STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on May 08, 2017 and completed on May 10, 2017, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 164		6/14/17

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

Electronically Signed | 05/26/2017

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F 164	Continued From page 1 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's educational information on privacy, and staff interview, the facility failed to provide privacy for 1 of 4 sampled residents (Resident #4) observed during personal cares in the resident's bathroom. Failure to provide privacy is an infringement of the resident's rights and may lead to a loss of dignity. Findings include: On the afternoon of 05/10/17, an administrative nurse (#1) stated the facility did not have a privacy policy and provided information from the Clinical Services Portal. This information titled, "Privacy and Confidentiality" dated 12/2012, stated, " . . . The resident has the right to personal privacy . . . 1. Personal privacy includes . . . personal care . . ."	F 164	F164 1) A psychosocial assessment was completed for resident #4 with no negative findings. CNAs #2 and #3 caring for resident #4 were re-educated with a 1:1 on closing the bathroom door or fully pulling the privacy curtain around roommate/resident to protect patient privacy. 2) Residents residing at the facility have the potential to be affected by this practice. Interviewed interviewable residents for staff maintaining privacy and observed non-interviewable residents for observable concerns related to privacy/dignity with no issues identified. 3) Education will be provided to nursing	

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F 164	Continued From page 2 Observation on 05/09/17 at 10:20 a.m., showed two certified nursing assistants (CNAs) (#2 and #3) toileting Resident #4 in the resident's bathroom. The CNA's failed to close the bathroom door or pull the privacy curtain allowing Resident #4's roommate to observe the cares provided. During an interview on 05/10/17 at 10:10 a.m., an administrative nurse (#1) stated she would expect staff to pull the roommate's privacy curtain when performing personal cares for Resident #4 in her bathroom.	F 164	staff by the DON or designee regarding the patient□s right to privacy. 4) The DON or designee will begin random audits immediately for maintaining privacy three times weekly for four weeks, then weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and correction if necessary. 5) Date of compliance June 14, 2017	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309		6/14/17

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F 309	Continued From page 3 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to provide the care and services necessary to attain the highest degree of safety possible for 1 of 1 sampled residents (Resident #7) requiring staff assistance with meals. Failure to provide proper positioning during/following meals, failure to cut the meats into appropriate bite sized pieces, and failure to follow the 3 cough rule as outlined by therapy, placed Resident #7 at a greater risk for aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 15, 16, 125, and educational handouts, identified, ". . . Signs and symptoms of dysphagia . . . coughing/choking . . . left hemisphere stroke indicative of oral dismotility . . . Parkinson's disease . . . swallowing problems . . . often begin with reduced tongue based retraction and repetitive tongue rolling, followed by delayed	F 309	F309 1) An assessment was completed for resident #7 for signs and symptoms of aspiration with no negative findings. An order was obtained for speech therapy to evaluate and Resident #7 and has been re-evaluated as her last speech therapy day was 7/1/16. Resident #7□s Care Plan and Kardex were updated to be more specific on need to be upright at a 90 degree angle for all food/fluid intake. 2) Residents who need to remain upright for food/fluid intake have the potential to be affected by this practice. Review of residents dependent for assistance with food and fluid intake was completed. An assessment was completed for signs and symptoms of aspiration and care plans and Kardex was updated as needed. 3) The DON or designee will provide	

