STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	02/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey, started on 02/14/11 and completed on 02/16/11, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**F 164** **Privacy/Confidentiality of records** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Social Service visited with resident #7, and #8 to inform them on the procedure for blood glucose testing and the need for resident privacy by not testing the blood in the hallway.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mindy D Hodgell
TITLE: Administrator
(X6) DATE: 03/21/2011

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.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the residents' right to personal privacy for 3 of 4 residents (Resident #7, #8, and #13) observed during blood glucose testing and/or insulin injection. Findings include: Review of the facility policy "Blood Glucose Testing" occurred on February 15-16, 2011. The policy, revised January 2009, stated, "Procedure 1. Provide privacy . . ." - On the afternoon of 02/14/11, when asked when she performs blood glucose tests and/or administers insulin, a licensed nurse (#2) stated, at about 5 p.m. each day, residents come to the nurse's station where the nurse (#2) performs the blood glucose tests and administers insulin. Observations on 02/14/11 revealed the following: * At 5:10 p.m. observation showed Resident #7 seated in a hall near the nurse's station. A licensed nurse (#2) approached Resident #7 obtained a drop of blood from the resident's finger with a lancet, and performed a blood glucose test with the resident seated in the hallway. *At 5:20 p.m., Resident #8 approached the medication cart, situated in the same hall. The licensed nurse (#2) obtained a drop of blood from the resident's finger, and performed a blood glucose test. After obtaining the results, the nurse then administered subcutaneous insulin in the resident's abdomen with the resident seated in	F 164	Resident # 13 was discharged on 3-17-11. Completed by 3-18-11 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** A list of residents that receive a blood glucose test will be generated and review as these are the residents that have the potential to be affected in this area. Completed by 3-22-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All Licensed nursing staff were re-educated on the procedure for Blood Glucose Monitor and the need to provide privacy for all blood glucose testing even if the resident requests the test to be provided in the hallway. Training includes a written post test. Completed by 3-22-11	

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F 164	Continued From page 2 her wheelchair near the medication cart. * At 5:40 p.m., observation showed Resident #13 seated in the hall near the nurse's station. A licensed nurse (#2) approached the resident, obtained a drop of blood from the resident's finger, and performed a blood glucose test with the resident seated in the hall. During an interview on 02/16/11 at 4:15 p.m. an administrative staff member (#4) agreed staff should provide privacy during blood glucose testing and insulin administration.	F 164	**This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Services/Designee will complete a weekly audit on all residents who have blood glucose testing and for providing privacy during the test. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to check the state registry for 1 of 5 newly hired staff members (#5). Failure to check the appropriate registry has the potential for the facility to offer employment to a person with a work history of abuse and/or neglect, placing residents at risk. Findings include: - Review of the facility policy titled, "Policy & Procedure Recruitment and Selection - Selection Registry/Licensure Verification" occurred on 02/16/11. This policy, dated 01/10, stated, "Purpose: To establish policy and procedure	F 226	**F 226 Develop/Implement Abuse/Neglect policies** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** No residents have been affected in this area. The Human Resource Coordinator completed the required state registry check for staff member #5.	

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F 226	Continued From page 3 regarding employee certifications, licenses and other credentials. To ensure compliance with applicable laws and regulations. . . . Procedure: New Employees: 1. The names of all new employees, regardless of positions, will be checked through the state registry to ensure that the potential employee, regardless of position, does not have a finding entered against him or her. All states where the employee worked and/or lived the last five years will be contacted. Documentation of the contact will be recorded on the Registry/Licensure Verification form . . ." On 02/15/11, the facility provided a list of staff hired in the last four months. Review of the staff file for a licensed staff member (#5), showed the facility failed to check the state registry, during the hiring process. The licensed staff member's (#5) employment history indicated he\she worked as a certified nursing assistant from 11/07 to 05/09 prior to becoming a licensed nurse. The facility hired the licensed staff member (#5) on 11/11/10. During an interview on, 02/16/11 at 2:30 p.m., an administrative staff member (#4) stated the facility clearly missed checking the state registry for the licensed staff member (#5) at the time of hire.	F 226	No problems were found and the documentation was filed in the employee's personal record. Completed by 3-28-11 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Human Resource Coordinator/Designee reviewed all current employee files to see if any current employee indicated they had worked as a Certified Nursing Assistant in another state. If the employee has indicated they work in another state as a CNA an appropriate state registry check was completed and any problems were corrected.	
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident	F 241	Completed by 3-28-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** The Human Resource Coordinator was re-educated on (date) on the need to check the state registry for any employee who notified us they	

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F 241	Continued From page 4 interview, and staff interview, the facility failed to provide care in a manner and in an environment that maintained and enhanced the dignity and respect of 2 of 10 sampled residents (Resident #7 and #9) on 2 of 2 resident care units regarding wet and unmade beds. Failure to make Resident #7's bed and change Resident #9's bed in a timely manner did not recognize the individuality of each resident and limited their self-esteem. Findings include: - Review of Resident #7's medical record occurred on February 14-16, 2011. The facility admitted the resident in 09/10. The resident's current quarterly Minimum Data Set (MDS), dated 12/28/10, identified the resident was cognitively intact. The facility identified the resident was interviewable. Observation throughout the day, on 02/15/11 from 7:40 a.m. to 5:55 p.m., showed Resident #7's bed unmade with the blankets and top sheet thrown back. During interview, on 02/15/11 at 7:50 a.m., a licensed nursing staff member (#3) reported the resident left the facility at approximately 5:00 a.m. for a scheduled treatment. Observation, on 02/15/11 at 1:00 p.m., showed Resident #7 seated on his unmade bed, with the top covers positioned as observed at 7:40 a.m., visiting with a family member seated in an arm chair. During interview, on 02/16/11 at 8:20 a.m., Resident #7 reported his bed is unmade at times "depends on who's working" and having the bed unmade during his family member's visit "bothered" him. Resident #7 did not identify a specific staff member who fails to make his bed, nor did he elaborate on how it "bothered" him.	F 241	had worked as a Certified Nursing Assistant in another state. Completed on 3-28-11 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Once per month, the Business Office Manager/Designee will audit all new hires to make sure appropriate state registry checks are completed. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11 **F 241 Dignity and Respect of Individuality** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Social Services visited with resident #7 and resident #9 to make sure they had no unresolved concerns related to the	

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F 241	Continued From page 5 During interview, on 02/16/11 at 11:00 a.m., a nursing management staff member (#1) stated her expectation is the facility staff would make Resident #7's bed each day. - Review of Resident #9's medical record occurred on February 15-16, 2011. A significant change MDS, dated 11/19/10, identified a brief interview for mental status (BIMS) summary score of 15. MDS guidelines identify a BIMS score of 13-15 as cognitively intact. On 02/14/11 the facility provided a list of interviewable residents, which included Resident #9. During the initial tour, on 02/14/11 at 12:55 p.m., observation showed Resident #9 lying in bed. When asked how she was doing, Resident #9 identified she spilled water in her bed at 4:00 a.m. and that she continued to lay in a wet bed. When asked, Resident #9 indicated he/she had alerted staff of his/her desire to have the bed linen changed when she/he spilled the water. Resident #9 indicated the staff would probably change the sheets when they have time. During an interview, on 02/16/11 at 10:15 a.m., with Resident #9,when asked, the resident smiled and stated, "They must have heard me talking to you. When I came back [to her room] the sheets had been changed." During an interview, on 02/16/11 at 4:10 p.m., with administrative staff members (#1 and #4), they agreed waiting over nine hours for wet sheets to be changed did not provide care for Resident #9 in a dignified manner. Failure to make Resident #7's bed 02/15/11 and	F 241	making/changing of bed linen. Any required follow was completed Completed by 3-18-11 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** Social Services interviewed residents who have the ability to make their needs known to see if they had any unresolved concerns relate to the making/changing of bed linen. Any required follow up was completed Completed by 3-28-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Certified Nursing Assistants were re-educated on the need to make or change bed linen promptly. Licensed Nurses were re-educated on the need to spot check rooms to make sure beds are made and any linen changes are made promptly. **This is how the facility will monitor to make sure the changes continue and the problem is prevented.**	

