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	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

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

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F 309	Continued From page 25 the emergency room for a soap suds enema. The Emergency Room Report, dated 01/09/10, identified: * "History of Present Illness: She was brought here because of problems with abdominal distention and two days of not having had a bowel movement. She has felt a little bit nauseated. She has not really vomited at all. She feels like she needs to go and feels like a 'bowel obstruction' that she had in December. . . . She has significant problems with scoliosis of her back and was recently started on a fentanyl patch about three days ago. The pain is being helped significantly, but she really has not had a bowel movement since they placed the patch. . . ." * "Impression: 1) Constipation secondary to pain medication. . . ." * "Plan: For her constipation I am going to cut her fentanyl patch in half. . . .She had a Fleets enema here and only got minimal results. Hopefully, she will have less side effects from the GI tract with a smaller dose of fentanyl. . . ." Resident #1's Dietary Consult, dated 01/04/10, identified ". . . hospitalization d/t [due to] . . . bowel obstruction . . . meal intakes poor . . ." The Nutritional notes for Resident #1 lacked any reference to approaches/interventions to assist her in maintaining normal/regular elimination patterns. Resident #1's Care Plan, dated 02/03/2010, identified the following: * "Problem: Altered Nutrition: . . . Approaches: Diet as ordered, Rx as ordered . . . Record meal intakes, Weigh weekly . . . Report emesis to CN [charge nurse], Supplements per med pass, Needs encouragement to eat, Likes ensure	F 309		

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F 309	Continued From page 26 pudding, Likes to have tray in her room." * "Problem: Alteration in Elimination: . . . Approaches: Administer treatments as per order. Administer meds as ordered. Monitor B & B every shift uses toilet. CN check bowel sounds q 3 day chart in TAR [Treatment Administration Record]. Enlarged BM record in resident bathroom for resident to chart on. Resident not accurate historian may say she has had BM and may have not continue to ask if she has had BM. Resident is independent with ambulation and toileting." During an interview on 02/24/10 at 9:45 a.m., an administrative nursing staff member (#2) stated, "If a resident was constipated, we would start them on a bowel management program. We would start with natural ways like offering water, prune juice, fiber, and then use stimulants . . . " The administrative nursing staff member (#2) agreed the record showed no evidence to indicate the facility put dietary interventions in place. The facility failed to ensure Resident #1 received effective interventions to maintain normal bowel elimination patterns to prevent constipation and/or fecal impaction which resulted in Resident #1 experiencing discomfort and requiring emergency care and/or hospitalization on two occasions. No dietary approaches/interventions were implemented on her revised care plan to minimize the side effects (which include constipation) of prescribed pain medications. 2. Based on observation, record review, staff interview, review of facility policy and procedure, and review of professional literature, the facility failed to ensure 1 of 1 sampled resident (Resident #2), with a history of aspiration, received the care and services necessary to prevent aspiration from	F 309		

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reoccurring. Failure to adequately assess and provide appropriate positioning during meals has the potential to affect the resident's overall swallow safety and limit her nutritional intake. Residents should sit at or as close to 90 degrees as possible while eating/drinking. Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue.

Findings include:

The Source for Dysphagia: Third Edition by Nancy B. Swigert copyright 2007 LinguiSystems, Inc, pages 9 and 125, identified the following:
* "Signs and Symptoms of Dysphagia: Drooling . . . - a patient showing drooling . . . may indicate dysphagia. Coughing/Choking - coughing and choking are very obvious symptoms of dysphagia. . . ."
* "Compensatory Treatment Techniques: . . . 1. Appropriate Seating - During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . ."
* "Why is it important for patients to sit at 90 degrees when eating? Many patients with dysphagia have decreased back of tongue control. This condition allows food or liquid to fall over the back of the tongue with risk of it entering the airway. Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue."
* "How would I know if my patient is at risk for aspiration? Any patient who is debilitated secondary to . . . a neurological disorder may be at risk for aspiration."

Review of the facility policy titled "Dysphagia"

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occurred on 02/25/10. This policy, dated January 2009, stated, "1. Dietary/Nursing staff will observe for signs and symptoms of dysphagia when interacting with residents or when observing the meal service. Signs and symptoms of dysphagia are as follows: wet "gurgly" voice after eating or drinking, coughing or choking when ingesting food or liquid . . . drooling . . . poor lip closure, poor control of head and/or body position . . . excessive time required to complete a meal . . . 2. Dietary/Nursing staff will notify the rehabilitation nurse and/or charge nurse if any of the above risk factors for dysphagia are present. 3. The rehabilitation nurse or charge nurse will contact the physician if risk factors do exist to request an . . . order by a dysphagia therapist . . . 4. The speech therapist will evaluate the resident . . ."

