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
	535050	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

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F 000	INITIAL COMMENTS A recertification and licensure survey was conducted on 10/31/16 in addition with complaint intakes WY2263 and WY2278. It was determined, bases upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. The following common abbreviations are used throughout this document: ADL Activities of Daily Living CAA Care Area Assessment CNA Certified Nurse Aide DON Director of Nursing MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents were free from unnecessary restraints for 1 of 3 sample residents (#18) with lap belt devices. The findings were:	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tamara A. Reed — TITLE: Administrator — (X6) DATE: 11/28/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Change made per phone call with Tammy Reed, WHA on 12/22/16 @ 2:50 p.m. POC accepted. Jamie C

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F 221	Continued From page 1 Review of the 10/27/16 quarterly MDS assessment for resident #18 showed diagnoses that included Parkinson's disease and bipolar disorder. Further review showed the resident had a BIMS (Brief Interview for Mental Status) score of 8/15 (indicating moderate cognitive impairment), used a wheelchair, required extensive assistance for transfers, and had a history of falls. The MDS did not assess the resident as having a physical restraint. The following concerns were identified: a. Observations periodically during the survey from 10/31/16 through 11/3/16 showed the resident was seated upright, had a lap belt in his/her wheelchair, and was able to self-propel the wheelchair. The resident's movement was limited to sitting in the wheelchair, and s/he was unable to stand. b. During an interview on 11/2/16 at 11:09 AM, CNA #1 stated the lap belt was in place due to the resident's history of falls related to self-transferring. The CNA further revealed if the resident was having a "good day," s/he was able to unfasten the belt buckle; however, if the resident was having an "off day," s/he was not able to unbuckle the belt. c. Interview on 11/2/16 at 11:15 AM with CNA #2 revealed the resident often attempted to self-transfer and had a history of falls. She added the resident was usually not able to unbuckle the lap belt, stating "on good days yes, but mostly no." d. Interview on 11/2/16 at 11:30 AM with RN #1 revealed the resident had a history of falls from attempting to self-transfer. She stated the lap belt was an intervention to reduce the number of falls. She added the resident did well with routines, and it was "best to just keep an eye on [him/her]." She stated she did not think the	F 221	**Quarterly MDS assessment for resident # 18 is closed and cannot be altered. Another order from Resident # 18's primary physician was obtained on 11/03/2016 "lap belt / seat belt to be used while in wheelchair to prevent falls". A consent by Resident # 18's designated power of attorney for the use of the lap belt / seat belt was obtained on 11/03/2016 and is in his chart.** **Resident # 18's care plan will be updated to include:** **"Nutrition Status" – mechanically altered diet (see mealtime plan) & staff assistance with eating required** **"At risk for falls and injury" – use of fall mat, lap belt / seat belt, and alarm** **"Incontinence" – approaches to improve and maintain continence** **A pre-restraining assessment will be completed for all Residents who currently have a seat belt / lap belt and for all Residents for whom a seat belt / lap belt is being considered.**	12-16-16

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F 221	Continued From page 2 resident was able to release the belt buckle due to hand tremors. e. Observation on 11/2/16 at 12:09 PM showed the resident in the hallway sitting in the wheelchair with the lap belt secured. RN #1 asked the resident to unfasten the buckle on the lap belt. The resident attempted, was unsuccessful, then asked the nurse to do it for him/her. f. Interview on 11/2/16 at 12:18 PM with the resident revealed s/he was unable to release the belt buckle. The resident stated it was "not working today." Observation at that time showed the resident positioned his/her hand on the buckle, but had hand tremors and did not squeeze the buckle to release it. g. Review of a fax correspondence form dated 4/11/16 showed the facility contacted the resident's physician for an order "for lap belt (self releasing) for safety concerns." Further review showed no evidence this request was acknowledged by the physician. h. Review of the medical record showed no evidence an assessment was completed for the use of a lap belt as a physical restraint, including safety or medical symptoms that warranted the use of the device. Additionally, there was no evidence of signed consent by the resident's designated medical power of attorney for the use of the device. i. Review of the resident's care plan, dated 10/5/16, showed no evidence the lap belt was part of the resident's plan of care. j. Interview with the DON on 11/3/16 at 8:30 AM revealed she did not consider the lap belt a restraint because she had seen the resident remove the device before. She acknowledged there was no consent for the use of a lap belt, and verified there was no evidence of an	F 221	**A policy regarding the use of restraints will be put in place.** **All residents who currently have a seat belt / lap belt will have a chart review to ensure they have the following in place:** **Physician order** **Signed consent** **Pre-restraining assessment** **Care planned for seat belt / lap belt use, alarm, fall mat etc.** **All nurses will be educated about restraints, required consent, physician's orders, and pre-restraining assessment.** **A quality improvement monitoring tool will be implemented by the DON and charge nurses to ensure that a pre-restraining assessment, a physician order, and a signed consent are in place before anyone has a seat belt / lap belt (restraint). All residents with seat belts / lap belts will have a chart review on or about the time of their scheduled MDS assessments to ensure all requirements have been completed. Results will be reported quarterly at the QI meeting.**	12-16-16