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F 309	Continued From page 4 initiation of the pharyngeal swallow . . . head and neck cancer . . . radiation therapy can have a significant impact on pharyngeal swallowing, sometimes years after the radiation therapy . . . During the oral intake of . . . liquids, it is optimal for a patient to be seated at a 90 degree angle . . . [when] in a chair . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, cancer, cerebral vascular accident (stroke), epilepsy/seizures, and dysphagia. The quarterly Minimum Data Set (MDS), dated 03/06/17, identified long and short term memory problems, extensive assistance with meals, and extensive assistance of two for bed mobility and transfers. A Speech Therapy progress note, dated 12/26/15, stated, ". . . She requires 1:1 feeding. Pt [patient] should be upright for all meals at least 90 degrees, straws are ok, 3 cough rule-discontinue texture if more than 3 coughs are noted and notify SLP [speech language pathologist], encourage self-feeding and monitor lungs/temps [temperatures] closely for any signs of aspiration. . . ." A current physician order, dated 04/27/17, identified, ". . . 3 cough rule - if pt coughs with anyone item - discontinue [sic] for current meal tray & notify SLP. Patient to remain upright for a min [minimum] of 30 - 40 minutes after intake. HOB [head of bed] up at 90 degrees and alert for all P.O. [oral] intake."	F 309	education to licensed nurses on providing supervision and oversight for compliance with proper positioning at meals and with food/fluid intake and updating the Kardex as needed. Certified nursing assistants will be provided education on signs and symptoms of aspiration and following Kardex instructions. 4) The DON or designee will begin audits immediately for proper positioning and the care plan and Kardex of residents with positioning needs for meals will be reviewed five times a week for four weeks, then twice weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and corrections if necessary. 5) Date of compliance June 14, 2017	

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Resident #7's current care plan stated, ". . . ADL [activities of daily living] . . . deficit as evidenced by the need for assistance related to disease process . . . physical limitations, visual impairment . . . all meals in dining room with assist of 1 for feeding . . . Regular diet, thin liquids, . . . cut up all meat, ..." Resident #7's current kardex also stated, ". . . Must sit upright 30-45 minutes after meals . . ."

Observation showed the following:
* On 05/09/17 at 8:10 a.m., Resident #7 sat in her reclining wheel chair in the dining room with the head of chair reclined at an approximately 35 to 45 degree angle. A CNA (#11) fed Resident #7 large pieces of sausage (approximately two inches in diameter), hash browns, toast, cream of wheat, and cranberry juice.
* On 05/09/17 from 8:30 a.m. to 10:50 a.m., Resident #7 sat in her reclining wheel chair in a lounge. Her chair remained in the same position (reclined to 35 to 45 degrees).
* On 05/09/17 at 10:50 a.m., after providing cares, a CNA (#3) raised the head of Resident #7's bed to an approximate 30 degree angle (which placed her at an approximate 35 degree angle with the pillow behind her head) and offered her a drink of water, which she swallowed. The CNA (#3) then lowered the head of the bed to an approximate 25 degree angle and exited the room.
* On 05/09/17 at 12:05 p.m., Resident #7 sat in her reclining wheel chair in the dining room with the head of the chair reclined to an approximate 35 to 40 degree angle. A CNA (#11) fed Resident #7 pieces of roast beef, mashed potatoes and gravy, peas, bread, and apple juice. Resident #7

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F 309	Continued From page 6 coughed (loose non-productive) four times during the meal. * On 05/09/17 at 12:20 p.m., Resident #7 fell asleep in her reclining wheel chair in her room. Her chair remained in the same position (reclined to 35 to 45 degrees). * On 05/10/17 at 8:45 a.m., Resident #7 laid in bed. The head of the bed remained reclined at an approximate 30 degree angle. The CNA (#12) left Resident #7 a glass of water on the table, within her reach, prior to exiting the room. Facility staff members failed to ensure Resident #7 sat at a 90 degree angle prior to offering food or fluids, failed to ensure she remained upright for at least 30 to 45 minutes after each meal, failed to cut her meats into appropriate bite sized pieces, and failed to follow the three cough rule as outlined by the SLP. During an interview on 05/10/17 at 11:35 a.m., an administrative staff member (#1) confirmed staff last assessed Resident #7's swallow ability in 2015. The medical record showed she was diagnosed with aspiration pneumonia in 2016. Facility staff failed to reassess her swallow following this last bout of aspiration pneumonia to determine if there were any additional changes to her swallowing ability.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 312	F312	6/14/17

