every six hours. During an interview at 2:50 p.m. on 11/04/13, Resident #8 (identified as interviewable by the facility) stated she was experiencing "5" out of 10 pain in her bilateral legs and lower back, radiating into both hips. The resident stated she asked a nurse for a pain pill "around 11:30 a.m." and never received one. Resident #8 expressed her pain was "6 or 7" out of ten at the time she requested medication. (At 3:00 p.m., this surveyor asked a certified medication assistant to inform the nurse of Resident #8's unrelieved pain.)	F 309	interventions and follow-up on intervention effectiveness as outlined in the policy. This education will be done by the DON during general orientation. Monitoring of compliance with the pain management policy and procedure will occur through random resident interviews of 6 residents who received PRN pain medication on the observation day, after review of the eMAR, monthly x 3 months, then quarterly x3. The QA monitoring process began on December 1st, 2013. The focus of the random resident interview is to determine if the resident received pain medication in a timely manner as satisfactory to the resident. Immediate concerns will be addressed at the point of identification of deficient practice through one to one education and counseling by the DON to staff members involved in the deficient practice. The interviews will be conducted by the DON or charge nurse. Outcome findings of resident interviews will be reported monthly to the DON and at the quarterly QA meetings.	12/3/13

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F 309	Continued From page 4 Resident #8's Medication Administration Record (MAR) identified Resident #8 received as needed Extra Strength Tylenol 1,000 mg at 3:05 p.m. on 11/04/13 (only as needed medication given on 11/04/13) for "all over pain at an [sic] 6." The nurse reassessed the resident's pain at 4:05 p.m. and documented "Medication was effective." A nurse failed to assess Resident #8's pain at approximately 11:30 a.m. on 11/04/13 and failed to provide an appropriate intervention, resulting in Resident #8 experiencing unrelieved pain for over three and one-half hours.	F 309	F 312 The facility recognizes the need to assure that proper hygiene and perineal care is provided to each resident after any incontinent episode and during morning and evening cares. Based on the findings from the annual survey which indicated deficient practice regarding perineal care for residents # 1, 4 and 6, (F-312), the facility has reviewed and revised the policy for toileting which includes perineal care to ensure proper cleansing of residents (#1,4 & 6 and others identified). Residents requiring perineal care will be identified on their care plan as such. Identification of other residents having the potential to be affected by the deficient practice is through the QA observation process as outline below. Education was completed on November 12th, 2013 and will be reviewed monthly x 3 and then quarterly at staff meetings for one year. All new employees will receive education on toileting and perineal cleansing practices during orientation. Education will be conducted by the CNA manager. An in-service will also be conducted by the TENA representative on perineal care and incontinent product use. This will be completed on December 10th, 2013.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff performed complete perineal cares for 3 of 7 sampled residents (Resident #1, #4, and #6) observed during toileting. Failure to cleanse the skin after contact with urine could result in the resident experiencing skin irritation and/or breakdown. Findings include: Review of the facility policy "Toileting" occurred on	F 312		

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F 312	Continued From page 5 11/07/13. The undated policy stated, "PROCEDURE: . . . 10. After the resident has finished voiding, pericares should be provided. Any skin impairment should be reported to the nurse. . . ." - Observation, on 11/04/13 at 3:15 p.m., showed a Certified Nursing Assistant (CNA) (#1) assisted Resident #6 with toileting. Upon entering the bathroom, a strong urine odor was evident. Observation showed the resident's incontinence product soaked with urine. Following toileting, the CNA assisted Resident #6 to put on a clean incontinent product without providing perineal cares. Review of Resident #6's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 08/11/13 identified the resident with moderate cognitive impairment, frequently incontinent of urine, and required extensive assistance with toilet use and personal hygiene. Resident #6's current care plan, dated 02/23/13, identified a problem: "Potential for skin breakdown related to bladder incontinence." Approaches to the problem included, ". . . Cleanse perineal area with soap and water following each incontinent urination. . . ." - Observation, on 11/04/13 at 5:00 p.m. showed a CNA (#9) assisted Resident #1 with toileting. Observation showed the resident's incontinence product wet with urine. Following toileting, the CNA provided perineal care using dry disposable wash cloths, which she wet with tap water. The CNA failed to use soap when providing perineal cares following incontinence of urine. Review of Resident #1's medical record occurred	F 312	Monitoring of perineal hygiene practices will occur through random (minimum of three) surveillance weekly for 4 weeks, then monthly for 2 months, then quarterly x3. QA monitoring will be done by the CNA manager or DON and began on December 1st, 2013. One on one education will be conducted with the staff member at the point of identification of deficient practice. Outcome of surveillance and monitoring will be reported to the DON monthly and QA team quarterly.	12/10/13