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F 221	Continued From page 3 assessment related to the device. The DON also confirmed the facility failed to have a policy regarding use of restraints.	F 221		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F225	**The facility will ensure a comprehensive system is in place to track all required new hire employees. Human Resource Department will inform all Department Managers in writing that no new hire employees may begin work until appropriate references, background checks and State Nurse Aide registry has been received by the facility. This will be monitored weekly by the Administrative Assistant and monthly by the Business Office Manager. This procedure will be completed with a monthly written audit. Facility will ensure employees attend monthly In-service trainings regarding Abuse and Neglect. In-service training completion will be reviewed every two months to ensure completion.**	12/1/16

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F 225	Continued From page 4 Incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, employee record review, state survey agency incident log review, and policy review, the facility failed to ensure an adequate system to prevent unsafe hiring practices was implemented for 4 of 5 sample employees (CNA #3, CNA #4, Housekeeper #1, LPN #1). In addition, the facility failed to ensure 2 of 5 sample incidents (involving residents #14, #17, #18) which involved allegations of abuse were reported to the state survey agency. The findings were: The following issues concerning background checks, reference checks, and CNA registry checks were identified for 4 new hires. 1. Review of the employee file for CNA #3 showed a 7/12/16 date of hire. Further review showed no evidence reference checks were completed prior to hire. Additionally, there was no evidence of a background check being completed prior to hire. Further, there was no evidence the aide was entered into the State nurse aide registry. 2. Review of the employee file for housekeeper #1 showed a 10/3/16 date of hire and start date. Further review showed no evidence reference checks were completed prior to hire. Additionally, review of the background check showed it was completed on 10/27/16, 24 days after the employee began work.	F 225		

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F 225	Continued From page 5 3. Review of the employee file for CNA #4 showed a 10/26/16 date of hire. Further review showed no evidence reference checks were completed prior to hire. 4. Review of the employee file for LPN (licensed practical nurse) #1 showed a 8/15/16 date of hire. Further review showed no evidence reference checks were completed prior to hire. 5. Interview with the administrator and DON on 11/3/16 at 8:45 AM revealed background checks should have been completed when the employees were hired. Additionally, they added reference checks were completed on the employees by the department supervisors, but they were not documented and kept in the file. 6. Review of the policy titled "Abuse and Neglect Prevention," undated, showed the process for screening employees for abuse included "... b. The Department of Health, Office of Health Licensing and Surveys is checked on all potential employees applying for CNA positions to identify if the individual has been placed on the registry to substantiated abuse, neglect, or misuse of Resident's property. c. All potential employees will have reference checks completed. d. Criminal background checks will be completed on all potential employees..." The following issues were identified concerning allegations of abuse: 1. Medical record review showed resident #14 had diagnoses which included convulsions or seizures and other intellectual disabilities. Review	F 225		

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F 225	Continued From page 6 of the 10/28/16 social service progress note showed: "It was reported to SW [social worker] that another resident hit [the resident] and kicked [him/her] on 10/27/16. SW notified the RN, DON, ADON [assistant director of nursing], [the resident's family], and the BIA [bureau of Indian affairs]. [The resident's] family reported no concerns. The BIA came and talked w/this other resident about that behavior. SW also notified the Ombudsman of the incident. SW and SS ast. [social services assistant] will monitor and support as necessary." Review of the complete medical record, and review of the state survey agency incident log, showed the facility failed to notify the State survey agency of this incident. 2. Review of the 10/27/16 quarterly MDS assessment showed resident #18 had diagnoses that included bipolar disorder. Review of the 7/1/16 nurse's note showed the resident became upset when resident #17 attempted to throw a napkin on him/her. Resident #18 then hit the other resident in the nose before the two residents were separated. Further review showed the resident's physician and family were notified. Review of the state survey agency incident log showed the facility failed to notify the State survey agency of this incident. 3. Interview with the DON and administrator on 11/3/16 at 11:25 AM confirmed the facility failed to notify the State survey agency regarding the two incidents of alleged resident to resident abuse. According to the undated facility policy titled, "Abuse and Neglect Prevention" under Reporting/Response was documented the following: "Any ALLEGED mistreatment, misappropriation of Resident's property	F 225	**The facility will notify the State Survey Agency of the following incidents:** **Resident to resident incident on 10/28/2016 involving resident #14** **Resident to resident incident on 07/01/2016 involving residents # 17 and # 18** **All nursing staff will be re-educated about incident reporting** **All nursing and administrative staff will be re-educated on incident reporting to the State Survey agency** **Facility will review and update policy on abuse and neglect prevention** **Interdisciplinary team will review all incident reports weekly to ensure all incidents have been reported to the proper persons/agencies appropriately.** **Results will be reported quarterly at the QI meeting.**	12/16/16