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F 312	Continued From page 7 faility policy, staff interview, and resident interview, the facility failed to provide activities of daily living (ADL) assistance for 2 of 9 sampled residents (Resident #3 and #7) observed during personal cares. Failure to provide assistance with oral care (Resident #3) and incontinence care (Resident #7) may result in decreased intakes, urinary tract infections, and a loss of dignity and comfort. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dysphagia and a history of weight loss. Resident #3's current Minimum Data Set (MDS), dated 04/03/17, identified intact cognition and supervision and set up help from staff for personal hygiene. The current care plan stated, ". . . Assist resident with applying fixadent sealer to bottom dentures daily . . ." A nurse's note, dated 11/23/16, stated, ". . . Patient returned from dental appt. [appointment] with upper and lower dentures. Pt [patient] was told to come back if she needs ay [sic] adjustment. Pt needs to use Fixodent with the lower denture per [provider name] . . ." Observations on the mornings of 05/09/17 and 05/10/17 showed staff assisted Resident #3 with morning cares, but failed to assist the resident with applying denture adhesive or cue the resident to apply it herself. Observations during these times showed the resident's dentures loose when she spoke. During an interview on 05/10/17 at 10:22 a.m.,	F 312	1) The day of survey findings for resident #3 the CNA caring for Resident #3 was re-educated on assisting with denture adhesive. A urinary assessment was completed for resident #7 and there were no untoward effects related to observations. CNAs #4 and #5 were re-educated on incontinence cares with skills competency demonstrated. 2) Residents needing assistance with applying denture adhesive and residents who are dependent on staff for incontinence care have the potential to be affected by this practice. Like residents have been assessed for decreased intakes and urinary tract infections. No negative effects were found. 3) The DON or designee will provide education to nursing staff on providing denture cares and incontinence cares. Skill validation will be completed with CNAs per facility guidelines. 4) The DON or designee will begin random audits immediately for compliance with assistance of dentures and incontinence care skill validation will be completed for CNAs two times a week for four weeks, then weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and correction if necessary. 5) Date of compliance June 14, 2017	

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Resident #3 stated, "The bottom ones [dentures] are loose. I knew that was going to happen, the gums have eroded."

Review of facility policy titled "INCONTINENCE CARE" occurred on 05/08/17. This policy, revised August 2014, stated, ". . . if feces present, remove with toilet paper or disposable wipe by wiping from front of perineum toward rectum. . . . Cleanse peri-area and buttocks with cleansing agent or disposable wipe wiping from front of perineum toward rectum. Use separate area of cloth or new disposable wipe for each stroke. . . . Gently separate labia and wash area using downward strokes from pubic area to rectal area. . . . Use alternative sites on washcloth or new disposable wipe with each downward stroke. . . ."

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included a history of urinary tract infections (UTIs). The current quarterly MDS, dated 03/06/17, identified extensive assistance of one for toileting and personal hygiene and always incontinent of stool.

Observation on 05/08/17 at 3:45 p.m., showed two certified nursing assistants (CNAs) (#4 and #5) provided incontinence cares for Resident #7 who had visible stool on her buttocks and perineal area. The CNA (#5) wiped the rectal area from back to front three times with visible stool on the second wipe, two times with the third wipe, and four times with the forth wipe, without folding any of the wipes to ensure a clean area of the wipe was used. The CNAs (#4 and #5) placed Resident #7 onto a bed pan and she had another bowel movement. The CNA (#5)

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F 312	Continued From page 9 removed the bedpan and cleansed the rectal area from back to front three times with visible stool on the wipe and without folding it. The CNAs (#4 and #5) applied a clean brief and failed to cleanse the front perineal area. During interview on the morning of 05/10/17, an administrative staff member (#1) confirmed staff should complete pericares from front to back.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide appropriate interventions and treatment to promote healing for 1 of 2 sampled residents (Resident #7) with a current pressure ulcer. Failure to provide timely and appropriate interventions and ensure staff consistently	F 314	F314 1) Resident #7 was assessed and medical records were reviewed with the pressure area healing at this time. The resident□s Care plan and kardex was update to don prevlon boots to bilateral	6/14/17