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F 312	Continued From page 6 on November 5-7, 2013. A Significant Change in Status MDS, dated 09/19/13, identified the resident with severe cognitive impairment, occasionally incontinent of urine and bowels, and required extensive assistance with personal hygiene. Resident #1's care plan, dated 06/21/12, identified a problem: "Potential for skin breakdown . . . occasional incontinence. Refusal of care at times." Approaches to the problem included, ". . . Cleanse perineal area with soap and water following each incontinent urination. . . ." - Observation, on 11/05/13 at 11:25 a.m., showed a CNA (#5) assisted Resident #4 with toileting. Observation showed the resident's incontinence product wet with urine. Following toileting, the CNA wiped the resident's perineal area with toilet tissue and placed a clean incontinent product without providing perineal cares. Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS, dated 08/01/13, identified the resident with severe cognitive impairment, frequently incontinent of urine, and required extensive assistance with toilet use and personal hygiene. Resident #4's current care plan stated, "Cleanse perineal area with soap and water following each incontinent urination. . . ."	F 312	F 314 The facility recognizes the need for providing the resident with skin prevention measures through thorough skin impairment risk evaluations and skin assessments. Based on the findings from the recent survey which indicated that pressure ulcer prevention was not implemented in a timely manner and failed to ensure the resident received the necessary treatment and services to promote healing: Resident #3's pressure ulcer was healed by 11/15/13. In order to prevent this deficient practice for resident # 3 and all other residents, the facility has revised the policy for Skin Assessment and Pressure Ulcer Prevention to ensure compliance with assessment and prevention measures. All residents having the potential to be affected by this deficient practice are identified through the following policy change process and QA monitoring as outlined below. The policy for Skin Assessment and Pressure Ulcer Prevention has been revised to include a Braden score on admission, (x4 weeks), after hospital return, with change in condition, function or cognitive ability and quarterly. This will be completed by the charge nurse and floor nurses.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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F 314	Continued From page 7 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to identify a pressure sore in a timely manner and failed to ensure the resident received the necessary treatment and services to promote healing for 1 of 3 sampled residents with a current pressure sore (Resident #3). Failure to identify Resident #3's right heel pressure sore and failure to ensure treatment measures were implemented limited the facility's ability to promote healing and prevent additional pressure sores. Findings include: Review of the facility policy and procedure, "Guidelines for Skin Assessment and Prevention," occurred on 11/07/13. This document, revised October 2010, stated "Purpose: To systematically assess resident's [sic] with regard to risk of skin breakdown. To implement interventions, monitor those interventions and revise as needed . . . Procedure: 1. Assess residents with the Pressure Risk Assessment upon admission, weekly for the first four weeks following admission . . . 3. CNA's [certified nursing assistants] inspect the residents skin condition on going during cares. Report any adverse findings to the nurse. 4. All residents will have a skin check weekly with their bath. Any skin issues will be reported to the nurse for further assessment and treatment if	F 314	An initial full body skin assessment will be completed by the floor nurse on admission (within 24 hours), return from the hospital and with change in condition. Weekly full body skin assessments will be done by the floor nurse for all residents who score a 15 or less on the Braden Scale (high risk). Skin assessments are documented in the electronic medical record. Additionally, residents may be added to the weekly full body skin assessment if the nurse feels their condition warrants it even if they score above 15 on the Braden Scale. CNA's will continue to do full body skin assessments daily with cares and weekly with their bath. Any adverse findings will be immediately reported to the nurse so interventions can be started according to the facility protocol. Residents who already have a pressure sore are assessed and treated according to physician orders. A comprehensive individualized care plan is developed to include individual prevention measures as identified based on their risk assessment. Education for skin assessments and prevention was presented to nurses and CMA's at an in-service on November 18th and was presented by the DON. Education to CNA staff will be completed on December 3rd and will be conducted by the DON.	