Review of the facility policy titled "Dining Room Guidelines" occurred on 02/25/10. This policy, dated February 2004, stated, ". . . 6. NO resident should be allowed to eat or be fed in a reclining position . . . 12. All staff must be alert to any signs of choking and swallowing difficulty, and immediately alert the nurse and the dining room supervisor when problems occur . . . "

Review of Resident #2's medical record occurred on February 22-25, 2010. The facility admitted the resident in August, 2007. Medical diagnoses included: dysphagia, history of aspiration, failure to thrive, head trauma, profound mental retardation, Parkinson's disease, gastroesophageal reflux disease, and surgical abdomen. Resident #2's quarterly Minimum Data Set (MDS), dated 01/22/10, identified severely impaired daily decision making skills, total assist with eating, chewing and swallowing problems, and mechanically altered diet.

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Resident #2's current comprehensive care plan, dated 01/27/10, identified "Problem: Mobility Impairment . . . Approaches: Uses reclining chair. Recline as needed for comfort . . . Problem: Alteration in Nutrition . . . Approaches: Total assist [with] eating. Feed slowly as hx [history] of aspiration."

Random observations showed Resident #2 sitting at an assisted table in the dining room in her tilt-in-space wheelchair during all meals. In addition, the following observations were made:
* On 02/22/10 at 5:35 p.m., a Certified Nurse Assistant (CNA) (#14) was observed as she fed Resident #2 while in a reclined position (approximately 45 degree angle). As she fed Resident #2, the CNA (#14) stated, "You're getting tired, aren't you?" Resident #2 showed fatigue, drooling, coughing five times, and a wet vocal quality. The CNA discontinued feeding Resident #2 due to her coughing episodes.
* On 02/23/10 at 8:15 a.m., a Restorative Aide (#12) was observed as she fed Resident #2 while in a reclined position (approximately 45 degree angle) . Resident #2 drooled while being fed.
* On 02/23/10 at 12:00 p.m., a administrative nursing staff member (#4) was observed as she fed Resident #2 while in a reclined position (approximately 45 degree angle) . Resident #2 drooled while being fed.
* On 02/24/10 at 8:40 a.m., a Restorative Aide (#12) was observed as she fed Resident #2 while in a reclined position (approximately 45 degree angle) . As she fed Resident #2, the Restorative Aide (#12) stated, "[Resident #2] is not eating well this morning." Resident #2 drooled while being fed and coughed twice.

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F 309	Continued From page 30 During an interview on 02/24/10 at 2:45 p.m., an administrative nursing staff member (#2) stated, "When would we make a referral for swallowing concerns? We work as a team . . . dietary, CNAs, and nurses would make observations of decreased mobility, positioning, coughing, history . . . No one's ever told me she [Resident #2] is coughing. I'm not aware of it." The administrative nursing staff member (#2) agreed the record showed no evidence the facility identified the signs and symptoms of aspiration the resident demonstrated or that they referred the resident to Speech Therapy and/or Occupational Therapy for a bedside swallowing evaluation. The facility failed to assess Resident #2 overall swallow safety while being fed in a reclined position (approximately 45 degree angle) and/or when fatigued.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F329 Drug Regimen **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #8's drug regimen was reviewed by the pharmacist, resident #8 was informed of the recommendations, her physician was notified of the recommendations and appropriate follow up completed. **2. 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.** All residents receiving antipsychotic drugs have the potential to be effected in this area.	

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F 329	Continued From page 31 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, review of facility policy/procedure, and staff interview, the facility failed to ensure residents received gradual dose reductions, unless contraindicated, for 1 of 4 sampled residents (Resident #8) who received antipsychotic medication. Failure to conduct gradual dose reductions has the potential for residents to receive unnecessary medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic	F 329	The DNS/Designee will completed a review of the resident currently receiving antipsychotic medications to make sure appropriate reviews were completed and follow up was appropriate. **3. 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 DNS educated the consultant Pharmacist on 3/26/10 Education provided included the requirements of drug review. **System Change:** A monthly meeting will be held where the consulting Pharmacist, DNS/Designee and Administrator/Designee review all residents on antipsychotic drugs. The DNS/Designee will be responsible to follow up with the resident, his/her physician, and his/her family member. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed to make sure a gradual dose reduction is attempted on all residents that	