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F 225	Continued From page 7 (exploitation), physical, mental, verbal, or sexual abuse...is to be reported to the proper authorities...Report alleged incidents as required to all local/state/federal agencies within 24 hours of the allegation."	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 3 resident areas (100 Hall, 200 Hall, Dining Room) were clean and in good repair. The findings were: Observation on 11/3/16 from 7:51 AM through 8:45 AM revealed the following environmental issues: 1. The following issues concerning doors and door frames were identified: a. In room 213, a 24-inch wide area on the closet door from the ground to 14 inches high, and a second door from the ground to 8 inches high, were scraped and in poor repair. b. In room 211, a 24-inch wide area on the closet door from the ground to 18 inches high, was scraped. c. In room 206, the inner bathroom door, from the kick plate to 16 inches high, was scraped. d. In room 111, the kick plate of the entrance door had a 15-inch by 8-inch area pulled loose. e. In room 106, the inside bathroom door kick	F 253	A1) Doors, door frames and kick plates in the following areas a. room 213 closet doors, b. room 211 closet door, c. room 206 inner bathroom door, and c. room 106 inside bathroom kick plate will be sanded, painted, glued or replaced to maintain a sanitary, orderly, and comfortable interior. A2) Floors in the following areas a. east wing hallway in front of room 213 and exit door, b. room 210 under sink, c. room 205, d. east wing 200 hall by fire doors, e. west shower room hall 100 between shower floor and room floor, f. dining room by exit door, and g. dining room will be cleaned, grouted, sealed or will be replaced with new tiles, h. room 201 wall by closet and wall by bathroom will be cleaned, patched and painted.	

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F 253	Continued From page 8 plate had a 9-inch by 1/2-inch pulled loose. 2. The following issues concerning floors and walls were identified: a. In the hallway by room 213, a 42-inch area in front of the exit door had chips in the floor which created a surface that could not be effectively cleaned. b. In room 210, three 12-inch by 12-inch tiles under the bathroom sink had one chip each, the largest was 3-inch by 1-inch, which created a surface that could not be effectively cleaned. c. In room 205, a 12-inch by 12-inch tile had a 3-inch by 1-inch chip which created a surface that could not be effectively cleaned. d. In room 201, the wall by the closet from the baseboard to 21 inches was scraped. The wall by the bathroom from the baseboard to 25 inches was scraped. e. The floor by the 200 hall fire door had three 12-inch by 12-inch tiles which were cracked. f. In the 100 hall tub room, the 31-inch division between the tiled shower floor and room floor had a 2 1/2-inch by 1/2-inch and a 2-inch by 1/2-inch cracks in the tile. g. In the dining room, the floor near the exit door had a tile with a 1-inch by 1-inch crack, which created a surface that could not be effectively cleaned. h. In the dining room, a 5-inch by 1 1/2-inch area covering two 12 inch by 12 inch tiles were chipped, and a 12-inch by 12-inch tile had a 1 3/4-inch by 1/2- inch chip, which created a surface that could not be effectively cleaned.. 3. Interview with the maintenance director on 11/3/16 at 9:03 AM revealed he performed audits and prioritized maintenance issues. In touring the facility with the maintenance manager, he	F 253	B) All residents and staff could be affected if infection control isn't maintained from unsanitized floors. Kick plates and door frames loose could cut residents or staff. Residents have the right to a sanitary, orderly and comfortable interior. Maintenance and Housekeeping will observe and audit all of the facility once a month and then repair. C) Environmental Services Manager will in-service housekeeping and maintenance staff on services necessary to maintain a sanitary, orderly, and comfortable interior. D) Environmental Services Manager will report observations and audits to the Quality Assurance Committee at the QAPI meetings.	12/18/16

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F 253	Continued From page 9 confirmed the issues with building damage and cleanliness.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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F 272	Continued From page 10	F 272		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure the comprehensive assessment of resident needs in a variety of areas for 7 of 9 open sample residents (#14, #15, #16, #17, #18, #19, #22). The findings were:

1. Review of the 5/10/16 annual MDS assessment for resident #14 showed triggered areas which required additional assessment included: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Activities, Falls, Nutritional Status, and Psychotropic Drug Use. Review of the CAAs showed analysis of data to support the care plan decision was lacking in each of these areas.

2. Review of the 9/26/16 annual MDS assessment for resident #15 showed triggered areas which required additional assessment included: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Psychosocial Well-Being, Falls, Nutritional Status, and Psychotropic Drug Use. Review of the CAAs showed analysis of data to support the care plan decision was lacking in each of these areas.

3. Review of the 3/14/16 annual MDS assessment for resident #16 showed triggered areas which required additional assessment included: Cognitive Loss/Dementia, Visual

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F 272	Continued From page 11 Function, Communication, Urinary Incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. Review of the CAAs showed there was no analysis of the data to support the care plan decision for these areas. 4. Review of the 2/12/16 MDS annual assessment for resident #17 showed triggered areas which required additional assessment included: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Mood State, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer. Review of the CAAs showed a lack of analysis of the data to support the care plan decision for these areas. 5. Review of the 1/18/16 annual MDS assessment for resident #18 showed triggered areas which required additional assessment included: Cognitive Loss/ Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the CAAs showed no analysis of the data to support the care plan decision for these areas. 6. Review of the 3/28/16 annual MDS assessment for resident #19 showed triggered areas which required additional assessment included: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, and Falls. Review of the CAAs showed analysis of data to support the care plan decision was lacking in each of these areas.	F 272	**The facility will ensure comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity as required. CAA's for residents 14, 15, 16, 17, 18, 19, and 22 are closed and cannot be altered. Going forward, CAA's for triggered areas will be complete and will include an analysis to support the care plan decision.** **A new MDS Coordinator started full time in October and has received MDS training at an AANAC course. An interdisciplinary team will review all newly completed CAA's monthly and assist the new MDS Coordinator to the best of their ability. The new MDS Coordinator will review facility resource book "Care Area Assessments" (ISBN 978-160146-881-9) for more information/training on completing comprehensive and accurate resident assessments.** **Results will be reported quarterly at the QI meeting.** Res #14, 15, 16, 17, 18, 19, and 22 will have updated CAA's for all triggered areas. will complete Section V and provide analysis to support CP decision for all areas identified.	12/31/16 ~~12/31/16~~