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F 314	Continued From page 10 implemented those interventions resulted in further deterioration of Resident #7's existing pressure ulcer. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included a cerebral vascular accident (CVA) with left leg paralysis (weakness), an unstageable pressure ulcer to the left heel, and impaired mobility. The quarterly Minimum Data Set (MDS), dated 03/06/17, identified severely impaired cognition, at risk for pressure ulcers, and extensive assistance of two or more persons for bed mobility. Resident #7's current care plan stated, ". . . Focus At risk for alteration in skin integrity related to: . . . impaired mobility. . . . Encourage to reposition as needed; use assistive devices as needed. . . . Observe skin condition . . . report abnormalities. . . . Focus deep purple tissue injury on left heel . . . Administer treatment per physician orders . . . Float heels as able. . . ." Resident #7's current certified nursing assistant (CNA) kardex stated, ". . . SKIN CARE encourage and/or assist to reposition frequently. HEEL PROTECTOR-left foot. SUSPEND HEELS . . ." The nurse practitioner progress note, dated 03/24/17, stated ". . . CHIEF COMPLAINT: complaints of pain in left heel . . . OBSERVATIONS: . . . approximately 4 cm [centimeter] round purplish area on left heel that is not blanchable. . . . DIAGNOSIS: . . . Pressure ulcer of left heel, unstageable, PLAN: when	F 314	feet. The NP was re-educated on the process of order communication. Staff was re-educated on pressure ulcer prevention and following kardex. 2) Residents with pressure ulcers have the potential to be affected. Medical records were reviewed with a wound assessment completed and observation of pressure relieving devices found to be in place as ordered. 3) The DON or designee will provide education to Unit Managers and licensed staff on prevention of pressure ulcers and nursing assistants on following kardex for pressure relieving devices. 4) The DON or designee will begin audits immediately for implementation of pressure relieving devices five times a week for four weeks, then weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and correction if necessary. 5) Date of compliance June 14, 2017	

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patient is up in her wheelchair she will have . . . boots [heel protector] on, when she is in bed she will have her heels floated so nothing is touching them. We'll continue to follow closely. If wound worsens will send her to wound clinic. . . ."

The progress notes identified the following:
* 03/22/17, "Deep purple area 4 x [by] 3 cm. Surrounding purple area is red, . . ."
* 03/24/17, "Wound rounds: Deep purple and not blanchable measuring 4 x 3 cm. . . ."
The progress's notes showed the nursing staff failed to notify the physician when the wound size increased.
* 04/07/17, ". . . Left heel has deep purple tissue injury to left heel measuring 6 x 4 cm. Skin around is blanchable. . . ."
* 04/14/17, ". . . Patient has deep purple tissue injury to left heel measuring 6 x 3 cm. Surrounding skin is light purple in color and blanchable. . . ."
* 05/05/17, ". . . Deep purple discoloration still to left heel measuring 6 x 2.5 cm. . . ."

Observations showed the following:
* 05/08/17 at 12:45 p.m., Resident #7 sat in her reclining wheel chair in the dining room with gripper slippers on both feet. The left heel rested directly against the foot board. The staff failed to place the heel protector boot on the left foot.
* 05/08/17 at 4:40 p.m., Resident #7 sat in her reclining wheel chair and the CNA (#4) placed the heel protector boot on the right foot. The left heel rested directly against the foot board. The CNA placed the heel protector boot on the wrong foot.
* 05/09/17 at 7:45 a.m., 8:30 a.m., 9:45 a.m. and 10:50 a.m., Resident #7 sat in her reclining wheel

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F 314	Continued From page 12 chair in her room with the heel protector boot located on a chair in her room. The left heel rested directly against the foot board. The staff failed to place the heel protector boot on the left foot. During an interview on 05/10/17 at 11:35 a.m. and 3:30 p.m., an administrative staff member (#1) confirmed Resident #7's deep tissue injury is from failure to off load the heel. The nurse manager should complete a weekly assessment on Resident #7's heel.	F 314		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 322		6/14/17