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F 329	Continued From page 32 medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. The Nursing 2009 Drug Handbook, 29th Edition, pp. 671-673, identified Risperdal as an antipsychotic medication and stated "Periodically reevaluate drug's risks and benefits, especially during prolonged use." Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 02/25/10. This policy, dated January 2007, stated "PURPOSE: 1. To evaluate behavior interventions and alternatives before using psychopharmacological medications . . . 2. To eliminate unnecessary psychopharmacological medications . . . DEFINITIONS: . . . Gradual Dose Reduction- the stepwise tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the dose or medication can be discontinued . . . POLICY: . . . Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: a. in excessive dose including duplicate therapy or b. for excessive duration or c. without adequate monitoring or d. without adequate indications for its use or e. in the presence of adverse consequences which indicate the dose should be reduced or discontinued f. any combination of the reasons above. Based on a comprehensive assessment of a resident, the center must ensure that: a. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.	F 329	receive antipsychotic medications. The audits will be completed by the DNS or her designee once a week for four week, then month times two months. The results of the audits will be reported to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 lg 5/4/10	

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F 329	Continued From page 33 b. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." Resident #8's medical record, reviewed February 22-25, 2010, identified the facility admitted the resident in May 2009. Resident #8's current medications include Risperdal 2 milligrams (mg) orally every HS (bedtime) for hallucinations. Resident #8 initially started on the current dose of Risperdal while in the hospital for hallucinations before admission to the facility. Resident #8's current comprehensive care plan, dated 11/11/09, stated "PROBLEM: Impaired thought process r/t [related to] dx [diagnosis] of confusion, hx [history] hallucinations, hypothyroid m/b [manifested by] ST [short term] memory loss and impaired cognition. GOAL: . . . Will have no hallucinations. APPROACHES: offer resident simple choices. Observe and report any unusual statements or hallucinations. Med as ordered." Review of Resident #8's Minimum Data Sets (MDSs) showed the facility last identified the resident as exhibiting hallucinations on the Admission MDS, dated 05/05/09. The current Resident Assessment Protocol (RAP) on psychotropic drug use, dated 05/05/09, stated "Hallucinations noted in hospital [and] started on Risperdal . . . No concerns noted [with] AIMS [abnormal involuntary movement scale]. No hallucinations noted. Is on Risperdal 2 mg [orally]. No psych consult [at] this time [and] may be something to consider in the future. Now that is [sic] medically stable may want to ask Dr. if a dose reduction would be appropriate."	F 329		

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F 329	Continued From page 34 Review of Resident #8's medical record identified the last documented occurrence of hallucinations occurred in July 2009. The medical record failed to show a GDR of the Risperdal or documentation to support a GDR to be clinically contraindicated for this resident since admission to the facility. During an interview on the morning of 02/24/10, both a nursing staff member (#5) and an administrative nursing staff member (#3) stated Resident #8 no longer experiences hallucinations. During an interview on 02/24/10 at 2:15 p.m., an administrative nursing staff member (#3) confirmed the physician failed to address Resident #8's Risperdal usage and stated she was unable to find any further documentation about the continued use of the Risperdal in the resident's medical record.	F 329		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON OCTOBER 8, 2009. Based on observation, record review, resident and staff interview, complainant information, and review of facility policy and procedure, the facility failed to ensure each resident received meals which honored his/her individual food preferences for 4 of 12 sampled residents (Resident #1, #5,	F 366	F366 Food Substitution offered **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Residents #1, #5, #6 and #8 had a food preference assessment completed. Residents #1, #5, #6 and #8 had their tray card updated to reflect their food preferences.	

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F 366	Continued From page 35 #6, and #8) and Resident A. Failure to provide substitutions to resident's who refuse food items served may place them at nutrition risk. Findings include: The facility's policy, "Substitutes at Meal Times," revised September 2009, stated, "Procedure: . . . 3. Staff will offer the prepared substitute (which has comparable nutritional value and texture consistency) to those residents who are refusing to eat, leaving more than 50 percent of a food item, or who verbalize their dislike for a food served. . . ." - During an interview on 02/23/10 at 1:40 p.m., an anonymous family member of Resident A stated, "There are so many sandwiches served in the evenings. It says right on the resident's chart that he/she doesn't like sandwiches." The anonymous family member also stated that he/she has spoken with both facility administrative and management staff about his/her dietary concerns, and has received no follow-up. He/she stated, "I feel like the concerns we bring up are falling on deaf ears." On 02/24/10 at 8:40 a.m., when asked what the facility served Resident A for supper the previous evening, the Dietary staff member (#7) stated, "I served [Resident A's Name] a turkey sandwich and beets. He/she didn't eat any of it." Resident A's Diet Card, obtained from Dietary staff on 02/24/10 at 8:45 a.m., identified "DISLIKES: . . . SANDWICHES . . ." Review of the facility menu (a five week; fall/winter cycle) on the morning of 02/24/10,	F 366	**2. 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.** All residents that desire a food substitute have the potential to be effected in this area. By changing the menu system to offer a greater variety of alternative menu items all residents will be offered appropriate food substations. Food Preference assessments will be reviewed quarterly during care conferences and care plan will be updated as needed at that time. **3. 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 Dietary Manager will work with the facility Dietician to review our food substitutions. The recommendations for changes to the substitutions will be brought to the Resident Council for their review. Any suggestions made by Resident Council will be reviewed by the facility Dietician for final approval. Nursing and Dietary staff will be educated on March 30, 2010. Staff	