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F 314	Continued From page 8 needed. 5. Reposition residents that are at risk periodically (or as often as the care plan indicates or at least every two hours.) . . ." Review of the facility policy and procedure, "Pressure Ulcers," occurred on 11/07/13. This document, revised October 2010, stated "Purpose: To provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary. Policy: . . . A resident who has pressure ulcers will receive necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Residents will receive appropriate assessment and services to promote and maintain skin integrity. . . ." Review of Resident #3's medical record occurred on November 04-07, 2013. The facility admitted the resident on 10/01/13. Admission diagnoses included right hemiplegia and edema. The admission Minimum Data Set (MDS), dated 10/07/13, identified the resident usually made herself understood and understood others, was severely cognitively impaired, required extensive assistance of one or two persons for bed mobility and transfers, and did not have any pressure ulcers. The Wound/Skin nursing progress note, dated 10/01/13 at 9:30 p.m., stated ". . . Resident presents with no bruises on body or extremities. Resident right ankle has 3+ [plus] nonpitting edema and the rest of the leg is slightly larger than the left. . . . Resident overall skin is in excellent [sic] condition. Heels and rest of feet are unremarkable. . . ."	F 314	Continued education will occur monthly at the staff meetings for all nursing staff x3 months, then quarterly x3. On-going surveillance will occur through weekly chart reviews on residents identified as high risk. This QA monitoring process began on December 1st, 2013. This will be done by the charge nurse and will occur weekly for 12 weeks, then monthly x 9 months. The focus of the chart reviews is to ensure that the weekly skin assessments identified to be done are completed and documented. Immediate concerns will be addressed at the point of identification of deficient practice through one to one education and counseling by the DON to staff members involved in the deficient practice. Findings of the chart reviews will be reported weekly to the DON and quarterly to the QA committee (F-314 cont) The facility recognizes the need for providing the resident with skin prevention measures through implementation of individualized prevention interventions.	12/3/13