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F 241	Continued From page 6 failure to change Resident #9's bedding in a timely manner after she spilled water on the bed, limited these residents' self-esteem and did not recognize their individuality.	F 241	Social Service/Designee will audit on a weekly basis, bed making and linen changes to make sure they are completed promptly. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY COMPLETED ON FEBRUARY 25, 2010. Based on observation, record review, and staff interview, the facility staff failed to provide services with reasonable accommodations of individual needs and preferences for 2 of 10 sampled residents for 3 of 3 days of survey (Resident #3 and #4) regarding use of palm protector splint devices (Resident #3 and #4) and a pressure pad call light within reach (Resident #4). Failure to use the palm protectors placed the residents at risk of reduced finger range of motion, increased pressure of the fingers into the palms, pain, and potential for skin breakdown. Failure to place the pressure pad call light in Resident #4's reach limited the resident's ability to call for staff assistance when necessary. Findings include:	F 246	**F 246 Reasonable Accommodation of Needs/Preferences** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #3 and #4 have been receiving their palm protector splint device according to their plan of care. They both have had range of motion assessment in the hands to ensure that no decline in the range of motion has occurred. Resident #4 now has the pressure pad call light in reach. Completed on 3-22-11	

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F 246	Continued From page 7 - Observation during the initial facility tour, on 02/14/11 at 2:00 p.m., identified a palm protector on Resident #4's bedside stand. Review of Resident #4's medical record occurred on February 14-16, 2011. The facility admitted the resident in January 2011. Current diagnoses included glaucoma, joint pain, and anxiety. The resident's current admission Minimum Data Set (MDS), dated 01/18/11, identified the resident was able to make herself understood, required assistance of two or more persons for bed mobility and transfers, and had functional limitation in range of motion of both upper extremities. An Inter-Department Communications, dated 02/01/11, from an occupational therapy (O.T.) staff member (#19), included with Resident #4's care plan, stated "1. D/C [Discontinue] O.T. Mon. [Monday] 7th [February] . . . 5. Lt. [Left] palm protector on during day. (Not being put on.) . . ." Resident #4's Vision Care Area Assessment, dated 01/26/11, identified a pressure pad call light replaced the standard push button call light due to the resident's low vision. The resident's current care plan, dated 02/06/11, stated "Problems, Impaired mobility r/t [related to] PMR [polymyalgia rheumatica], DJD [degenerative joint disease] . . . Potential for impaired skin integrity r/t impaired mobility . . . Approaches . . . Left hand palm protector on during the day PRN [as needed] . . . Problems . . . Impaired vision r/t glaucoma . . . Approaches . . . Has pressure pad call light . . ." Resident #4's care plan was not updated to include the occupational therapist's intervention of wearing the palm protector during the day.	F 246	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** Nursing identified all other residents who have palm protector splint devices and assessed them to make sure the palm protector splint devices are performing as need in protecting residents from reduced range of motion. Completed by 3-28-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All nursing staff have been re-educated on the use of splinting devices, and for updating the residents care plan to identify which resident use splinting devices. All nursing staff were re-educated on the need to keep call lights within reach of all residents. Education included a written test. Completed by 3-28-11	

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F 246	Continued From page 8 Observations throughout the day on 02/15/11 and until 12:00 noon on 02/16/11 identified a palm protector on Resident #4's bedside stand or in a drawer of the bedside stand. Observation during these time periods revealed Resident #4 did not wear a palm protector and facility staff did not offer or attempt to apply the palm protector. Observation of a transfer at 8:45 a.m. on 02/15/11 (identified below) showed limited mobility and tightness of the resident's left hand. Observations on 02/15/11 identified the following: Throughout the survey, Resident #4 responded appropriately to staff questions such as offers of toileting, fluids, and meal item choices. *At 8:45 a.m. - A certified nursing assistant (CNA) (#8) transferred Resident #4 from her wheelchair to her bed with a sit to stand lift. The CNA manually opened Resident #4's left hand to place the resident's fingers around the lift grab bar. After positioning the resident on the bed the CNA (#8) attached a push button call light to her blanket. A pressure pad call light was present on the resident's bedside stand, out of the resident's reach. The pressure pad call light remained out of the resident's reach until the facility staff assisted her to a wheelchair at approximately 11:15 a.m. *At 12:15 p.m. - A CNA (#9) transferred the resident from her wheelchair to her bed and attached a push button call light to her blanket. A pressure pad call light was present on the resident's bedside stand, out of the resident's reach. The pressure pad call light remained out of Resident #4's reach until cares were provided by a CNA (#10) at 4:30 p.m. During interview, on 02/16/11 at 11:00 a.m., a nursing management staff member (#1) reported	F 246	**This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Nurse Manager/Designee will develop and complete an audit one time per week to monitor the padded call lights, splinting devices according to their care plan, and that the splint is positioned properly. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	

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F 246	Continued From page 9 her expectation would be that facility staff would attempt to place the palm protector in Resident #4's left hand throughout each day and facility staff would make the pressure pad call light accessible to Resident #4. - Review of Resident #3's medical record occurred on February 14-16, 2011. The current care plan for self care deficit, related to a left cerebrovascular accident hemiparesis, identified Resident #3 uses a "palm guard daily to [left] hand," implemented on 11/22/10. Observations on 02/14/11, at 12:55 p.m., 4:40 p.m. and 5:46 p.m., showed staff failed to place the palm guard to Resident #3's left hand. Throughout observations on 02/15/11 at 7:40 a.m., 7:59 a.m., 9:07 a.m., 9:15 a.m., 10:40 a.m. 12:15 p.m., 1:05 p.m., 3:55 p.m. and 02/16/11 at 8:20 a.m. and 12:15 p.m., showed staff failed to apply Resident #3's palm guard to the left hand. All observations showed Resident #3's left hand curled into a fist. During an interview with administrative staff members (#11 and #12), on 02/16/11 at 9:00 a.m. they confirmed staff should use adaptive equipment provided for Resident #3. Failure to attempt and ensure the use of the palm protectors for Resident #3 and #4 placed these residents at risk of reduced mobility, pain, and potential skin breakdown. Failure to ensure the pressure pad call light was accessible to Resident #4 limited the resident's independence and limited the resident's ability to request staff assistance when needed.	F 246	**F 309 Provide Care/Services for Highest Well Being** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #7 was assessed by nursing with no residual problems with his/her fistula and upper chest port. All lab values from the past 60 days are being reviewed.. Any needed follow up was completed and the resident's care plan was updated to included weekly physical assessments of the upper chest area and fistula. Lab values will be reviewed and noted in the nursing notes when received. Completed by 3-22-11	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident receiving hemodialysis (Resident #7) regarding monitoring of dialysis status, coordination of dialysis treatment, and development and implementation of a dialysis management plan. Failure to provide appropriate care and services placed Resident #7 at risk of hemodialysis access complications and illness related to progression of renal failure, including fluid and electrolyte imbalance, weight loss, and confusion. Findings include: Review of the facility policy and procedure, "Dialysis Services", occurred on 02/16/11. This policy, revised 01/09, stated "PURPOSE, To provide dialysis services to residents when necessary. . . . At a minimum, the plan of care, protocols, and procedures as they relate to the patient(s)/resident(s) dialysis, shall include: 1. Procedures for medical and non-medical emergencies, including but not limited to: complications, equipment failure, etc.;	F 309	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The facility does not have any other residents receiving dialysis services. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All licensed nursing staff were re-educated on the dialysis services policy. All licensed nurses also were re-educated on the care plan policy including the need to update care plans to reflect the currents needs of the residents. Education included written testing. The Nurse Manager will also be responsible to communicate to the Dietary Manager and Facility Consulting Dietitian all lab results so proper nutritional assessment and adjustment can be made. Completed by 3-28-11 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Director of Nursing/Designee will audit on a weekly basis all	