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F 366	Continued From page 36 identified sandwiches served both as the main entree and the alternative entree for the evening meals as follows: * On 3 of 7 days of week one, the facility served sandwiches for both the main and alternative entrees * On 3 of 7 days of week two, the facility served sandwiches for both the main and alternative entrees * On 4 of 7 days of week three, the facility served sandwiches for both the main and alternative entrees * On 1 of 7 days of week four, the facility served sandwiches for both the main and alternative entrees * On 2 of 7 days of week five, the facility served sandwiches for both the main and alternative entrees On 02/23/10 at 5:00 p.m., when asked what a resident would be served at these meals as a substitute if he/she did not like sandwiches, an administrative dietary staff member (#8) stated, "I don't know." - During an interview on 02/23/10 at 11:45 a.m., Resident #1 (whom the facility identified as being interviewable) stated, "Look, they brought me a tray with no meat on it, just mashed potatoes and green beans. I don't know why I don't get any meat." During an interview on 02/23/10 at 12:00 p.m., when asked why Resident #1 did not receive meat on her tray, the Dietary staff member (#19) stated, "She doesn't get meat, because the smell of meat was making her sick. If that has changed, we haven't been notified." During an interview at 5:45 p.m., the Dietary staff member (#7) stated,	F 366	were educated on the need to provide substitute menu items to residents. The education will include using the tray card for review. Staff will also be educated on their need to make changes to the tray card that reflects the resident's preferences. **System Change:** The Dietary Manager/Designee will review tray cards on a weekly basis to make sure they match the food preference assessment in the resident's medical record. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Social Service will request that the Resident Council address any food concerns at the monthly Resident Council meeting. Social Service will address any food concerns brought up in the Resident Council meetings and be responsible to make sure the concern is resolved. This will continue on an on-going basis. Social Service will interview 3 residents per month to see if appropriate food substations are	

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F 366	Continued From page 37 "NO MEAT is listed under dinner and supper on Resident #1's Diet Card. It was written by the Dietary Manager." During an interveiw on 02/24/10 at 8:45 a.m, when asked why Resident #1 does not receive meat on her trays, the management Dietary staff member (#8) stated, "After she got back to the facility (12/15/09) . . . from the hospital . . . she would get sick from the smell of the food in the dining room. We gave her a room tray. Even seeing meat on her plate would make her sick. I asked her if she wanted 'no meat' added to her dietary card and she said, "yes." I should have gone back down to check with her, [to see] if she wanted meat again." The facility did not reassess her food preferences even though she had recovered from her previous illness. Review of Resident #1's medical record occurred on February 22-25, 2010. The facility admitted the resident in June, 2008. Medical diagnoses included: decreased appetite and peptic ulcer disease. Resident #1's quarterly Minimum Data Set (MDS), dated 09/18/09, identified moderate independence with making daily decisions, setup help only with eating, weight loss, leaves 25% or more of food uneaten at most meals, on therapeutic diet and dietary supplements between meals. Resident #1's Weight Record, dated 12/01/09 - 02/25/10, identified the following: * On 12/03/09 (prior to her hospitalization), the resident weighed 122.3 pounds * On 02/21/10, the resident weighed 113.4 pounds Failure of dietary staff to re-evaluate Resident	F 366	being offered. Results of the audits will be submitted to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

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F 366	Continued From page 38	F 366		

#1's dietary preferences contributed to staff not serving Resident #1 meat items (protein), and has the potential to cause weight loss and decreased protein levels.

- Observation of Resident #5 at the evening meal on 02/23/10 at 5:20 p.m. showed facility staff served the resident baked beans. The food item remained untouched on his plate at the end of the meal. Observation showed staff did not offer Resident #5 a substitute for the baked beans.

Resident #5's diet card, used for serving the resident's tray, identified the resident disliked baked beans.

- Observation of Resident #6 at the noon meal on 02/23/10 at 11:40 a.m. showed facility staff had served salmon to the resident.

Resident #6's diet card, used for serving the resident's tray, identified the resident disliked salmon.

When interviewed on 02/23/10 at 5:45 p.m., a dietary staff member (#7) stated, "I know what the residents like."