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F 314	Continued From page 9 Resident #3's care plan, dated 10/11/13, stated "Problem, Potential for skin breakdown-hemiplegia, incontinence . . . Approaches . . . Reposition resident routine rounds and 3:00 a.m., Place pressure-relieving product mattress and wheelchair pressure cushion . . ." The resident's current care plan, dated 10/28/13, stated "Problem, Resident has an unstageable pressure ulcer to right heel . . . Approaches, Notify MD [physician], Refer to PT [physical therapy] for initial eval [evaluation] . . . Notify dietary of special needs . . . Reposition resident every 2 hours & [and] prn [as needed], Pressure reducing mattress . . . Dressing changes to wound per order . . . Multi-purpose boot to right foot at all times. Multi-purpose boot to left foot on when in bed. . . ." Resident #3's nursing progress notes, dated 10/28/13, identified a CNA notified the licensed nurse of a pressure area to the resident's right heel. Observation on 11/05/13 at 9:30 a.m. showed a licensed nurse (#11) removed Resident #3's right pressure relieving boot, sock, and an adherent pad and revealed a blackened unopened area on the heel. The nurse reapplied an adherent pad, sock, and pressure relieving boot. At this time the licensed nurse reported the physical therapist measures the pressure ulcers during their treatments. Physical therapy progress notes stated the following: *10/28/13 at 12:02 p.m. - "Re-evaluation and treatment performed today for right heel ulcer. Ulcer measures 5.5 x [by] 2.8 cm [centimeters] and is unstageable due to closed wound with	F 314	Based on the findings from the recent survey which indicated that services to promote healing and prevent infection and prevent new sores from developing (F-314), the facility has implemented instructions (posted at bedside), on how to manage the air mattress alarms if they occur. The facility also will complete education to nurses and CMA staff on a one to one basis by our Licensed Certified Occupational Therapy Assistant on care and use of the air mattresses. Education to CNA staff will occur on December 3rd, 2013. This education will be completed by the OTA. Observation of air mattress functioning will be randomly (minimum of three) monitored weekly x4 weeks. This monitoring began on December 1st, 2013. Immediate concerns will be addressed at the point of identification of deficient practice through one to one education and counseling by our Licensed Certified Occupational Therapy Assistant to staff members involved in the deficient practice. Findings of random monitoring will be reported to the DON each week and presented to the next quarterly QA meeting.	12/3/13

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F 314	Continued From page 10 distinct underlying tissue damage. . . . Evaluation is placed in the patient's chart . . . for further review. POC [Plan of Care] will include ultrasound, debridement, dressing changes . . . to aid in improving tissue integrity . . ." *10/30/13 at 11:23 a.m. - ". . . continued treatment for her unstageable ulcer of the right heel. . . . does not offer any complaints in [sic] pain to the heel region today . . . Ultrasound to the surrounding area of ulceration . . . Dressing of adherent telfa applied. Pressure relieving boot reapplied . . . Area of wound approximately the same dimensions. Wound bed firmer with pressure. Underlying area is demonstrating tissue healing as there seems to be some dried blood and greater firmness of the area. . . ." *11/06/13 at 10:52 a.m. - ". . . Wound appearance: unopen, unstageable ulcer. Dried blood beneath covering tissues. Dried, peeling skin in surrounding and overlying tissue. Wound bed firm to pressure. After debridement small open area of non-granular tissue approximately 0.3 x 0.2 cm. Today's treatment: Ultrasound . . . Debridement . . . Dressing of non-adherent Telfa with safegel, secured with Curlex [sic] and tape. Dressing change ordered. Pressure relieving boot reapplied. . . . Assessment: . . . She does not have any complaints of pain with wound care today. . . ." Resident #3's medical record lacked any information indicating facility staff identified any redness or change in appearance of the resident's right heel before 10/28/13 when facility staff identified the ulcer as 5.5 x 2.8 cm and unstageable. Observation on 11/04/13 from 2:00 p.m. to 4:50 p.m. (two hours, 50 minutes) identified Resident	F 314	F 323 The facility recognizes the need to provide a safe environment to our residents. To ensure safety of our residents during ambulation and transfers, the facility will follow the current policy for use of gait belts. Based on the findings during the annual state survey, which indicated a deficient practice regarding the use of gait belts for (residents # 1 & 8) , the facility reviewed the current policy for gait belt use for residents #1 and 8 and all residents identified, and began enforcement. Gait belts will be used on all residents unless the care plan directs them not to be used as stated by the policy which indicates any assisted transfer requires the use of a gait belt. Resident # 1 and 8 and all other residents having the potential to be affected by the deficient practice are identified through the QA monitor process as outlined below. Education to all nursing staff was completed on November 12th (CNA staff) and November 18th 2013 (CMA's and nurses). The education will be conducted by the DON or CNA manager. Gait belt education will be done thereafter to all new employees during general orientation.	