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F 309	Continued From page 11 2. Follow-up care, observation, and monitoring; 3. Medications; 4. Nutritional needs and fluid restrictions; 5. Patient(s)/resident(s) education/instruction; and 6. Emotional and social well-being. . . ." Review of Resident #7's medical record occurred on February 14-16, 2011. The facility admitted the resident in 09/10. Current diagnoses included diabetes mellitus and renal failure. The resident attended hemodialysis three times each week. The resident's current quarterly Minimum Data Set (MDS), dated 12/28/10, identified the resident was cognitively intact. The facility identified the resident was interviewable. The resident's current medications include Humalog insulin 75/25, 22 units, each morning, Humalog insulin 75/25, 8 units, each evening, and sliding scale insulin with blood glucose monitoring four times each day. Resident #7's current care plan, dated 11/20/10, stated "Problems, Alteration in nutrition r/t [related to] disease process m/b [manifested by] dialysis, DM [diabetes mellitus] . . . Approaches . . . Therapeutic diet as ordered. . . . Problems, Potential for skin integrity impairment r/t renal failure, dialysis m/b electrolyte imbalance, dialysis port site. . . . Approaches, Weekly skin check with shower. . . . Tx [Treatment] as ordered. . . . Problems, Potential for impaired social interaction r/t dialisis [sic] . . . Invite resident to activities as tolerated . . ." Observation of Resident #7, on February 14-16, 2011, identified a small piece of gauze on his right upper chest, barely visible under his shirt. The resident reported this gauze covered an intravenous dialysis access site.	F 309	communication between the dialysis unit, resident's physician and lab. Any problems found from the audit will be corrected immediately. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	

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F 309	Continued From page 12 Resident #7's medical record identified concerns regarding possible irritation and drainage of the dialysis access fistula in the left arm in January 2011. Physician orders included monitoring of the fistula and a fistulagram on 01/20/11, showed no problems. Physician orders following the fistulagram were to discontinue monitoring. The resident's medical record lacked evidence of monitoring of the fistula prior to the fistulagram. The medical record lacked identification of the right upper chest dialysis access site. The resident's medical record lacked evidence the facility staff monitored Resident #7's dialysis access sites. Resident #7's Interdisciplinary Progress Notes identified the resident attended hemodialysis three times each week and left the facility at approximately 5:00 a.m. or 10:00 a.m. During interview, on 02/15/11 at 7:50 a.m., a supervisory nursing staff member (#3) reported the resident was out of the facility for an early dialysis treatment. During interview, on 02/16/11 at 8:20 a.m., Resident #7 reported he left the facility at approximately 5:00 a.m. on 02/15/11 for dialysis and the facility staff did not provide any meal or snack items, did not check his blood glucose, and did not provide insulin before he left. He returned at approximately 10:00 a.m. and received a snack and medications at that time. The resident reported this is the routine for the early morning treatments. During the interview on 02/16/11 at 8:20 a.m., Resident #7 expressed an understanding of some of his dietary and fluid restrictions and reported he leaves the facility on outings with family and	F 309		

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F 309	Continued From page 13	F 309		

friends. He also reported the facility staff have provided him with little instruction or guidance regarding his dialysis treatment plan or restrictions. He reported the dialysis center staff have provided him with most of the information he has received.

Resident #7's medical record identified episodes, on 12/31/10 and 02/03/11, of early morning dialysis treatments without snacks, blood glucose checks, or insulin until he returned to the facility at approximately 10:00 a.m.

The medical record included physician orders received from the dialysis center regarding the resident's medication, diet, and a fluid restriction of 1.5 liters per day, dated 01/25/11. During interview, on 02/16/11 at 11:00 a.m., an administrative nursing staff member (#1) reported the facility and the dialysis center staff are in contact as questions or problems may develop regarding Resident #7's care. This staff member (#1) reported the facility did not receive the resident's laboratory results from the dialysis center on a regular basis.

During interview, in the afternoon on 02/15/11, a supervisory dietary manager (#14) reported facility staff have observed Resident #7 bringing in food items from outside the facility that are not on his diet and it is known the resident does not always adhere to his diet and fluid restrictions. At this time, the facility's consultant dietitian (#20) reported concerns regarding obtaining accurate weights of Resident #7 and the facility has used the "dry" weight obtained at the dialysis center as the most consistent weight. Resident #7's medical record included periodic assessments by the consultant dietitian (#20) which identified the

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F 309	Continued From page 14 resident's weight fluctuations and failed to address the resident's laboratory values. During interview, on 02/16/11 at 2:15 p.m., a supervisory dietary staff member (#14) reported the facility received monthly reports of the resident's laboratory values with comparison to the previous month, including albumin, potassium, phosphorus, and calcium. This staff member (#14) reported the consultant dietitian (#20) maintained these reports and he could access only one report at the time of the interview. At the exit conference, on 02/16/11 at 4:45 p.m., the staff member (#14) provided copies of the dialysis laboratory reports for the months of October 2010 through January 2011, which he reported he obtained from the resident's medical record. Resident #7's laboratory values from the dialysis center identified the following: *Albumin, blood protein - Acceptable level 3.2 (grams per 100 milliliters) or above - October 2010 - 3.0, January 2011 - 2.9. *Potassium - Acceptable level 3.5 - 5.5 (milliequivalents per liter) - October 2010 - 6.0, December 2010 - 5.8. *Phosphorus - Acceptable level 3.5 - 5.5 (milligrams per 100 milliliters) - October 2010 - 5.7, November 2010- 5.6, December 2010 - 3.4. The medical record lacked the facility's management plan regarding the resident's laboratory values from the dialysis center or adjustments to his diet regarding the laboratory values. Resident #7's care plan lacked information regarding his current fluids restriction of 1.5 liters per day.	F 309		