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F 272	Continued From page 12 7. Review of the 10/17/16 admission MDS assessment for resident #22 showed triggered areas which required additional assessment included: Communication, ADL Functional/ Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, and Pressure Ulcer. Review of the CAAs showed no analysis of the data to support the care plan decision for these areas. 8. Interview with the DON on 11/3/16 at 11:25 AM confirmed the CAAs reviewed by the survey team were not comprehensive.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, Resident Assessment Instrument (RAI) manual review and staff interview, the facility failed to ensure a significant change in status assessment (SCSA)	F 274		

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F 274	Continued From page 13 was performed for 1 of 1 sample residents (#13) with a significant change. The findings were: Review of physician's orders dated 5/6/16 showed resident #13 had orders for hospice care. Review of the hospice meeting/care plan update form dated 8/10/16 revealed the resident had a revocation of hospice care on 8/9/16 per family and patient request. Review of MDS records for the resident showed an MDS assessment was conducted on 4/1/16, and a quarterly MDS assessment was conducted on 7/2/16. There was no evidence an SCSA was conducted for either the placement of hospice care or the revocation of hospice care. Interview with the DON and administrator on 11/3/16 at 11:25 AM revealed the MDS coordinator was not available to respond to why a significant change was not performed. The DON was not aware of the reason a significant change was not completed. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14, October 2016 showed "A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident"... "A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be	F 274	**The facility will ensure a comprehensive assessment of a resident will be done within 14 days after the facility determines that there has been a significant change of condition. A significant change of status assessment for resident # 13 will be completed. Going forward, significant change of status assessments will be completed within the 14 day window. All residents who are currently on hospice will have a chart review to ensure an SCSA has been completed.** **An interdisciplinary team will review all residents who are being admitted or discharged from hospice at their weekly meeting to ensure that the SCSA assessments are being completed.** **Results will be reported quarterly at the QI meeting.**	12/7/16 ~~12/31/16~~

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F 274	Continued From page 14 within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill".	F 274	The facility will ensure assessments accurately reflect the resident's status. The mentioned MDS assessments for resident's # 13 and # 18 are closed and cannot be altered. Going forward, the facility will ensure the MDS assessments accurately reflect the condition of the resident. An interdisciplinary team will review a random sample of completed MDS assessments for one month and then quarterly after that to ensure they accurately reflecting the resident's status. Results will be reported quarterly at the QI meeting.	12/31/16
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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F 278	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure the MDS assessment accurately reflected the condition of 2 of 9 sample residents (#13, #18). The findings were: 1. Review of the 10/27/16 quarterly MDS assessment showed resident #18 had diagnoses that included Parkinson's disease and anemia. Further review showed the resident had 1 fall resulting in minor injury and was not at risk for developing pressure ulcers. The following concerns were identified: a. Review of the nurse's notes showed the resident had falls on 3 separate occasions since the previous assessment, 8/17/16, 10/5/16, and 10/9/16. b. Review of the "Pressure Ulcer Risk Assessment," dated 10/13/16, showed the resident was identified as being high risk for pressure ulcers. 2. Review of the quarterly MDS assessment dated 10/2/16 for resident #13 showed the resident had no falls since the previous MDS assessment, and was not at risk for developing pressure ulcers. The following concerns were identified: a. Review of progress note dated 8/4/16 at 8 PM showed the resident had suffered a fall. This fall was in between the 7/2/16 and 10/2/16 assessment dates. b. Review of the pressure ulcer risk assessment/prevention intervention protocol sheet dated 10/1/16 showed the resident had an accumulative score of 16. A score of 12 or above	F 278		

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F 278	Continued From page 16 was considered high pressure ulcer risk. 3. Interview with DON and administrator on 11/3/16 at 11:25 AM revealed the MDS coordinator was not available to respond to why the documented fall and pressure risk weren't recorded in the quarterly assessments for these residents. The DON was not aware of the inaccuracy in the assessment.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to	F 279		

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F 279	Continued From page 17 develop comprehensive care plans based on resident needs for 2 of 9 sample residents (#18, #20). The findings were: 1. Review of the 10/27/16 quarterly MDS assessment showed resident #18 had diagnoses that included Parkinson's disease, bipolar disorder, anemia, and urine retention. Further review showed the resident required extensive assistance for transfers and toileting and limited assistance with eating. Additionally, the resident had frequent bladder and bowel incontinence, had a history of falls, and had a mechanically-altered diet. The following concerns were identified: a. Observation on 10/31/16 at 4:54 PM showed the resident in the dining room with the meal served in bite-size pieces. A staff member was assisting the resident to eat. Observation on 11/2/16 at 11:38 AM showed the resident in the dining room being assisted with eating by a staff member. Review of the "Nutrition Status" care plan, dated 10/5/16, showed the resident's goal was to have minimal weight loss, with the approach being to provide high-calorie, high-protein supplements. The care plan did not show the resident's need for mechanically-altered food or staff assistance with eating. b. Observation during the survey from 10/31/16 through 11/3/16 showed the resident had a fall mat next to his/her bed, utilized a lap belt while in the wheelchair, and had an alarm on the back of the wheelchair which at times was clipped to the resident's shirt. Interview with the DON on 10/31/16 at 5:01 PM revealed these interventions were due to the resident's history of falls. Review of the "At risk for falls and injury" care plan dated 10/5/16 showed the resident's goal was to remain safely in the facility without	F 279		