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F 314	Continued From page 11 #3 supine in bed on an air mattress overlay and wearing pressure relieving boots to both feet with the boots in contact with the overlay. The air mattress overlay did not inflate during this period of observation. Staff members failed to offer repositioning and failed to check the operation of the air mattress overlay during this observation. During interview, on 11/06/13 at 2:30 p.m., supervisory nursing staff members (#4) and (#12) confirmed the facility staff failed to identify skin changes to Resident #3's right heel until 10/28/13. These staff members also stated their expectation is facility staff would reposition or offer to reposition Resident #3 every two hours as care planned and ensure the air mattress overlay is operating. Failure to identify skin changes to Resident #3's right heel during routine cares and weekly nursing assessments resulted in a 5.5 x 2.8 cm blackened area to her heel requiring treatment, debridement, and further resulted in a 0.3 x 0.2 cm open area. Failure to reposition the resident and failure to ensure the air mattress overlay was providing alternating pressure may have contributed to the right heel ulcer and placed Resident #3 at risk of developing additional skin breakdown.	F 314	This education will be completed by our Licensed Certified Occupational Therapy Assistant and reinforced by the infection control nurse during orientation. All staff will receive education on gait belt use quarterly by the CNA manager or DON. Care plans for residents #1 & #8 as well as all other residents were reviewed and updated on November 20th, 2013 to reflect gait belt use and will be updated with any changes to resident preference or status improvement or decline to assure safety. The care plans will reflect the use or non use of gait belts during transfers and ambulation. All assisted transfers will require the use of a gait belt. Care plans will be updated by the QR team. On-going surveillance of safe and effective gait belt use will be conducted through observation of staff during transfers or ambulation of residents. Monitoring will occur by the CNA manager on a weekly basis for 4 weeks, then monthly x 2, then quarterly x3. This observation process began on December 1st, 2013. One on one education to staff will occur by the CNA manager or DON when a deficient practice is identified to assure safety of residents. Findings of the surveillance will be reported monthly to the DON and quarterly to the QA team.	12/3/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 2 sampled residents (Resident #1 and #8) who required a gait belt for transfers. Failure to use gait belts appropriately has the potential for residents to experience falls, injuries, and/or pain. Findings include: Review of the facility policy titled "Gait Belts For Transfer" occurred on 11/07/13. This policy, revised December 2010, stated, "Policy: . . . Gait belts are indicated for use when staff is [sic] assisting with transfers, unless the care plan directs them not to use a gait belt . . . You are to utilize the gait belts during cares to provide the residents with a comfortable and safe mode of transferring. . . ." - Review of Resident #8's medical record occurred on all days of survey and identified diagnoses of osteoporosis, osteoarthritis, and history of compression fractures. The current care plan stated, "Ambulation: W/C [wheelchair] for locomotion with total assist. May ambulate in room [with] limited assist [assistance] of 1 [staff member]. . . ." Observation on 11/05/13 at 10:10 a.m. identified a certified nursing assistant (CNA) (#8) transferred Resident #8 from her wheelchair to her chair without using a gait belt. The CNA (#8)	F 323	F 441 The facility recognizes the need for compliance of an infection control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of disease and infection. The current policy was reviewed and enforced to assure compliance with infection control practices. Based on the findings of our annual survey which indicated a deficient practice (F-441) as it relates to failure to maintain an infection control program to prevent disease and infection by failure to perform hand hygiene after changing gloves in contact with visible stool (placing the resident at risk for developing infection and illness); the facility has incorporated a program for infectious disease prevention. The infection control nurse will be responsible for education and surveillance of hand washing practices through random observation of staff. The nursing staff was educated by the infection control nurse on November 12th (CNA staff) and 18th, 2013 (CMA's and nurses) on proper hand washing techniques and appropriate intervals to use hand washing as outlined in the hand hygiene policy.	