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F 309	Continued From page 15 The dialysis center provided monthly laboratory reports to the facility. The laboratory reports showed levels higher and lower than acceptable for several months. The medical record lacked information the facility staff provided Resident #7 with education to control these levels by adhering to his diet and fluid restrictions or used this information as part of the resident's treatment plan. Resident #7's medical record lacked evidence the facility monitored his dialysis access sites, except when specifically ordered by the physician in January 2011. Failure to follow the facility's policy and procedure, failure to develop, implement and educate Resident #7 in an organized management plan for his renal disease and dialysis treatment placed the resident at risk of increased progression of the renal disease.	F 309	**F 312 ADL Care Provided for Dependent Residents** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #2 and #3 had his/her a nutritional assessment completed by the facility Registered Dietitian. Both residents are on comfort cares so appropriate follow up from the Dietitian's report was incorporated, where appropriate into the residents care plan. The Hospice Provider and the residents' families were updated on the changes made to the care plan. Completed by 3-28-11 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Director of Nursing/Designee will identify a list of residents than need extensive assistance in eating. These residents will be have their nutrition needs review and if need a	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, facility staff failed to provide the necessary services to maintain good nutrition for 2 of 4 sampled residents (Resident #2 and #3) who require extensive assistance to carry out the daily activity of eating. Failure to assist residents	F 312		

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F 312	Continued From page 16 who are unable to consume food without encouragement or assistance has the potential to contribute to weight loss and/or poor nutrition. Findings include: - Review of the medical record for Resident #2 occurred February 14-16, 2011. A quarterly Minimum Data Set (MDS), dated 11/08/10, identified Resident #2 required extensive assistance of one staff member for eating and a weight of 100 pounds. A dietary consult note, dated 02/04/11, identified Resident #2 as a nutrition risk, has a low body mass index, a weight of 98.6 pounds, a loss of 5.2 pounds in six months, and is on comfort cares. The dietary card for Resident #2 indicated the facility serves the resident an eight-ounce hi-protein milk at every meal to supplement the resident's nutrition. Observation of meal service to Resident #2 showed the following: * Breakfast 02/15/11 - consumed 100% of the hi-protein milk, juice and water. Ate bites of egg and hot cereal. * Noon meal 02/15/11 - consumed 100% of the hi-protein milk. Ate bites of scalloped potato with ham, wax beans and jello. * Breakfast 02/16/11 - consumed 100% of the hi-protein milk, juice and water. Ate bites of biscuits and gravy. Resident #2 consumed her hi-protein milk and refused other foods offered. The milk is fortified to provide extra nutrition. Staff failed to offer another glass of milk when Resident #2 showed a willingness to consume fluids during the meals.	F 312	referral will be made to the facility's Registered Dietitian. The Director of Nursing/Designee followed up with the Dietitian's recommendations and updated care plans. Completed by 3-28-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Residents who are at identified as nutritional at risk will have "Offer maximum caloric intake" noted on the tray card. All nursing staff were re-trained on the need to maximize the caloric intake during meal service for residents at nutritional risk the need to check the tray card to identify residents who need maximum caloric intake. All Dietary Department staff were re-trained on the fortified foods policy/process. Dietary Staff will support Nursing Staff when nursing staff request additional fortified foods. Completed by 3-28-11	

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F 312	Continued From page 17 During an interview with administrative staff members (#11 and #12), on 02/16/11 at 9:00 a.m., they agreed staff should offer Resident #2 additional fluid/foods the resident is consuming at a particular meal. These staff members identified Resident #2 is on comfort cares and though weight loss may not be avoidable, Resident #2's gradual weight loss is a concern. Offering her more milk would be appropriate. Observation of the noon meal on 02/16/11, showed Resident #2 consumed the first glass of milk provided and when asked if she would like more milk replied "yes". Resident #2 consumed an extra three glasses of hi-protein milk and 75% of a fourth. Resident #2 ate little if any of the food provided. Observation showed a dietary staff member obtained milk from a container in the kitchen to provide the additional glasses of milk for Resident #2. When asked, this unidentified dietary staff member stated the milk is hi-protein milk. - Review of the medical record for Resident #3 occurred February 14-16, 2011. A significant change MDS, dated 01/19/11, identified Resident #3 required limited assistance of one staff member for eating, a weight of 241 pounds, identified as not a physician-prescribed weight loss. Review of Resident#3's dietary consult notes for December 2010, January and February 2011, identified an initial weight loss related to a hospital stay resulting in a loss of edema. These notes identified expected continued weight loss due to the resident's medical condition. The dietary card for Resident #3 identified the facility provides an eight-ounce skim milk with Beneprotein for	F 312	**This is how the facility will monitor to make sure the changes continue and the problem is prevented.** On a weekly basis, the Director of Nursing/Designee will audit the nutritional status of 25% of the residents needing extensive assistance. The audit will include reviewing meal intake documentation. Any problems noted will be follow up with immediately. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. The Dietary Manager/Designee will audit on a weekly basis all tray cards to make sure residents identified as needing maximum caloric intake have this noted on the tray card. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	

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F 312	Continued From page 18 nutritional supplementation at breakfast. Observation showed Resident #3 received all meals in her room and staff provided extensive assistance as follows: * Breakfast 02/15/11 - a certified nurse aide (CNA) (#18) fed Resident #3 half a bowl of hot cereal, and held the glass while the resident used a straw to consume 90% of a glass of milk and over half a glass of apple juice. * Breakfast 02/16/11 - a CNA (#18) fed Resident #3 hot cereal. Resident #3 consumed a few bites of cereal then stated she did not want more. The resident consumed 100% of the milk and juice provided with the meal. Resident #3 also requested ice water and drank water. The CNA offered more cereal and yogurt, but the resident declined. Observation at breakfast on 02/16/11 showed Resident #3 consumed fluids but not wanting the food provided. The CNA (#18) failed to offer more milk, rather removed the tray when the resident no longer wanted to eat. During an interview with administrative staff members (#11 and #12), on 02/16/11 at 9:00 a.m., they agreed staff should offer Resident #3 additional fluid/foods the resident consumes. These staff members identified Resident #3's weight loss is a concern, and offering/providing more milk would be appropriate.	F 312	**F 323 Free of Accident Hazards/Supervision/Devices** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #4 and #5 were assessed for any injuries related to transferring and are being transferred according to the facility Gait Belt procedure, and care plan has been updated. Completed by 3-28-11	
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	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** A list of residents that require staff assistance with transfers have the potential to be affected in this area. Each resident will be assessed for	

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F 323	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 2 of 5 sampled residents (Resident #4 and #5) using sit to stand lifts or assistance of one or two persons for transfers received adequate supervision and assistance to prevent accidents. Failure to properly position Resident #4 in the sit to stand lift and ensuring adequate assistance as care planned, placed her at risk of injury or potentially falling from the lift during the transfer. Failure to use a gait belt during transfers limited the staff's ability to safely assist Resident #5 and placed her at risk of injury. Findings include: Review of the facility procedure, Gait (Transfer) Belt, occurred on 02/16/11. This procedure, revised 01/09, stated "PURPOSE, To safely transfer or ambulate resident, To aid resident in maintaining balance, To avoid injury to both resident and staff member. NOTE: Gait belts used unless medically contraindicated. . . ." - Review of Resident #4's medical record occurred on February 14-16, 2011. The facility admitted the resident in 01/11. Current diagnoses included pain, degenerative joint disease, and anxiety. The resident's current admission Minimum Data Set (MDS), dated 01/18/11, identified the resident required extensive assistance of two or more persons for transfers	F 323	proper transferring techniques according to the facility's resident transfer policy, and care plans updated as needed. Completed by 3-28-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All Nursing Staff were re-trained on proper transferring technique. Licensed Nurses were re-trained on the resident transfer policy and re-educated on the care plan policy including the need to update care plans to reflect the currents needs of the residents. Education included written testing and return demonstrations. Completed by 3-28-11 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Rehab Nurse/Designee will audit 3 resident transfers per week to see if they are appropriate and are being done by nursing staff appropriately. The results of the audits will be reported on a monthly basis to the QA/CQI	