When interviewed on 02/24/10 at 5:00 p.m. and on 02/25/10 at 9:50 a.m., an administrative dietary staff member (#8) stated facility staff should write on residents' diet cards if food is refused at a meal and she types the cards at the end of the week. This staff member agreed dietary staff should read and follow the diet cards and facility staff serving should review the trays for accuracy.

- During an interview on 02/23/10 at 12:10 p.m.,

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F 366	Continued From page 39 Resident #8 stated she dislikes applesauce, but continues to receive it on her room supper tray several times a week. She stated her dislike for applesauce should be on her dietary preference card. She told both the certified nursing assistants and the dietary assistants about her dislike for applesauce, but she still continues to receive it often. Review of Resident #8's dietary card occurred on 02/23/10. The dietary card failed to include applesauce as a dislike.	F 366		
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: THIS IS A REPEAT CITATION FROM THE SURVEY COMPLETED ON 03/11/09. Based on observation, policy and procedure review, manufacturer's recommendations review, and staff interview, the facility failed to store, prepare, and serve food in a safe and sanitary manner in 1 of 1 kitchen, 1 of 1 satellite kitchen, 2 of 2 nourishment centers, and 2 of 3 medication carts (west hall medication cart and the medication cart used by the certified medication	F 371	F371 Store/Prepare/Serve food in a sanitary manner **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** No residents were specifically identified **2. 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.** All resident have the potential to be effected in this area. The system changes made will protect all residents who may be affected. **3. 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.**	

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F 371	Continued From page 40 assistants). Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored, prepared, and served in these areas. Findings include: The facility's policy, "Food Temperatures," revised March 2009, stated, "Procedure . . . 3. . . . The thermometer will be cleaned and sanitized after testing each food item. . . . 6. Cold foods will be held at or below 41 [degrees] F. . . ." The facility's policy, "Food Storage," revised March 2009, stated, "Procedure . . . 5. . . . Potentially hazardous foods will be discarded after three (3) days in refrigerator. . . . " - Observation of meal service on 02/23/10 at 5:45 p.m., identified a dietary staff member (#7) serving turkey and cheese sandwiches from a container on a worktable in the satellite kitchen. At the end of meal service for the residents, this surveyor requested this dietary staff member (#7) measure the temperature of the remaining food items on trayline including the sandwiches. This dietary staff member rinsed a thermometer with water from a sink after testing each food item (observation showed this dietary staff member unable to locate an alcohol swab to sanitize the thermometer). This dietary staff member used the thermometer to measure the sandwich(s) temperature and obtained a temperature of 50 degrees F. The dietary staff member (#7) confirmed the serving temperature of 50 degrees F as too high and stated the remaining sandwiches, fifteen of twenty five prepared, would be discarded. When questioned regarding placing the container of sandwiches on ice during meal	F 371	Dietary Staff were educated on 4/5/10. Staff received education on the need to keep cold food held prior to meal service at a temperature 41 degrees or below. Dietary Staff were educated on the procedure Substitutes at Meal Times, to properly check temperatures, and to sanitize the thermometer between food items. Dietary Staff were educated on proper storage of meat in refrigerators and on the checklist used to monitor proper cold food storage. Nursing and Dietary Staff were educated on March 30, 2010 on not storing measuring/scoops in food product containers. This education will include items stored on mediation carts, the need to keep the microwave ovens located at each nutrition center clean on an ongoing basis. Dietary Staff will monitor the cleaning when re-stocking the nutrition centers. Problems will be corrected by Dietary Staff and reported to the DNS/Designee for follow up.	

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F 371	Continued From page 41 service, this dietary staff member stated, "We should." When interviewed on the afternoon of 02/24/10, an administrative dietary staff member (#8) confirmed the sandwiches should be served at 41 degrees F or less. The administrative dietary staff member (#8) further stated, dietary staff member (#7) had obtained a box of alcohol swabs for the satellite kitchen and agreed alcohol swabs should be available for measuring temperatures. - An initial tour of the kitchen occurred on 02/22/10 at 11:40 a.m. with an administrative dietary staff member (#8). Observation showed the following in the walk-in refrigerator: *One, opened 15 pound case of sliced raw bacon labeled with the date opened, 02/14/10, (8 days prior). When interviewed, the administrative dietary staff member (#8) stated dietary staff would use the bacon the following Sunday, 02/28/10. (Two weeks storage). *One, unopened ten pound roll of raw hamburger labeled "Date taken out [freezer] 02/13/10 (9 days prior) and Date to be used 02/17/10. - A main tour of the kitchen, satellite kitchen, and nourishment centers conducted on 02/24/10 at 9:20 a.m. with an administrative dietary staff member (#8), identified the following on a shelf: *One can of protein powder with a scoop stored in the product. (potential for contamination) The manufacturer had labeled the product with the recommendation, "Shelf stable up to 6 months from the date opened," and dietary staff had labeled the can with the date opened, 02/19/09. The administrative dietary staff member (#8) agreed dietary staff should not store a scoop in the product and discarded the protein powder. This staff member also confirmed dietary staff	F 371	**4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Dietary Manager/Designee will audit food storage areas on a weekly basis. The Dietary Manager will also observe food holding methods and temperatures prior to meal service. A report of the observations and audits will be submitted to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