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F 279	Continued From page 18 preventable complication, with approaches including education for the resident on safety awareness and use of the call light, educate staff on the resident's fall risk, and keep the room free of clutter and with adequate lighting. The care plan did not address the resident's use of a fall mat, alarm, or lap belt. c. Review of the "Incontinence" care plan, dated 10/5/16, showed the resident's goal was "will be continent." The approaches listed included providing incontinence care, protective skin barriers, and observing skin. There were no approaches to improve or maintain the resident's continence. 2. Review of the admission MDS dated 10/13/16 showed resident #20 had diagnoses that included Alzheimer's disease, and was moderately impaired with cognitive skills for daily decision making. Observation of the resident periodically from 10/31/16 to 11/3/16 showed the resident had a tabs alarm which was in use while the resident was in his/her wheelchair. The following concern was identified: a. Review of the resident's care plan for falls, dated 10/11/16, did not show the intervention of using a tab alarm. 3. Interview with the DON and administrator on 11/3/16 at 11:25 AM revealed the MDS coordinator was not available to respond to the development of the care plan. The DON also confirmed the care plans did not reflect resident specific interventions, and added she was unable to provide additional information regarding the care plans. She further revealed the MDS coordinator would be in charge of developing care plans with the assistance of other disciplines, to make them more comprehensive.	F 279	**The facility will ensure a comprehensive care plan for each resident will be created and updated.** **The new MDS Coordinator and interdisciplinary team will update the care plans for resident's # 18 and # 20.** **A quality improvement monitoring tool will be implemented by the DON to ensure comprehensive care plans for all residents will be relevant and up to date. Care plans for all residents will be reviewed by the MDS coordinator and interdisciplinary team every two months and PRN.** **Results will be reported quarterly at the QI meeting.**	12/16/16

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan was followed for 1 of 9 sample residents (#17). The findings were: Review of the admission face sheet, dated 8/15/16, showed resident #17 had diagnoses that included spastic hemiplegia affecting the right dominant side. Review of the 8/14/16 quarterly MDS assessment showed the resident had the swallowing disorder of coughing or choking during meals or when swallowing medications, and was receiving a mechanically-altered diet. Review of the resident's care plan, dated 10/12/16, showed staff were to "follow mealtime plan from SLP [speech language pathologist]". Review of the "Mealtime Plan," dated 10/15/16, showed the SLP recommended a liquid consistency of "nectar thick liquids presented from a teaspoon." The following concerns were identified: a. Observation on 11/2/16 at 11:50 AM showed CNA#5 assisting the resident with the noon meal. The CNA used a scoop to add powder from an unlabeled plastic tub to a cup of coffee and a cup of "caramel mocha". The aide did not measure the powder but added several scoops of powder a little at a time to the cups. Interview with the CNA at that time revealed the	F 282		

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F 282	Continued From page 20 powder was a thickening agent used to thicken liquids. The aide stated there were no set measurement to use to achieve the right consistency, and that depending on if the liquid was hot or cold, she would add different amounts of powder. CNA #6, who was assisting another resident at the same table, agreed and added "it depends on the temperature, you have to add a lot." Continued observation showed the thickened coffee was the consistency of honey and the caramel mocha was the consistency of pudding; both were thicker and more restrictive than the care-planned nectar-thick liquids. b. Interview with the DON on 11/3/16 at 10:30 AM revealed the nursing staff, including nurses and CNAs, were responsible for thickening liquids for residents. She provided "Guidelines for Consistency Modification of Foods and Liquids," which she stated was the basis of the education provided, but was unable to provide evidence the education had been provided to staff.	F 282	The facility will ensure that services provided are by qualified persons in accordance with each resident's written plan of care. All nursing staff will be re-educated on liquid diet textures using the "Guidelines for Consistency Modification of Foods and Liquids" and by the facility RD. Charge nurses will monitor daily that the mealtime plan is being followed and that liquids are being thickened correctly. Results will be reported quarterly at the QI meeting.	12/16/16
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a discharge	F 283		

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F 283	Continued From page 21 summary with recapitulation of stay was completed for 1 of 1 closed records reviewed (#38). The findings were: Review of the medical record showed resident #38 was admitted to the facility on 1/8/15 and was discharged to another skilled nursing facility on 8/5/16. Further review showed no evidence a discharge summary with a recapitulation of stay was completed. Interview with ward clerk #1 on 11/3/16 at 11:06 AM confirmed the facility could not produce a discharge summary.	F 283	**The facility will ensure that any residents discharged from the facility will have a discharge summary which includes a recapitulation of the resident's stay. In regards to resident # 38, he was discharged from the facility on 08/05/2016 and no further actions can/will be taken. Moving forward, all residents being discharged/transferred from the facility will have a discharge summary which includes a recapitulation of their stay. All nurses will be educated about the discharge planning process.**	
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	**All residents referred for discharge will be reviewed by the interdisciplinary team and results will be reported quarterly at the QI meeting.**	12/16/16
	This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and review of policies and procedures, the facility failed to ensure interventions were developed and implemented related to falls for 2 of 3 sample residents (#18, #20) who had falls. The findings were: 1. Review of the 10/27/16 quarterly MDS assessment showed resident #18 had diagnoses			