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F 323	Continued From page 20 and functional limitation in range of motion in left and right upper and lower extremities. Resident #4's care plan, dated 02/06/11, stated "Problems, Impaired mobility r/t [related to] PMR [polymyalgia rheumatica], DJD [degenerative joint disease] . . . Approaches . . . Assist of 1 with sit to stand while toileting . . . Assist of 2 with gait belt for all other transfers besides toileting. . . ." Observation of Resident #4's transfers included the following: *02/15/11, 8:45 a.m. - A certified nursing assistant (CNA) (#8) positioned the sit to stand lift in front of the resident seated in a wheelchair and placed the resident's feet on the lift platform. The CNA positioned the thoracic strap behind the resident's back, manually opened her left hand, and placed her hands on the lift grab bars. The CNA failed to attach the calf strap to support the resident's legs on the lift. As the CNA brought the resident to a partially standing position, her knees remained bent, she was up on her toes, her knees were together, and her knees were not in contact with the knee pad of the lift. Resident #4 stood in this position as the CNA (#8) moved the lift to the bed and lowered the resident to a sitting position at the edge of the bed. Failure to position Resident #4's feet securely on the platform with her knees in contact with the knee pad, placed the resident in a position of limited support from her lower extremities and at risk of falling from the lift. Failure to attach the calf strap did not allow available external support if Resident #4 did lose the support of her lower extremities. *02/15/11, 8:55 a.m. - A student nurse (#16)	F 323	Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	

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F 323	Continued From page 21 reported she assisted Resident #4 to pivot transfer with a gait belt from the wheelchair to the bed without the assistance of another staff person. Previously, at 7:33 a.m., the facility staff instructed the student nurse (#16) to wait for and was assisted by a CNA (#17). *02/15/11, 12:15 p.m. - A CNA (#9) assisted Resident #4 to transfer from the wheelchair to the toilet and returned to the wheelchair using a gait belt and a grab bar in the bathroom. The CNA (#9) wheeled the resident to the bed and assisted the resident to stand and pivot transfer with the gait belt from the wheelchair to the bed. During both observations, facility staff failed to provide care consistent with Resident #4's care plan. During interview, on 02/16/11 at 11:00 a.m., a nursing management staff member (#1) reported Resident #4 may not be able to stand foot flat on the sit to stand lift platform, but facility staff should have the resident's knees supported by the knee pad. This staff member (#1) also confirmed two staff members should transfer Resident #4 with the gait belt. - Review of Resident #5's medical record occurred on February 14-16, 2011. The resident's diagnoses included a history of falls, general decline, impaired gait, macular degeneration, osteoporosis, and chronic back pain. Her current MDS, dated 11/05/10, identified extensive assistance of one person with transfers. - Observation on 02/15/11 at 1:15 p.m. showed a CNA (#6) assisted Resident #5 to transfer from a wheelchair to the toilet, and back to her	F 323		

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F 323	Continued From page 22 wheelchair. The CNA used a pivot transfer and held the resident around the waist of her pants while the resident grasped a grab bar. Observation on 02/16/11 at 1:55 p.m., showed a CNA (#7) assisted Resident #5 to transfer from the toilet to a wheelchair. The CNA used a pivot transfer and held the resident around the waist of her pants while the resident grasped a grab bar. During an interview on 02/16/11 at 2:00 p.m., a CNA (#7) confirmed Resident #5 did not refuse a gait belt. The CNA stated she was "not sure" and planned to "find out" if she needed to use a gait belt to transfer Resident #5. During an interview on 02/16/11 at 2:10 p.m., an administrative staff member (#1) stated "residents with weakness should be transferred with a gait belt" including Resident #5. The staff member confirmed residents that need a gait belt should be care planned for use of a gait belt. Failure to properly position Resident #4 on the sit to stand lift, failure to transfer Resident #4 with assistance as care planned, and failure to assess and use a gait belt when indicated for Resident #5's transfers placed these residents and facility staff at risk of injury.	F 323		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.	F 360	**F 360 Provide diet that meets the needs of each resident** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #7 had his/her diet evaluated by the Registered Dietitian, the tray card was updated, and his care plan was review and revised as needed. Resident #7's physician was updated on the nutritional assessment. Completed by 3-22-11	

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F 360	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's diet manual, review of facility policy and procedure, resident interview, and staff interview, the facility failed to provide a well-balanced diet that met the special dietary needs of 1 of 1 sampled resident receiving hemodialysis (Resident #7). Failure to provide the proper diet placed the resident at risk of developing complications of renal failure, including fluid and electrolyte imbalances, confusion, and weakness. Findings include: Review of the facility policy and procedure, Dialysis/Renal Diets, occurred on 02/16/11. This document, dated 03/09, stated "PURPOSE, To provide residents with nutritional care in order to help slow the progression of renal disease, To attain or maintain optimal nutritional status. PROCEDURE . . . 2. The registered dietitian will individualize nutrition care of each resident to maintain adequate calories, protein and fluids intake. . . . 10. The dietary staff will provide appropriate brown bag lunch, if resident travels to dialysis over mealtime. 11. Dietary staff will follow recommendations of the diet manual and written extensions on the menus. . . ." Review of the facility's Diet Manual occurred on 02/16/11. This manual, dated 2008, included "Renal Disease . . . Medical Nutrition Therapy for Renal Disease . . . Diet prescription recommendations are individualized depending	F 360	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** No other residents are on dialysis and have a dialysis diet requirement. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Nursing will review any lab results from residents on dialysis with the Dietary Manager. A note of this review will be made in the resident's chart. The Dietary Manager will be responsible to notify the Registered Dietitian of all lab results. Nursing Staff were re-trained on renal diets. Dietary Staff were re-trained on renal diets. Residents on renal diets will have this noted on his/her tray card. Training included written testing. Completed by 3-28-11	

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F 360	Continued From page 24 on the type of CKD (chronic kidney disease) present and based on specific values for protein, energy, phosphorus, sodium, potassium, fluid and calcium. . . . High Potassium Foods . . . Vegetables . . . Potato, mashed . . . baked . . . hash brown . . . Dairy . . . Yogurt . . . High Phosphorous Foods . . . Cheese . . . PLANNING A RENAL MENU . . . Meat/Meat Alternative . . . Avoid highly salted items such as ham . . . Dairy . . . Prepare pudding with nondairy creamer, instead of eating yogurt or pudding made with milk. . . ." Review of Resident #7's medical record occurred on February 14-16, 2011. The facility admitted the resident in September 2010. The resident's current diagnoses included diabetes mellitus and renal failure. The resident currently attends hemodialysis treatment three times each week. The resident's current quarterly Minimum Data Set (MDS), dated 12/28/10, identified the resident was cognitively intact. The facility identified the resident was interviewable. The resident's current care plan, dated 11/20/10, stated "Problems . . . Alteration in nutrition r/t [related to] disease process m/b [manifested by] dialysis, DM [diabetes mellitus] . . . Approaches . . . Therapeutic diet as ordered. . . ." Resident #7's current physician orders included an 1800 calorie two gram Sodium Renal Diet. The resident's current diet card, dated 01/13/11, included "Renal Diet . . . 1800 cal [calorie] . . . NAS [no added salt] . . . 2 eggs with no yokes! DUE TO DIALYSIS: DO NOT GIVE ANY . . . TOMATOES . . . LIMIT POTATOES . . ." - Resident #7's nurse's notes identified the	F 360	**This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Services/Designee will visit with resident #7 to see if appropriate food is being offered to him/her and any problem found will be follow up immediately. The Social Services/Designee will complete a weekly audit. The results of the audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee. Completed by 3-28-11	