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F 371	Continued From page 42 had discarded the hamburger observed during the initial dietary tour. *Observation showed one microwave in the satellite kitchen, one microwave in the North nourishment center, and one microwave in the West nourishment center. Observation showed the interior surfaces of the microwaves heavily soiled with a build-up of food debris. When interviewed, the administrative dietary staff member (#8) agreed the microwaves should be cleaned. This staff member identified the microwave in the satellite kitchen to be on a cleaning schedule for dietary staff, however housekeeping staff cleaned the microwaves in the nourishment centers. When interviewed, administrative housekeeping staff members (#9 and #10), identified the microwaves in the nourishment centers should be cleaned daily by housekeeping and stated housekeeping staff did not have a schedule or list of duties that included the microwaves in the nourishment centers. The administrative housekeeping staff member (#10) identified the condition of the microwave in the West nourishment center as "bad" and agreed staff should clean this microwave and the microwave in the North nourishment center. - Inspection of the West hall medication cart on 02/24/10 at 4:30 p.m., identified a plastic scoop inside a container of Benefiber powder and Cholestyramine powder. - Inspection of the medication cart used by the certified medication assistants occurred on 02/24/10 at 4:40 p.m., and identified a plastic scoop inside a container of Reliv Original Classic powdered dietary supplement.	F 371		
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428	F428 Drug regimen review reports **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #8's drug regimen was reviewed by the pharmacist, resident #8 was informed of the recommendations, her physician was notified of the recommendations and appropriate follow up completed.	

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F 428 SS=D	Continued From page 43 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility's consultant pharmacist failed to identify and report irregularities to the attending physician and the director of nursing for 1 of 4 sampled residents (Resident #8) receiving an antipsychotic medication. Failure to identify and report the need for a gradual dose reduction (GDR) of an antipsychotic medication has the potential for the resident to receive unnecessary medications, develop adverse consequences, and fail to maintain their highest level of functioning possible. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined the "Medication Regimen Review" (MRR) as a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting,	F 428	**2. 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.** All residents that currently receive an antipsychotic medication have the potential to be effected in this area. The DNS/Designee has completed a review of all residents receiving antipsychotic drugs to make sure appropriate reviews were completed and follow up was appropriate. **3. 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 DNS educated the consultant Pharmacist on 3/26/10. The pharmacist received education on the requirements of drug review. Systems change: A monthly meeting will be held where the consulting Pharmacist, DNS/Designee and Administrator/Designee review all residents on antipsychotic drugs. The DNS/Designee will be responsible to follow up with the resident, his/her physician, and	

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F 428	Continued From page 44 and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. Review of Resident #8's medical record identified the last documented occurrence of hallucinations occurred in July 2009. The medical record failed to show a GDR of the Risperdal or documentation to support a GDR to be clinically contraindicated for this resident since admission to the facility. During an interview on the morning of 02/24/10, both a nursing staff member (#5) and an administrative nursing staff member (#3) stated Resident #8 no longer experiences hallucinations. Review of the consultant pharmacy reports occurred on 02/25/10. The reports indicated the pharmacist conducted a review of medications each month. The reports failed to show any recommendation by the pharmacist for a GDR on Resident #8's Risperdal usage. During an interview on 02/25/10 at 9:00 a.m., the consultant pharmacist (#6) stated as long as Resident #8 has not been having any hallucinations, he should have recommended a GDR.	F 428	his/her family member. This will continue on an on-going basis **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Health Information Management director will audit residents, designated on the MDS as on antipsychotic medication, to make sure drug reviews are being completed. Results of the audits will be submitted to the A report of the audits will submitted to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC (F329) dated 5/4/10 KS 5/4/10	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F441 **1. This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Residents #2, #3, #4, #5 and #9 were assessed by Nursing staff for any signs or symptoms of infection	