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F 322	Continued From page 13 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the appropriate treatment and services for 1 of 1 supplemental resident (Resident #18) observed receiving medications through a gastrostomy tube. Failure to administer the appropriate amount of fluid with administration of medications into a gastric tube and clean the syringe after administration may result in harm to the resident. Findings include: Review of the facility policy titled "Enteral Tubes: Medication Administration" occurred on 05/10/17. The policy, dated February 2012, stated, ". . . Procedure . . . dissolve medication in medicine cup using 10 to 30 ml (milliliters) of water . . . [before medication] Flush tube with a minimum of 30 ml of water . . . flush between each medication with a minimum of 5-10 ml of water . . . flush tube at end of medication administration with a minimum of 30 ml water . . . rinse reusable syringe, allow to air dry . . ." - Review of Resident #18's medical record occurred on 05/09/17. The current physician order stated, "Flush [gastric] tube with at least 30 ml of water before and after an external feeding and/or medication administration" Observation on 05/09/17 at 3:42 p.m. showed a licensed nurse (#6) entered Resident #18's room to administer the contents of the Lyrica (nerve pain) medication capsule. The nurse (#6) checked placement of the tube, checked the stomach residual with a syringe, and flushed the syringe with 5 ml of water. The nurse (#6)	F 322	F322 1) Resident #18 was assessed for harmful effects from failure to administer the appropriate amount of fluid with administration of medications into a gastric tube and clean the syringe after administration with none found. During the survey immediate education and skills validation for medication administration through a g- tube was completed with Nurse #6 who provided care to Resident #18. 2) Like residents are those receiving medications through gastric tubes. No like residents identified at this time. 3) The DON or designee will provide education to Nurses on medication administration through a G-tube and cleansing of medication syringe prior to placing back in bag. Medication administration through a G-tube skill validation will be completed for Nurses. 4) The DON or designee will begin audits immediately of medication administration through the G-tube two times a week for four weeks, then weekly for three months and quarterly times three. Results of audits will be submitted to the QAPI committee for review and correction if necessary. 5) Date of compliance June 14, 2017	

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F 322	Continued From page 14 administered the Lyrica powder with 5 ml of water into the gastric tube, flushed with 20 ml of water, clamped the gastric tube, and placed the used syringe in a bag to air dry. The licensed nurse (#6) confirmed she flushed the gastric tube with 5 ml of water, then gave the medication with 5 ml of water, and did a final flush with 20 ml of water. The nurse (#6) failed to flush the tube with 30 ml of water before and after medication administration, dissolve the medication in 10 to 30 ml of water, and rinse the reusable syringe. Observation on 05/09/17 at 5:05 p.m. showed a licensed nurse (#6) entered Resident #18's room to administer a crushed pyridostigmine (muscle strength) medication. The nurse checked placement, checked the stomach residual, and gave the medication with water flushes. When completed the nurse failed to rinse the reusable syringe. During an interview on 05/10/17 at 2:15 p.m., a nurse manager (#1) confirmed nursing staff are to follow doctors orders and facility policy on water flushes and cleaning of syringes with each use.	F 322		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 328		6/14/17

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F 328	Continued From page 15 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a	F 328		

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F 328	Continued From page 16 resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #8) receiving oxygen therapy. Failure to follow the medical providers orders, and provide guidance to the facility staff on oxygen usage does not allow the facility or the health care provider to assess the effectiveness of the resident's oxygen therapy. Findings include: Berman and Snyder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1259 states, ". . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. . . ." Review of the facility policy titled "Respiratory: Oxygen Administration" occurred on 05/10/17. This policy, dated February 2017, stated, ". . . Procedure: 1. Verify Physician's order . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included chronic	F 328	F328 1) Resident #8 was assessed at the time of survey for any negative effects of receiving the oxygen at 2 liters per minute and none were identified. Oxygen orders for Resident #8 were reviewed. The medical record to include the administration records, care plan and Kardex were updated to reflect current orders. 2) Residents who use supplemental oxygen have the potential to be affected by this practice. Oxygen orders were reviewed and clarified or revised as indicated for like residents with updates completed to administration records, care plans, and Kardex when indicated. 3) The DON or designee will provide education to licensed nurses on Oxygen administration and timely updates of Care Plans and Kardex to reflect current orders for oxygen useage. 4) The DON or designee will begin audits immediately of new Oxygen orders, three times weekly for four weeks then weekly for three months and quarterly times	