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F 323	Continued From page 22 that included Parkinson's disease, anemia, and bipolar disorder. Further review showed the resident had a BIMS score of 8/15 (indicating moderate cognitive impairment) and required extensive assistance for transfers and toileting. Additionally, the resident had a history of falls and utilized a wheelchair. Review of the resident's care plan for falls, dated 10/5/16, showed the resident was at risk for falls due to diagnoses and an unsteady gate, and needed commonly used personal items in reach and education on safety awareness. The following concerns were identified: a. Observation on 10/31/16 at 5:01 PM showed the resident was seated in the wheelchair with a lap belt secured over his/her lap. An alarm was on the back of the wheelchair, but was clipped to the back center of the wheelchair and not onto the resident. Additionally, a fall mat was on the floor next to the resident's bed. Interview at that time with the DON revealed the lap belt and alarm were interventions used to reduce falls, and the fall mat was used to reduce injury from falls. She further stated the resident often attempted to self transfer. b. Observation on 11/2/16 at 2:45 PM showed the resident was seated in the wheelchair in the dining room, with the alarm again clipped to the back center of the wheelchair. Interview at that time with the resident revealed s/he did not like the alarm, and occasionally unclipped it from his/her clothing. The resident further stated s/he could not reach the back center of the wheelchair, and that staff "might not have put it on" when s/he was assisted into the chair. c. Review of nursing notes from 2/16/16 through 11/1/16 showed the resident had fallen on 23 separate occasions. Review of the "Incident/Accident Report" forms showed a form	F 323		

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F 323	Continued From page 23 was completed for 15 of these falls. Further review of the incident forms showed no evidence the falls were analyzed to determine causes or effectiveness of interventions. d. Interview with the DON on 11/3/16 at 8:30 AM confirmed the alarm, fall mat, and lap belt were not on the care plan. Additionally, she stated the clip alarm should have been in place at all times, and she was unsure how it got clipped to the back of the wheelchair instead of onto the resident's clothing. She further revealed the facility did not do an investigation or analysis of falls beyond what was reported on the Incident/ Accident Report forms. 2. Review of the admission MDS dated 10/13/16 showed resident #20 had short term and long term memory problems and was moderately impaired with cognitive skills for daily decision making. The following concerns were identified: a. Observation on 11/2/16 at 12:02 PM showed the resident was seated at a dining room table eating. S/he had a tabs alarm clipped to the back of his/her shirt, and the main unit of the alarm was placed in a pocket on the back of the wheelchair which prevented the magnetic device from disengaging when pulled. The resident was observed to stand up, causing the clip on his/her shirt to come off without setting off the alarm. b. Observation on 11/2/16 at 12:02 PM with CNA#7 showed that tab alarm mechanism was in working order, as she was able to pull the magnetic device off of the machine which set off the alarm. The CNA, after demonstrating the tab alarm, placed the device back into the pocket on the back of the wheelchair, which again prevented the magnetic device from working properly.	F 323	**The facility will ensure that interventions are developed and implemented related to falls for residents # 18 and # 20.** **Falls will be reviewed immediately by the charge nurse. Charge nurse will implement immediate interventions as needed. All falls will be reviewed weekly by the interdisciplinary team to address potential causes. All implemented interventions will be addressed in the care plan.** **Care plans for all residents will be reviewed by the new MDS coordinator and interdisciplinary team every two months and PRN with results being reported quarterly at the QI meeting.**	12/31/16

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F 323	Continued From page 24 3. Review of the facility policy and procedure titled "POLICY Related to Falls," revised 9/19/12, showed: "... Fill out incident report as soon as possible, Care Plan will be updated with fall assessment within 72 hours of fall, review care plan to assess for any special needs or equipment, Needed protection equipment will be put in place ASAP [as soon as possible]... Assess resident for potential causes of fall also for any environmental issues or underlying clinical conditions and functional decline that may be a risk factor for falls..."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the medication regimen for 1 of 9 sample residents (#18) was free from unnecessary drugs. The findings were: Review of physician orders for resident #18 showed on 5/26/15, Latuda (antipsychotic) 80 mg once per day was ordered for "depression." Further review of the medical record showed no evidence a gradual dose reduction (GDR) was attempted, nor documentation from the physician to indicate a GDR would be contraindicated. Interview with the DON on 11/3/16 at 8:30 AM revealed she was unable to locate any additional documentation related to the antipsychotics medication.	F 329	**The facility will ensure that all residents who are on an antipsychotic medication have a GDR review by their physician at their scheduled 60 day appointments and PRN.** **Nurses and ward clerk will be educated on the GDR process.** **Interdisciplinary team will audit all residents who are on antipsychotic meds every two months and PRN with results being reported quarterly at the QI meeting.** the physician has addressed the Latuda for Res #18. 12/31/16 12/7/16	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide thickened liquids at the prescribed consistency for 1 of 1 sample residents (#17) with orders for thickened liquids. The findings were: Review of the admission face sheet, dated	F 365	A) The Container for the thickener will have the manufacturer's instructions for thickening liquids posted to it. B) All residents who have a mechanically-altered diet with a recommended liquid consistency could choke. Dietary Manager will observe and audit weekly for one month and then once monthly that the manufacturer's instructions for thickening liquids posted to it. Charge nurses are doing daily v; med check of consistency of thickened liquids + using the guidelines for consistency per Monitor Res #17.	