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F 441	Continued From page 45 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, review of professional literature, and staff interview, the facility staff failed to implement infection control practices that were consistent with acceptable professional standards of practice for 5 of 12 sampled residents (Resident #2, #3, #4, #5, and #9) observed	F 441	and Nursing has follow up as needed. Residents #14 and #15, who require blood glucose monitoring were assessed for any signs or symptoms of infection and Nursing Staff has followed up as needed. **2. 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.** All resident have the potential to be effected in this area. By making changes to our systems other residents potentially by these practices will be protected. **3. 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 DNS has ordered an approved germicide to clean blood glucose monitors. Licensed Nursing Staff have been educated on proper procedure to clean glucose monitors. All Nursing Staff have been educated on March 30, 2010 on the proper procedures for hand washing, blood glucose monitoring,	

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F 441	Continued From page 46 receiving personal cares, and 2 supplemental residents (Resident #14 and #15) requiring blood glucose monitoring. Failure to implement accepted infection control practices has the potential to affect the health and safety of facility residents, staff, and visitors. Findings include: Review of the facility policy titled "Blood Glucose Monitoring" occurred on 02/25/10. This policy, revised January 2009, stated "PROCEDURE: . . . 8. Wipe resident's finger clean, clean per manufacturer's instructions and put away equipment. . . ." Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 02/25/10. This policy, revised July 2009, stated "Hand Hygiene Product Selection: Wash hands with plain soap and water or with anti-microbial soap and water: If hands are visibly soiled (dirty), if hands are visibly contaminated with blood or body fluids, before eating, after using the restroom. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: Before having direct contact with residents, after having direct contact with a resident's skin, after having contact with body fluids, wounds or broken skin, after touching equipment or furniture near the resident, after removing gloves. . . ." Review of the facility policy titled "Standard Precautions" occurred on 02/25/10. This policy, revised July 2009, stated "PROCEDURE: Hand Hygiene- 1. Avoid unnecessary touching of surfaces in close proximity to the resident to prevent contamination of hands or surfaces . . . 4.	F 441	Standard Precautions, cleaning and storing of wash basis and emesis basins. Education includes when to wash hands and when the use of hand sanitizer is appropriate. Education also includes return demonstration and written testing. Staff Development is responsible to make sure any staff that fail the demonstration or test are retrained until they pass the testing. **4. This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Staff Development/Designee will audit 1/3 of the Nursing Staff (Licensed Nurses, CMA and CNAs) each month to make sure they appropriately wash hands. Audits will include written testing and observations. The audits will be scheduled so all staff are audited in a 3 month period. The DNS/Designee will be responsible to follow up with any Nursing Staff member who can not demonstrate proper infection control procedures. The Nurse Managers/Designee will audit resident rooms checking for proper storage of equipment. The	

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F 441	Continued From page 47 Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g. [example given], C. [clostridium] difficile) is likely to have occurred. Gloves- 1. Gloves will be worn when contact with blood or other potentially infectious materials, mucous membranes, nonintact skin or potentially contaminated intact skin (e.g., of a resident incontinent of stool or urine) could occur . . . 3. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) . . . Resident-Care Equipment- . . . 2. Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and disinfected. Single use items will be properly discarded. . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding infection control which states hand hygiene (washing hands with water & soap or applying an alcohol-based hand rub) is the primary means of preventing the transmission of infection. Hand washing with soap and water is required under certain conditions, including before and after assisting a resident with toileting. The CMS has outlined standards of practice regarding disinfecting of glucometers which states glucose monitoring devices may transmit pathogens if devices contaminated with blood or body fluids are shared without cleaning and disinfecting between uses for different residents. Glucometers are considered semi-critical items. For such items, it is recommended to use either an Environmental Protection Agency (EPA) registered detergent/germicide with a tuberculocidal or HBV (hepatitis B virus)/HIV	F 441	audit will include storage of wash basins. Results of the audits will be submitted to the QA/CQI committee for further recommendations. 5. April 5, 2010 See Addendum to the PoC dated 5/4/10 KS 5/4/10	

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	355100	A. BUILDING _____ B. WING _____	C 02/25/2010

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F 441	Continued From page 48 (human immunodeficiency virus) label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water). - Random observation of blood glucose monitoring occurred on 02/23/10 at 11:25 a.m. After testing Resident #15's blood glucose, a nursing staff member (#20) wiped the glucometer with an alcohol pad. The nursing staff member (#20) then tested Resident #14's blood glucose with the same monitor. After testing Resident #14's blood glucose, a nursing staff member (#20) disinfected the glucometer with an alcohol pad. The staff member failed to disinfect the glucometer with an approved EPA germicide or a dilute bleach solution. - Observation of cares for Resident #3 occurred on 02/23/10 at 7:50 a.m. A certified nursing assistant (CNA) (#21) provided pericares to Resident #3, changed her gloves, put on a clean brief and pulled the resident's pants up, removed her gloves, and transferred the resident to her wheelchair. The CNA (#21) applied foot pedals to the resident's wheelchair, and assisted the resident with a drink of water without washing her hands. The CNA (#21) then donned a clean pair of gloves, dumped out the water from the resident's wash basin used to wash the top half of her body into the bathroom sink, rinsed the wash basin with water from the bathroom sink, dried the wash basin, and placed it on the top shelf of the resident's closet, without placing it in a bag. The CNA (#21) placed the wash basin, with water still visible on all surfaces, directly next to clean briefs and bed protectors in the closet. With the same gloves still on the staff member's hands, she brushed Resident #3's dentures, provided total assist with oral care, assisted with sips of	F 441		