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F 328	Continued From page 17 obstructive pulmonary disease (CPOD), congestive heart failure (CHF), and chronic respiratory failure. Current physician's orders stated, "OXYGEN AT 3L [liter] PER NASAL CANNULA AT BEDTIME AND AS NEEDED FOR SOB [short of breath]/WHEEZING." Resident #8's care plan identified the following "Focus: Resistive/noncompliant with oxygen therapy related to: COPD, belief that treatment is not needed/working . . ." The certified nurse aide (CNA) kardex identified "OXYGEN 2L continuous, neb [nebulizer] prn [as needed], patient will remove O2 [oxygen] at times." Observations of Resident #8 showed the following: * 05/08/17 at 4:26 p.m. sitting in her room in her wheelchair wearing a nasal cannula connected to an oxygen tank set at 2 liters per minute (LPM). * 05/09/17 at 8:51 a.m., self propelling her wheelchair in the hallway wearing a nasal cannula connected to an oxygen tank set at 2 LPM. * 05/09/17 at 12:27 p.m. self propelling her wheelchair in the hallway wearing a nasal cannula connected to an oxygen tank set at 2 LPM. * 05/09/17 at 2:00 p.m. in her room lying on the bed wearing a nasal cannula connected to an oxygen tank set at 2 LPM. During an interview on the afternoon of 05/10/17, an administrative nurse (#1) confirmed information on the kardex failed to match the physician's order. The facility failed to ensure the consistency in the	F 328	three. DON or designee will complete random audits on residents receiving Oxygen to validate residents are receiving amounts prescribed by the provider. Results of audits will be submitted weekly to the QAPI committee for review and correction if neccessary. 5) Date of compliance June 14, 2017	

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F 328	Continued From page 18 delivery of Resident #8's O2 per nasal cannula in regard to the liter flow rate and usage of O2.	F 328		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policies, manufacturer recommendations, and staff interview, the facility failed to store and/or prepare food in a safe and sanitary manner in 2 of 3 food service areas (kitchen & North nurses station). Failure to ensure sanitizing solutions are	F 371	F371 1. a. Sanitizing solution in triple sink and dining room cleaning buckets □ Buckets will be changed and tested between dining rooms. Triple sink solution will be	6/14/17

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F 371	Continued From page 19 at the correct concentration and failure to store food appropriately in a refrigerator may result in a food borne illness that can affect all residents who eat food prepared and served in these areas. Findings include: Review of the facility policy titled "Manual Ware Washing" occurred on 05/09/17. This policy, revised July 2015, stated, ". . . Some items which cannot be washed in the dishwasher are washed manually in the three compartment sink. . . . Fill the third sink with hot water. . . . Add Oasis 146 [multi-quaternary sanitizer] to give a concentration of 200-400 ppm [parts per million]. . . . Test the concentration with the QT-40 [quaternary] test strip designed for Oasis 146 . . . Check the concentration of the sanitizing solution periodically and add sanitizer or replace solution if necessary . . ." Review of the manufacturer wall chart titled "Oasis 146 Multi-Quat Sanitizer" occurred on 05/09/17. The undated wall chart, stated, ". . . Sanitation range . . . should be between 150-400 ppm . . ." Review of the facility policy titled "Pantry/Nutrition Room Cleaning" occurred on 05/09/17. This policy, revised 03/01/03, stated, ". . . Housekeeping staff will clean and disinfect the Medication Room on a daily schedule. . . . Clean and defrost refrigerator as needed . . ." - An observation of the kitchen on 05/09/17 at 2:00 p.m. showed a cook (#8) washed soiled dishes in a three compartment sink. The cook	F 371	changed between each meal service and midway through wash as needed. Ecolab will set dispenser to dispose at a concentration level of 250 PPM to prevent testing levels from falling below 200ppm. Appropriate testing range is 200-400PPM b. Refrigerators□ throughout the center were inspected immediately, cleaned and outdated material destroyed. 2. Current residents could be affected by the deficient practice. Residents were assed for evidence of food borne illnesses and none were found. 3. a. FSD or designee will conduct employee education on triple sink and sanitizing solution testing, and will review infection control principles in the sanitizing of dining room tables b. FSD or designee will be responsible for the weekly inspection of all nutrition refrigerators and freezers in the facility for cleanliness and outdated nutrition products. Employee Education was provided to Dietary staff by the FSD on cleaning and inspection of facility Refrigerators and documentation of inspection. 4. a. The FSD or designee will audit documentation of daily sanitizer solution testing results in the triple sink and the dining room sanitizing buckets. All audits and documentation will begin immediately	