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F 360	Continued From page 25	F 360		

resident attended hemodialysis three times each week and left the facility at approximately 5:00 a.m. or 10:00 a.m. During interview, on 02/15/11 at 7:50 a.m., a supervisory nursing staff member (#3) reported the resident was out of the facility today for an early dialysis treatment.

During interview, on 02/16/11 at 8:20 a.m., Resident #7 reported he left the facility at approximately 5:00 a.m. on 02/15/11 for dialysis and the facility staff did not provide any meal or snack items before he left. He returned at approximately 10:00 a.m. and received a snack at that time. The resident reported this is the routine for the early morning treatments. The resident reported the facility provides a sandwich for him when he has a later dialysis treatment, approximately 10:00 a.m.. He reported he frequently does not eat the sandwich because it has "cheese" which he does not like and he's "not supposed to have."

During interview, on 02/16/11 at 2:30 p.m., a dietary staff member (#15) reported Resident #7 is provided a lunch of "turkey and cheese or ham and cheese sandwich, yogurt, and cookie" when he has a dialysis treatment during the facility's noon meal. This staff member (#15) reported the staff provide the resident a snack on his return to the facility from early morning dialysis treatments and do not provide any meal items before he leaves for dialysis.

- Observation of Resident #7's meal service in the facility dining room identified the following: *02/14/11, 5:40 p.m. - Received and consumed part of a sloppy joe (ground meat with tomato sauce or ketchup and other seasonings). Review of the facility's Liberal Renal diet menu choices,

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F 360	Continued From page 26 on 02/16/11, identified hamburger on a bun or low salt pork patty. *02/15/11, 12:00 noon - Received and consumed the ham portion of a ham and potato casserole. The Liberal Renal diet menu choices identified low salt beef stroganoff and noodles or pork cutlet with noodles. *02/15/11, 5:55 p.m. - Received and consumed egg bake and hash browns. The Liberal Renal diet menu choices identified eggs and cooked rice or baked chicken. During interview, on 02/16/11 at 8:20 a.m., Resident #7 reported he frequently receives potatoes and tomatoes as meal items. The resident reported he does not care for these items and "shouldn't have" them. During interview, on 02/16/11 at 2:15 p.m., a supervisory dietary staff member (#14) reported the dietary staff follow the renal diet menu for Resident #7. The staff member (#14) reported the resident does obtain food items not on his diet when he is out of the facility for his dialysis treatments and from family members. The facility failed to provide Resident #7 a nutritional snack or meal item prior to leaving the facility for early morning dialysis treatments. The facility did provide a snack on his return, approximately five hours later and one and a half hours before the scheduled noon meal. When Resident #7 received a later dialysis treatment, at approximately 10:00 a.m., the facility provided lunch including ham, cheese, yogurt, and food items not recommended for the resident's renal diet. The facility provided Resident #7 with a sloppy	F 360		

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F 360	Continued From page 27 joe, ham, potatoes for two consecutive meals, and eggs which may have contained yolks. The facility provided meal items for Resident #7 that were not included in the Liberal Renal diet menu and were not recommended by the facility's diet manual. Resident #7 reported he does not always consume the meal items the facility provides because he knows he should not eat them and does not like them. The facility provided meal items for Resident #7 that were not recommended by its diet manual and failed to provide meal and snack items that met his dietary requirements. Failure to provide Resident #7 a well-balanced diet that meets his daily nutritional and special dietary needs placed the resident at risk of increased progression of his renal disease and lowered nutritional status.	F 360		
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, policy and procedure review, professional literature review, and staff interview, the facility failed to store food and wiping cloths in a safe and sanitary manner in 2 of 2 kitchens. This practice placed residents, who	F 371	**F371 Store/Prepare/Serve food in a sanitary manner** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** The Dietary Manager/Designee reviewed all food stored in refrigerators to make sure they are not being kept longer than stated in our storing food policy. Wiping clothes have been placed in the 2 kitchens. The fresh tomato edges, mixed fruit, shredded cheese, fresh carrots, dill pickles, sliced onions, jello, and spiced apple rings have been thrown away. A note was posted in both kitchen areas reminding staff to store sanitation cloths in sanitation containers. Completed by 11-22-11 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.**	

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F 371	Continued From page 28 eat food stored and prepared in these areas, at risk for foodborne illness. Findings include: Review of the facility's policy titled "Leftovers" occurred on the morning of 02/16/11. The policy, revised March 2009, stated, " . . . Leftover cold food will be . . . labeled, dated, and stored immediately following meal service . . . ." Review of the facility's policy titled "Cleaning-Sanitation of Non-Food Contact Surfaces" occurred on the morning of 02/16/11. The policy, revised March 2009, stated, " . . . 2. Wiping cloths must remain in sanitizing solution until used. . . ." An initial tour of the kitchens occurred on 02/14/11 at 12:55 p.m. with an administrative dietary staff member (#14). Observation showed the following containers of food for the salad bar stored in the walk-in cooler: *fresh tomato wedges, no label with the name of product or the date opened *mixed fruit, dated 01/24 (21 days prior) *shredded cheese, dated 01/26 (19 days prior) *fresh carrots, dated 01/30 (15 days prior) *dill pickles, 02/02, (12 days prior) *fresh sliced onions, 02/04 (10 days prior) *jello, 02/04 (10 days prior) *spiced apple rings, 02/04 (10 days prior) During an interview on 02/14/11 at 1:15 p.m., an administrative dietary staff member (#14) stated, "I have no idea" regarding required length of storage for salad bar food items. Observation during the initial tour of the kitchens,	F 371	All residents could be affected by these practices but by correcting this they will be protected. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All Dietary Staff were re-educated on the facility policy on storing food. Dietary Staff were also re-trained on daily job tasks that includes checking for any outdated food. Dietary Staff were re-educated on proper sanitation. Education included written testing. Completed by 3-28-11 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Dietary Manager will audit the refrigerator two times per week to check for proper food storage. The Dietary Manager will audit both kitchen two times per week to make sure sanitation cloths are stored in the sanitation containers. The results of the both audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then as directed by the QA/CQI Committee.	