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

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F 365	Continued From page 26 8/15/16, showed resident #17 had diagnoses that included spastic hemiplegia affecting the right dominant side. Review of the 8/14/16 quarterly MDS assessment showed the resident had the swallowing disorder of coughing or choking during meals or when swallowing medications, and was receiving a mechanically-altered diet. Review of the resident's care plan, dated 10/12/16, showed staff were to "follow mealtime plan from SLP [speech language pathologist]". Review of the "Mealtime Plan," dated 10/15/16, showed the SLP recommended a liquid consistency of "nectar thick liquids presented from a teaspoon." The following concerns were identified: a. Observation on 11/2/16 at 11:50 AM showed CNA #5 assisting the resident with the noon meal. The CNA used a scoop to add powder from an unlabeled plastic tub to a cup of coffee and a cup of "caramel mocha". The aide did not measure the powder but added several scoops of powder a little at a time to the cups. Interview with the CNA at that time revealed the powder was a thickening agent used to thicken liquids. The aide stated there were no set measurement to use to achieve the right consistency, and that depending on if the liquid was hot or cold, she would add different amounts of powder. CNA #6, who was assisting another resident at the same table, agreed and added "it depends on the temperature, you have to add a lot." Continued observation showed the thickened coffee was the consistency of honey and the caramel mocha was the consistency of pudding; both were thicker and more restrictive than the care-planned nectar-thick liquids. b. Interview with the dietary manager on 11/2/16 at 3 PM revealed the powdered thickener was delivered in a large bag, and the powder	F 365	C) The Registered Dietitian and Dietary Manager will in-service Dietary and Nursing staff on liquid consistency and how to prepare those liquid consistently. D) Dietary Manager will report observations and audits to the Quality Assurance Committee at the QAPI meetings.	12/18/16

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F 365	Continued From page 27 would be distributed into plastic containers for staff to use. At that time, she was unaware of the brand name of the thickener or its instructions for use. c. Interview with the DON on 11/3/16 at 10:30 AM revealed the nursing staff, including nurses and CNAs, were responsible for thickening liquids for residents. She provided "Guidelines for Consistency Modification of Foods and Liquids," which she stated was the basis of the education provided, but was unable to provide evidence the education had been provided to staff. d. Interview with the dietary manager on 11/3/16 at 11:05 AM stated she found the manufacturer's instructions for thickening liquids taped to a wall in the kitchen next to the serving window. She further revealed CNAs did not have access to those instructions when mixing thickened liquids.	F 365		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was prepared and served under sanitary conditions in 1 of 1 food	F 371	A1) All 3 rodent glue traps a. pantry under food storage cart, b. below food processor under food preparation table and c. under the three-compartment sink will be removed. A2) All 5 air vents will be cleaned in the following areas: a. over the ice machine, b. two over the food prep tables, c. over the coffee machine, and d. over the steam table.	11/3/16 11/4/16

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F 371	Continued From page 28 preparation areas (main kitchen). The findings were: 1. Observation on 11/2/16 from 9:40 AM through 12 PM showed the main kitchen had three uncovered rodent glue traps in use in the following locations: a. In the pantry under the food storage cart. b. Below the food processor under the food preparation table. c. Under the three-compartment sink. According to Food Code 2013, U.S. Public Health Service: 7-206.12 "Rodent bait shall be contained in a covered, tamper-resistant bait station." 2. Observation on 11/2/16 at 11:50 AM showed the following ceiling air vent covers were darkened with grease and collecting dust: a. One air vent cover over the ice machine. b. Two air vent covers directly over the food prep tables. c. One air vent cover over the coffee machine. d. One air vent cover over the steam table. 3. Interview with the dietary manager on 11/2/16 at 12 PM confirmed the facility currently used uncovered rodent glue traps in the pantry and food preparation areas. Further, she confirmed the ceiling air vent covers were not routinely cleaned and were not on a cleaning schedule.	F 371	B) All residents and staff could be affected if infection control isn't maintained from under sanitized conditions. Maintenance and Dietary will observe and audit once weekly for one month and then once monthly the kitchen for rodent glue traps and air vents for grease and dust. Any wrong findings will be corrected. C) Environmental Services Manager and Dietary Manager will in-service Dietary and Maintenance staff on how to store, prepare, distribute and serve food under sanitary conditions. D) Dietary Manager will report observations and audits to the Quality Assurance Committee at the QAPI meetings.	12/18/16
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 29 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications available for use were not outdated in 2 of 2 medication carts (East Cart, West Cart). In addition, the facility failed to ensure medications were secured in 1 of 2 medication carts (East cart). The findings were:	F 431		