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F 371	Continued From page 20 (#8) washed pots, ladles, and steam table buckets in the three compartment sink and set them out to dry. Using a QT-40 test strip, the dietary manager (#9) obtained a reading of 150 ppm in the third compartment sink containing Oasis 146 sanitizing solution. Observation also showed a quaternary wash bucket sitting on a counter. The dietary manager (#9) obtained a reading of 0 ppm in the wash bucket, and confirmed staff had used the mixture to clean tables in the dining room. During an interview on 05/09/17 at 2:30 p.m., the dietary manager (#9) confirmed the Oasis 146 sanitizing solution should range from 200-400 ppm in the three compartment sink and the quaternary wash buckets should be at least 150 ppm. - An observation of the North nurses station on 05/09/17 at 2:35 p.m. showed a refrigerator freezer containing three nutrition supplement cartons dated 11/01/16 and an ice cream cup frozen to the freezer. The dietary manager (#9) confirmed staff needed to clean the freezer. During an interview on 05/09/17 at 3:00 p.m., the dietary manager (#9) confirmed staff needed to clean the refrigerator, and reported staff did not have a cleaning schedule for the refrigerator.	F 371	and will be forwarded to the QA committee weekly by the FSD for review and monitoring for corrections if necessary. Audits will be weekly X 4 weeks, monthly x 4 months, and quarterly thereafter b. The FSD or designee will begin Refrigerator audits immediately and provide weekly refrigerator inspection documents to the QA committee for review and corrections if necessary. Audits will be weekly X 4 weeks, monthly x 4 months, and quarterly thereafter. 5. June 14 2017	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		6/14/17

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F 441	Continued From page 21 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 22 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policies, review of professional literature, and staff interview, the facility failed to follow infection control practices for 2 of 9 sampled residents (Resident #4 and #7) observed during personal cares and/or foley catheter cares. Failure to follow infection control practices of hand hygiene following perineal cares (Resident #4 and #7) and foley catheter cares (Resident #7) has the potential to spread infection to other personnel, residents, and visitors. Findings include: Review of the facility policy titled, "Hand Hygiene"	F 441	F441 1) CNA #2 caring for resident #7 was educated on infection control practices related to hand hygiene. Resident #4 did not have any ill effect related hand hygiene practices. CNA #10 was educated on infection control practices related to catheter care. Resident #7 did not have any ill effect related catheter care practices. 2) Residents requiring assistance with perineal care and catheter care have the potential to be affected by this practice. Residents have been assessed for signs	