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F 371	Continued From page 29 showed three moist wiping cloths not in use and lying on work table surfaces. A main tour of the kitchens occurred on 02/16/11 at 9:40 a.m. with an administrative dietary staff member (#14). Observation showed the following containers of food for the salad bar stored in the walk-in cooler: *dill pickles, dated 02/02 (14 days prior) *sliced peaches, dated 02/07 (9 days prior) During an interview on 02/16/11 at 10:00 a.m., a dietary staff member (#15) stated macaroni and fruit salads are discarded after three days and everything else on the salad bar after seven days or earlier if needed. During interviews completed during the main dietary tour on 02/16/11, an administrative dietary staff member (#14) confirmed facility staff should label and date opened containers of food and store wiping cloths in sanitizing solution between uses.	F 371	Completed by 3-28-11	
F 441 SS=F	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.	F 441	**F 441 Infection Control practices** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #1 had been discharged. Resident#10 has been assessed and has no signs or symptoms of a urinary infections. This was completed on 3-18-11 The blood glucose monitor was properly cleaned and licensed nurse #2 was re-educated on the proper process for cleaning the blood glucose monitor. Completed on 2-14-11.	

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F 441	Continued From page 30 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to treat infections in accordance with accepted professional standards for 2 of 2 sampled residents (Resident #1 and #10) with a urinary tract infection (UTI). Failure to obtain urine cultures prior to implementing antibiotic treatment could increase the incidence of antibiotic resistant infections. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding multi-drug resistant organisms	F 441	The Director of Nursing/Designee has reviewed the data from August 2010 to January 2011 and has completed an analysis according to policy. Completed by 3-28-11. **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** By changing our process all residents will be protected. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All licensed Nurses have been re-trained on Disease Surveillance, Infection Control Committee, Urogenital Tract Infections, Blood Glucose Monitoring and cleaning blood glucose monitor cleaning. Training included written testing. All Licensed Nurses have been trained to include in communication to the resident's physician a request for obtaining	

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F 441	Continued From page 31 (MDROs). Because of increases in MDROs, review of the use of antibiotics, including comparing prescribed antibiotics with available susceptibility reports, is a vital aspect of the infection control program. It is the physician's responsibility to prescribe appropriate antibiotics and to establish the indication for use of specific medications. The Long-Term Care Pocket Guide for Infection Control, 2008, Health Care Compliance Company, Marblehead, MA, page 18 states, "Nurses sometimes believe that malodorous or dark, concentrated urine are diagnostic of UTI. There are many plausible reasons for these problems in the absence of an infection. These symptoms are commonly related to inadequate fluid intake. . . . All long-term care facilities should develop, adopt, and adhere to an evidence-based policy for identifying and managing potential urinary tract problems. . . ." Review of the facility policy "Definitions of Infection" occurred on 02/16/11. The policy, revised July 2009, stated, "To provide standard definitions of infections to be used as a guideline for surveillance and outcome measures. . . . The infection control nurse should educate the staff regarding these definitions. . . . Urinary Tract Infections (Symptomatic) Resident without indwelling catheter must have three of the following: Fever ([equal to or greater than] 100.4 [degrees] F [Fahrenheit]) or chills New or increased burning pain on urination, frequency or urgency New flank or suprapubic pain or tenderness Change in character of urine Worsening of mental or functional status (may be	F 441	urine cultures and sensitivity testing. The Director of Nursing has designated a new Infection Control Nurse. The licensed nurse has been trained according to infection control policy and will be responsible to ensure all infections are tracked, analyzed and action taken to prevent the spread of infections. Completed by 3-28-11 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Director of Nursing/Designee will on a weekly basis audit for proper cleaning of the blood glucose monitor, communication to physician related to requesting culture and sensitivity testing for suspected resident infections and review the tracking done by the designated Infection Control Nurse. The results of these three weekly audits will be reported on a monthly basis to the QA/CQI Committee for 3 months and then	

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F 441	Continued From page 32 new or increased incontinence) . . . Note: Urinary tract infection includes only symptomatic UTI: Surveillance for asymptomatic bacteruria (positive urine culture without new signs and symptoms of UTI) is not recommended." - Resident #10's medical record, reviewed on February 15-16, 2011, identified diagnoses including bipolar disorder, anxiety, and UTI (on 11/10/10 and 01/14/11). The record showed Resident #10 had symptoms of delusions and anxiety for which her physician increased her Seroquel (an antipsychotic medication) dose on 08/2/10 and 12/15/10. On 01/13/11, the physician initiated a two week trial of Ativan (an antianxiety medication) to address Resident #10's anxiety. Interdisciplinary Progress Notes (IDPNs) identified the following: 01/14/11: 8 a.m. "Res [resident] weepy this AM [morning], difficult to transfer, takes meds [medications]. did transfer [with] assist of 2, eventually took meds [with] a lot [sic] of encouragement. Cries 'Help Me.' 'Help Me.' when ask [sic] what she needs help [with] cont. [continues] to say 'Help Me' 'Help Me.' Asked if she has pain states 'No.' temp [temperature] 97.3 [pulse] 66 [respirations] 22 [blood pressure] 124/72. . . ." 4:30 p.m. "Daughter [name] here & [and] notified of Res. Behavior today. Res sleeping in wheelchair." 5:05 p.m. "Daughter concerned ? [questions] UTI. Urine does smell odorous. Will Call [physician name]." 5:45 p.m. "Orders received from [physician name] for Rocephin 1 Gm [gram] IM x [times] 3 days for UTI . . ."	F 441	as directed by the QA/CQI Committee. Completed by 3-28-11	

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	355100	A. BUILDING _____ B. WING _____	02/16/2011

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F 441	Continued From page 33 6:00 p.m. "[Physician name] phoned & notified of last tx [treatment] of UTI as ? previous . . . Res was on Doxycycline 100 mg [milligrams] po [orally] bid [twice a day] x 10 days in Nov [November]. [Physician name] now orders Rocephin 1 Gm x 1, then Doxycycline 100 mg po bid x 10 days starting 1-15-11." 7:30 p.m. "Res vitals 98.2 - 73 - 20 - 144/ [illegible]." 7:35 p.m. "Res has [no] noted frequency, urgency, or c/o [complaints of] dysuria [painful urination]." IDPNs, dated January 14-27, 2011 showed Resident #10 displayed no symptoms of a UTI throughout her course of antibiotic treatment. The record lacked evidence the physician ordered a urinalysis prior to diagnosing a UTI and prescribing antibiotics for Resident #10, who had a history of anxious behaviors and no fever, chills, or complaints of frequency, urgency, or painful urination. When interviewed on 02/16/11 at 12:45 p.m., an administrative nurse (#1) stated the physician did not order a urinalysis, but based the diagnosis of UTI on Resident #10's symptoms of increased behaviors. This conflicts with the facility's policy that requires three signs/symptoms to identify a symptomatic UTI. - Resident #1's medical record, reviewed on February 14-16, 2011, identified diagnoses including glioblastoma [brain tumor], pneumonia, and UTI. Resident #1's IDPNs identified the following: 12/21/10: 2:50 p.m. ". . . family also concerned that resident is more confused. Did tell family we have not	F 441		