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F 323	Continued From page 13 held on to both of the resident's hands and pulled up to assist her to stand. The CNA (#8) failed to lock the brakes during the transfer and the wheelchair rolled back. Observation showed a gait belt in the basket of the resident's walker which the CNA (#8) failed to use. On 11/05/13 at 11:55 a.m., a CNA (#8) assisted Resident #8 to the bathroom from her chair without using a gait belt. The resident walked with her walker and the CNA (#8) held on to the back of the resident's pants as she walked. The CNA (#8) ambulated the resident back to her wheelchair using the same method. Observation on 11/05/13 at 2:20 p.m. showed a CNA (#6) applied a gait belt around Resident #8's waist to assist her from her bed to a standing position. During the transfer, the CNA (#6) held on to the gait belt with one hand and pulled up on the resident's left arm with her other hand. During an interview on the morning of 11/07/13, an administrative nurse (#7) stated staff should not be pulling on residents' arms during transfers. - Observation on 11/04/13 at 5:00 p.m., showed a CNA (#9) assisted Resident #1 to ambulate from her chair to the bathroom. As the CNA assisted Resident #1 to stand, she failed to use a gait belt, but held the resident by her right arm. The resident then independently ambulated to the bathroom using a front wheeled walker with the CNA providing stand by assistance. On 11/05/13 at 10:50 a.m., a CNA (#10) assisted Resident #1 to ambulate from her chair to the bathroom. The CNA assisted the resident to stand without using a gait belt. Observation	F 323	Education to all nursing staff will occur monthly x6 months and then quarterly x2. On-going education will also be done on an individual one to one basis when deficient practice is identified during surveillance. Implementation of the infection control plan and surveillance of practices is already in place by the infection control nurse. The infection control nurse will do random staff monitoring (four staff members) weekly for four weeks, then quarterly thereafter. This monitoring process began on December 1st, 2013. The infection control nurse is also responsible for analyzing this data on a monthly basis. This report will be taken to the DON monthly and to the quarterly QA meetings. (F 441 cont) The facility recognizes the need for development of an infection control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of disease and infection.	12/3/13

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F 323	Continued From page 14 showed the resident's gait initially unsteady as she ambulated with the front wheeled walker and the CNA providing stand by assistance. Review of Resident #1's medical record occurred on November 5-7, 2013. A Significant Change in Status Minimum Data Set, dated 09/19/13, identified the resident required extensive assistance with transfers. Resident #1's care plan, dated 07/06/11, identified the resident at risk for falls due to history of falls and decreased vision. The care plan stated, "09/21/11 Requires assist with ADLs [Activities of Daily Living] d/t [due to] decreased physical and cognitive status . . . Transfers: Resident may require assist during transfers. . . . Has an electric lift chair. . . ." Failure to utilize a gait belt and cue or assist Resident #1 to activate the lift chair to assist with standing placed the resident at risk of a fall and/or injury.	F 323	Based on the findings of our annual survey which indicated a deficient practice as it relates to sanitation of the whirlpool tub (F-441), the facility failed to maintain an infection control program to prevent the development of disease and infection by failing to provide a sanitary environment through cleaning of the whirlpool tub; the facility has incorporated guidelines from the manufacturer and has provided staff education on cleaning protocols. The facility has identified the infection control nurse as the person who will implement and carry out surveillance and education of sanitation practices for the whirlpool tub. The infection control nurse conducted education on sanitation practices at an in-service to all CNA staff on November 12th, 2013. On-going education will be targeted toward bath aides on a quarterly basis. Newly trained bath aides will have one to one education on sanitation practices by the infection control nurse prior to giving any bathes. Weekly monitoring will occur for 4 weeks and then quarterly thereafter beginning on December 1, 2013. On-going education will also be done on an individual one to one basis when deficient practice is identified during surveillance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441		