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F 441	Continued From page 23 occurred on 05/10/17. This policy, dated 12/2009, stated, " . . . When to wash hands or use an alcohol-based hand rub: * Before applying and after removing gloves . . . *After contact with body fluids and excretions . . . " Review of facility policy titled, "INCONTINENCE CARE" occurred on 05/10/17. This policy, revised August 2014, stated, ". . . if feces present, remove with toilet paper or disposable wipe . . . Discard soiled materials and gloves. . . . Perform hand hygiene . . . Dry peri-area and buttocks . . . Remove and discard gloves. . . . Perform hand hygiene. . . . Reposition for comfort . . . provide additional care needs . . ." - During observation on 05/09/17 at 10:20 a.m., two certified nursing assistants (CNAs) (#2 and #3) provided perineal cares for Resident #4 after using the toilet. A CNA (#2) completed the cares, including the cleansing of a smear of bowel movement (BM). Following the incontinence care and assisting Resident #4 into the wheelchair, the CNA (#2) removed her gloves, failed to perform hand hygiene, and donned a new pair of gloves. The CNA then proceeded to complete other tasks of pushing Resident #4 out of the bathroom and applying leg rests to the wheelchair. During an interview on 05/10/17 at 10:10 am, an administrative nurse (#1) stated she would expect staff to perform hand hygiene after removing gloves, and before doing other tasks. Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process,	F 441	and symptoms of infection related to infection control practices with perineal care/catheter care and none were found. 3) The DON or designee provided education to licensed nurses, nurse managers, and CNAs on infection control practices, hand hygiene, and perineal/catheter care. 4) The DON or designee will begin random audits of perineal and catheter care immediately and weekly for four weeks, then monthly for three months and then quarterly times three. Results of audits will be submitted to the QAPI committee for review and correction if necessary. 5) Date of compliance June 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 24 and Practice, Tenth Edition," Pearson Education, Inc., New Jersey, page 1192 and 1198, states, ". . . MAINTAIN THE URINARY CATHETER . . . Maintain a sterile, closed drainage system. . . . Empty the collection bag regularly with a separate, clean collecting container . . . prevent contact of the drainage spigot with the nonsterile collecting container. . . . Nursing care of the client with an indwelling catheter and continuous drainage is largely directed toward preventing infection of the urinary tract . . . preventing contamination of the drainage system . . ." Dugan, "Successful Nursing Assistant Care", Second Edition," Hartman Publishing Inc., New Mexico, page 300-301, states, "Emptying a catheter drainage bag . . . Open drain or clamp on the bag. Allow urine to flow out of the bag into the graduate. When urine has drained, closed clamp. Using alcohol wipe, clean the drain clamp. Replace the drain in its holder on the bag. . . ." - Review of Resident #7's medical record occurred all days of survey. Diagnoses included a history of urinary tract infections. The current quarterly Minimum Data Set (MDS), dated 03/06/17, identified an indwelling catheter (suprapubic), always incontinent of bowel, and extensive assistance of one to two required for all cares. During an observation on 05/09/17 at 1:45 p.m., two CNAs (#2 and #10) assisted Resident #7 with perineal cares. The CNA (#2) applied gloves and cleansed the front perineal area which showed visible stool on the wipe. The CNA (#2) picked up a piece of stool off the blanket on the bed with a wipe, placed it in the garbage can,	F 441		

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F 441	Continued From page 25 and without removing her soiled gloves adjusted the clean brief, pulled up the resident's pants, adjusted her shirt, and repositioned the resident. The CNA (#2) removed her gloves and adjusted the level of the bed using the controls then washed her hands and left the room. The CNA (#2) failed to remove her gloves and perform hand hygiene after providing perineal cares and prior to completing other cares. During an observation on 05/09/17 at 2:00 p.m., a CNA (#10) entered Resident #7's room to empty the catheter drainage bag. She applied gloves, went into the bathroom, took two clean collection containers and placed approximately 75 milliliters (ml) of water from the bathroom faucet into one of the containers. The CNA placed the container with the water on the bedside table. She placed a paper towel on the floor and the empty container on the paper towel, opened the end of the drainage tube from the indwelling catheter collection bag, and drained the urine in to the container. The CNA (#10) took the end of the collection bag tube, turned it upwards, and poured water from the other container into the catheter bag, shook the bag and stated "I'm rinsing out the catheter bag." The CNA (#10) drained the water back into the container, wiped off the port with an alcohol swab, and disposed of the contents in the toilet. The CNA removed her gloves and sanitized her hands. During an interview on 05/10/17 at 11:35 a.m., an administrative staff member (#1) confirmed the CNA (#10) did not follow facility practice when emptying the catheter drainage bag.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 26 A complaint investigation was conducted in conjunction with the standard Medicare/Medicaid recertification survey. The complaint issues regarding transfers, timeliness of answering call lights, and therapy services, could not be substantiated.	F9999		