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F 441	Continued From page 34 noticed increased confusion. She has always been confused." 3:10 p.m. "Message left [with] [physician name] regarding . . . and family concerns [with] [arrow up] confusion . . . could mabe [sic] do a UA [urinalysis]." 5:45 p.m. "Did receive call from MD [Medical Doctor] office. Orders for a UA- Will obtain during lab hours tomorrow." 5:50 p.m. "VS [vital signs] T [temperature] 97.5 P [pulse] 86 R [respirations] 16. BP [blood pressure] 117/66." 12/22/10: 5:15 p.m. "Rec [received] call from MD office. UA positive & ABT [antibiotic] orders for UTI. . . ." A urinalysis report, dated 12/22/10, identified Resident #1's urine showed the following indicators of a urinary tract infection: 5 to 10 white blood cells, 4 plus bacteria, and positive nitrites. Physician's orders, dated 12/22/10 at 5:45 p.m., stated, "Levaquin 500 mg p.o. daily for 7 days. dx [diagnosis] UTI." The record lacked evidence the physician ordered a urine culture and sensitivity (C&S) prior to prescribing the antibiotic. Resident #1's medical record identified treatment for several infections since her admission in September 2010. The record identified the following infections and antibiotics prescribed: 09/17/10: pneumonia - Zosyn 13.5 Gm once a day until 09/23/11 and Vancomycin 1 Gm daily until 09/23/10 09/24/10: pneumonia - Clindamycin 300 mg every 6 hours for 14 days 10/18/10: pneumonia - Clindamycin for seven more days 12/22/10: UTI - Levaquin 500 mg daily for seven	F 441		

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F 441	Continued From page 35 days 01/13/11: upper respiratory symptoms - Rocephin 1 Gm IM daily for three days and Amoxicillin 500 mg three times a day for seven days When interviewed on 02/16/11 at 10:30 a.m., an administrative nurse (#1) stated the facility has no criteria for obtaining urine cultures. She stated if the physician wants a urine culture, he/she will order it when ordering the urinalysis, without waiting for the results. Resident #1's frequent infections and treatment with various antibiotics placed her at risk for acquiring a MDRO. Failure to obtain a urine culture prior to treatment of the UTI may have increased that risk. The practice of approriately cleaning the blood glucose device between residents use was cited during prior survey of 02/25/10 2. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed accepted infection control practices for cleaning of the blood glucose monitor for 3 of 4 residents (Resident #7, #8, and #13) observed during blood glucose testing. Findings include: Review of the facility policy "Blood Glucose Testing" occurred on February 15-16, 2011. The policy, revised January 2009, stated, "Procedure: 6. Prepare drop of blood and test according to specific equipment manufacturer's instructions. . . . 8 . . . clean per manufacturer's instructions and put away equipment. 9. Remove gloves and wash hands. . . ."	F 441		

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F 441	Continued From page 36 On 02/16/11, an administrative nurse (#3) provided the manufacturer's instructions for cleaning the blood glucose meter. The instructions stated, "Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the meter between patients. Clean the outside of the meter with a lint-free cloth. Dampen with soapy water or isopropyl alcohol (70%-85%). To disinfect the meter, dilute 1 mL [milliliter] of household bleach (5%-6% sodium hypochlorite solution) in 9 mL of water. This is a 1:10 dilution. . . ." Observations on 02/14/11 revealed the following: * 5:10 p.m.: Resident #7 seated near the nurse's station. A licensed nurse (#2) donned gloves and performed a blood glucose test. The nurse (#2) then removed her gloves, washed her hands, and, without cleaning the glucose monitor, placed it on the medication cart. *5:20 p.m.: Resident #8 seated in her wheelchair near the medication cart. The licensed nurse (#2) donned gloves, obtained the glucose monitor from the medication cart, and performed a blood glucose test. The nurse then administered insulin, removed her gloves, washed her hands, and without cleaning the glucose monitor, placed it on the medication cart. * 5:40 p.m.: Resident #13 seated near the nurse's station. The licensed nurse (#2) donned gloves, obtained the glucose monitor from the medication cart, and performed a blood glucose test. The nurse then removed her gloves and placed the glucose monitor in a drawer in the medication	F 441		

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F 441	Continued From page 37 cart. The nurse failed to clean the monitor or wash her hands after performing the blood glucose test. When interviewed on 02/14/11 at 5:40 p.m., an administrative nurse (#1) stated staff should clean the glucose monitor with Sani-Wipes after each use. This conflicts with the manufacturer's instructions which stated to use soapy water or an alcohol solution. 3. Based on review of the facility's infection control program, review of facility policy, professional literature review, and staff interview, the facility failed to maintain an infection control program designed to track, analyze, and prevent the spread of infections within the facility for 6 of 6 months (August 2010 - January 2011) of infection control information reviewed. Failure to track and analyze infections has the potential to affect the health and safety of facility residents, staff, and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the minimum standards of practice regarding infection control which includes establishing and maintaining an Infection Prevention and Control Program in order to investigate, control, and prevent infections in the facility. . . . Additional activities involved in program development and oversight may include but are not limited to: . . . Monitoring and documenting infections, including tracking and analyzing outbreaks of infection as well as implementing and documenting actions to resolve related problems. . . . An effective infection prevention and control program incorporates, but	F 441		

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F 441	Continued From page 38 is not limited to, the following components: . . . Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation, . . . Antibiotic review including reviewing data to monitor the appropriate use of antibiotics in the resident population. . . . The outcome surveillance process consists of collecting/documenting data on individual cases and comparing the collected data to standard written definitions (criteria) of infections. The . . . designated staff reviews data (including residents with fever or purulent drainage, and cultures or other other diagnostic test results consistent with potential infections) to detect clusters and trends. Other sources of relevant data may include antibiotic orders, laboratory antibiograms (antibiotic susceptibility profiles) . . . . . As part of the medication regimen review, the consultant pharmacist can assist with the oversight by identifying antibiotics prescribed for resistant organisms or for situations with questionable indications, and reporting such findings to the director of nursing and the attending physician. Review of the facility's policy titled "Surveillance/Report Forms" occurred on the morning of 02/16/11. The policy, revised July 2003, stated, " . . . Surveillance is the activity that a health care institution employs to find, analyze, control, and prevent nosocomial [facility/center acquired] infections; and also the collection, collation, analysis of data and passing of information to those who need to know in order to take action . . . Components of surveillance are the following: . . . analysis by using cultures, changes in prevalent organisms and increase in rates, results which are given to appropriate persons . . . A monthly report of surveillance data is routed to the Infection Control and QA [quality	F 441		

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F 441	Continued From page 39 assurance] Committees. . . ." Review of the Infection Control Log for the past six months (August 2010 - January 2011) occurred the morning of 02/15/11. For some entries, the log failed to include the causative agent/organism determined from cultures, failed to identify action taken by the facility to prevent the spread of infection, and failed to identify if the infection was facility acquired. During an interview on 02/15/11 at 2:00 p.m., the infection control nurse (#1) stated she had not reviewed the cultures to identify the causative agent/organism and determine if it was susceptible to the antibiotic used for treatment. This staff member stated she was aware the logs were incomplete. She stated a monthly report that summarizes the log information and Infection Control committee meetings should be completed. When requested, on the afternoon of 02/15/11, the infection control nurse (#1) failed to provide evidence of a monthly report of surveillance data, as stated in the policy, for August 2010 - January 2011. During an interview on 02/15/11 at 2:30 p.m., the consultant pharmacist (#13) stated he did not review every infection. If the physician ordered a culture, then he reviewed the completed culture to verify the use of the correct medication for that particular organism. Failure of the facility to maintain an infection control program that included complete information about cultures taken, causative agents, the actions taken by the facility to prevent	F 441		

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F 441	Continued From page 40 the spread of infection, whether the infection was facility acquired, and data reviewed to monitor the appropriate use of antibiotics has the potential to affect the health and safety of facility residents, staff, and visitors.	F 441		