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F 441	Continued From page 15 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, review of manufacturer's operating manual, and staff interview, the facility failed to maintain an infection control program to prevent the development of disease and infection regarding 2 of 6 sampled residents (Resident #4 and #8) observed receiving perineal care and failed to provide a sanitary environment regarding cleaning 1 of 1 bathing tub. Failure to perform perineal care in an appropriate manner (Resident #4) and failure to perform hand hygiene after changing gloves in contact with visible stool (Resident #8) placed residents at risk of developing infections and illness. Failure to allow	F 441	Findings of whirlpool sanitation surveillance will be reported to the DON monthly x1 and quarterly to the QA committee at the quarterly meetings.	12/3/13

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F 441	Continued From page 16 adequate contact time for the tub cleaning solution placed all residents who utilize the tub at risk of transmission of infections. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 11/07/13. This policy, dated January 2010, stated, ". . . Procedure: . . . The use of gloves do [sic] not replace hand washing or hand hygiene . . . When hand hygiene is required: . . . Before and after assisting the resident with personal care . . . Before and after assisting a resident with toileting. . . ." - Observation on 11/05/13 at 9:15 a.m. showed a certified nursing assistant (CNA) (#5) transferred Resident #4 onto the toilet using a mechanical lift. The resident had a bowel movement and the CNA (#5) donned gloves and performed perineal care. After removing her gloves, the CNA (#5) transferred the resident to her recliner, removed the mechanical lift sling, elevated her legs, opened the curtains, adjusted the resident's clothing, clipped the call light to the recliner, and then washed her hands before exiting the room. The CNA (#5) failed to perform hand hygiene after completing perineal care and prior to completing other tasks once placing the resident in a safe position. - Observation on 11/05/13 at 2:20 p.m. showed a CNA (#6) assisted Resident #8 to the bathroom using a walker and a gait belt. The resident voided in the toilet and the CNA (#6) donned gloves and performed perineal care. After removing her gloves, the CNA (#6) assisted the	F 441		

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F 441	Continued From page 17 resident to walk back to her chair, placed a flower in her hair, touched the straw on the resident's water glass with her hand and handed it to the resident who took a drink, handed the resident her popcorn, and clipped the call light to the resident's chair. The CNA (#6) washed her hands before exiting the room, failing to do so immediately after completing perineal care. During an interview on the morning of 11/07/13, an administrative nurse (#7) stated she expected staff to perform hand hygiene immediately after perineal cares after ensuring the resident's safety. - Review of the facility policy and procedure, "Tubs-Job Description & [and] Duties" occurred on 11/07/13. This undated document stated ". . . Clean tub after each bath. . . ." Review of the facility's bathing tub manufacturer's operating manual occurred on 11/07/13. This undated document stated "SYSTEM CLEANING (AFTER EVERY BATH), Clean and disinfect the tub after every bath . . . 6. . . . thoroughly scrub all interior surfaces of the tub. Let disinfectant stay on the surface for 10 minutes. . . . 8. Rinse the tub's interior surfaces . . ." During observation and interview, on 11/06/13 at 9:05 a.m., a CNA (#1) cleaned the facility's resident bathing tub after a resident's bath in preparation for the next resident's bath. The CNA drained the tub, added cleaning solution to the tub, scrubbed the sides and bottom of the tub and tub chair, allowed approximately two minutes of contact time, and rinsed the tub. The CNA (#1) reported he would get the next resident scheduled for a bath and allow "contact time" for	F 441		

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F 441	Continued From page 18 the cleaning solution. When asked if the cleaning solution should remain on the tub for "contact time" before being rinsed, the CNA was uncertain. When asked if there was a "contact time" requirement for the cleaning solution, the CNA reported he did not know. During interview on 11/06/13 at 2:50 p.m., the facility's infection control nurse (#2) reported the policy and procedure and manufacturer's instructions previously identified are posted in the facility's tub room. This licensed nurse (#2) reported she visited with the CNA (#1) immediately after the observation on 11/06/13 at 9:05 a.m. and confirmed the CNA failed to follow the procedure for cleaning the tub.	F 441		
F9999	FINAL OBSERVATIONS Based on record review and staff interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid survey could not be substantiated. ND00000781	F9999		