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F 431	Continued From page 30 1. The following concerns were identified regarding the securing of medications: a. On 10/31/16 at 4:15 PM, RN #1 was observed leaving the East medication cart unattended, and upon returning at 4:19 PM was able to open a drawer without the use of a key. At 4:23 PM the nurse left the same cart unattended without locking it. b. Observation on 11/2/16 at 4:55 PM showed the East medication cart was unlocked and unattended by staff. The cart was in the hallway near the main dining area during the evening meal service, and residents and staff were in the area. Interview on 11/2/16 at 4:58 PM with RN #3 confirmed the East medication cart had been unlocked and unattended, and this was not an acceptable practice. 2. The following concerns were identified concerning proper labeling of medications: a. Observations of the West and East medication carts on 11/3/16 at 11:20 AM showed the majority of medications were filled by a federal entity. The observation showed all of the medication containers in both medication carts that were filled by the federal entity failed to have an expiration date on the label or packaging. Both carts contained medications from the same federal entity. b. At that time, LPN #2 on the West medication cart confirmed there were no expiration dates on the medication labels or packaging provided by the federal entity. c. Interview with the DON on 11/3/16 at 11:25 AM confirmed the medications filled by the federal entity did not have expiration dates. She stated the federal entity filled 70% of the prescriptions for the facility residents.	F 431	**The facility will ensure medication carts are locked unless they are attended by a nurse. All nurses will be re-educated about locking medication carts.** **Random audits will be completed by the DON and Administrator weekly and PRN for one month.** **The facility will contact Indian Health Service to see if they will put expiration dates on their labels. The facility has no control over Indian Health Service and what they send out of their pharmacy.** **Results will be reported quarterly at the QI meeting.**	12/31/16

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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 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.	F 441		

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F 441	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure safe infection control practices were followed in a variety of areas that included handwashing (#23), residents with urinary catheters (#14), and glucometer use. The findings were: Issues concerning handwashing: 1. On 10/31/16 at 4:42 PM CNA #1 was observed feeding resident #23 without the use of eating utensils. The CNA had a hamburger in her bare hand and was bringing it to the resident's mouth to bite it. The CNA further fed the resident sweet potato fries by folding them in half with her bare hand and bringing them to the resident's mouth to bite. The CNA was observed touching the resident's personal water bottle, the table, and wiping the resident's mouth with a napkin in between feeding the resident. The CNA did not perform hand washing or sanitizing between contact with other surfaces and assisting the resident to eat. 2. On 11/2/16 at 11:15 AM, CNA #2 was observed feeding resident #23 at an assistive dining table. The CNA, in between giving the resident bites of food with a fork, was observed touching her own glasses and hair, adjusting the wheelchair of another resident, touching the wheelchair handles and brakes, and touching the back of another resident. The CNA did not perform hand washing or sanitizing between contact with other surfaces and assisting the resident to eat. 3. Interview with CNA #2 on 11/2/16 at 12:19 AM revealed that hand washing should be performed	F 441	**All staff will be re-educated about infection control / handwashing.** **Random dining room / feeding audits will be completed by the DON and Administrator for a weekly total of not less than 5 audits and PRN for one month.** **Results will be reported quarterly at the QI meeting.**	12/31/16

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F 441	Continued From page 33 in between cares provided to more than one resident and if in contact with any fluids or surfaces. Issues concerning urinary catheters: 4. Medical record review showed resident #14 had diagnoses which included neuromuscular dysfunction of the bladder. Observation on 10/31/16 at 4 PM showed the resident was seated in a wheelchair in the lobby area. The following concerns were identified: a. Observation on 10/31/16 at 4:20 PM showed the resident's urinary catheter tubing was dragging on the floor underneath his/her wheelchair. b. Observation on 11/1/16 from 8:20 AM through 10 AM showed the resident's catheter tubing was dragging on the floor underneath his/her wheelchair. 5. Interview with the DON on 11/1/16 at 4:35 PM confirmed it was her expectation that no resident with a urinary catheter should have the catheter tubing dragging on the floor. Issues concerning glucometer use: 6. Observation on 11/1/16 at 11 AM showed RN #2 used a glucometer to complete glucose testing for resident #23. The following concern was identified: a. After the testing, the RN placed the glucometer in the top drawer of the West medication cart without placing it in a container or sanitizing it. b. Interview at that time with the RN revealed the procedure at the facility was to clean the glucometer once every 24 hours on the night shift	F 441	**All nursing staff will be re-educated about catheter care.** **Charge nurses will complete daily audits to ensure bags are covered and catheter tubing is secured and off the floor.** **Results will be reported quarterly at the QI meeting.**	12/31/16

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F 441	Continued From page 34 with alcohol wipes. He stated there was one glucometer for each of the 2 medication carts, and glucometers were not assigned to individual residents. c. Interview with the DON on 11/3/16 at 11:25 AM confirmed the facility routinely cleaned the glucometer once every 24 hours at night with alcohol wipes. 7. Review of "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" (2012, May 2) Retrieved on 11/8/16 from http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html showed "...If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents .... "	F 441	**All nurses will be educated about blood glucose monitoring** **Operating procedure** **Policy / procedure** **Storage** **Maintenance** **Quality control tests** **Demonstrated proficiency** **Individual glucose monitor meters will be purchased by the facility to eliminate carry over of blood and infectious agents.** **A policy for glucose monitoring was implemented on 11-23-2016.**	12/16/16