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water to rinse, and then removed her gloves, but did not cleanse her hands. The CNA (#21) donned a new pair of gloves, placed the resident's dentures in her mouth, combed her hair, put her glasses on, clipped and filed Resident #3's fingernails, rinsed out the emesis basin used to rinse out the resident's mouth, placed the toothbrush and toothpaste inside it, and placed the emesis basin in the bathroom cupboard. The CNA (#21) failed to dry off the emesis basin and placed it in the cupboard when still visibly wet, next to other personal hygiene products. The CNA (#21) removed her gloves, made the resident's bed, removed the bag of garbage from the trash can next to the resident's bed, placed the bagged garbage on the resident's bed, and then went to the bathroom to wash her hands with soap and water, the first time hand hygiene occurred during the entire observation.

The staff member (#21) failed to wash her hands with soap and water after providing pericare, failed to perform hand hygiene between tasks and with glove removal, failed to handle garbage appropriately, and failed to dry and store the wash and emesis basins properly.

Observation of cares for Resident #3 occurred on 02/23/10 at 9:50 a.m. The CNA (#21) provided pericares, removed her gloves, and proceeded to transfer the resident to her bed. The staff member assisted the resident to lay down on her bed, covered her up, and wiped food residue from around Resident #3's mouth with a wet cloth. The CNA (#21) then donned gloves, bagged the garbage, removed her gloves, exited the resident's room to dispose of the garbage, and then sanitized her hands while in the corridor, performing hand hygiene for the first time. The

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staff member (#21) failed to wash her hands with soap and water after providing pericare.

- Observation of cares for Resident #4 occurred on 02/23/10 at 9:25 a.m. The CNA (#21) provided pericares, changed her gloves, transferred the resident to her wheelchair, removed the gloves, applied the wheelchair foot pedals, assisted Resident #4 with a drink of water, and combed the resident's hair. The staff member then assisted Resident #4 out of her room to the commons area, retrieved and opened a can of soda for the resident, assisted her to the chapel, and then the CNA (#21) sanitized her hands while walking out of the chapel, performing hand hygiene for the first time since providing pericares. The staff member (#21) failed to wash her hands with soap and water after providing pericare.

During an interview on 02/25/10 at 9:30 a.m., an administrative nursing staff member (#22) stated the facility lacks a policy regarding cleansing of wash basins, but stated the staff members change out the disposable wash basins monthly and as needed. The staff member stated between uses, she expected staff to rinse the wash basins out with hot soapy water, thoroughly dry off, and place in a plastic bag if being stored in the resident's closet. She confirmed each resident has their own wash basin labeled with their name and the implementation date of the wash basin. The staff member (#22) also stated she expected staff to use an approved EPA disinfectant for cleaning glucometers, and agreed alcohol is not effective or acceptable for disinfecting glucometers.

- Observation of cares for Resident #5, on

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02/23/10 at 4:00 p.m., showed CNA (#18) assisted the resident with pericare and removed her gloves. The CNA did not complete hand washing once the resident had been moved to a safe position.

- Observation of cares for Resident #5, on 02/23/10 at 11:05 a.m., showed CNA (#12) assisted the resident with pericare, removed her gloves, and applied an alcohol based hand rub. The CNA did not complete hand washing after she moved the resident to a safe position.

- Observation of cares for Resident #2 occurred on 02/23/10 at 9:15 a.m. CNA (#21) and CNA (#23) both gloved before transferring the resident from her wheelchair to her bed. Both CNA's lowered the resident's pants and CNA (#23) removed her soiled peri-pad. CNA (#23) provided pericares. Both CNA's placed a new peri-pad, and pulled up the resident's clothing. Both CNA's removed their gloves and used hand sanitizer before adjusting the resident's bedding and leaving the room. The CNAs failed to wash their hands with soap and water after providing pericare.

- Observation of cares for Resident #9 occurred on 02/24/10 at 4:33 p.m. The CNA (#24) gloved before assisting the resident to the bathroom. Observation showed Resident #9's clothing to be visibly wet. The CNA (#24) lowered the resident's clothing and cued the resident to sit down. The CNA (#24) removed the resident's pants and pull-up, and placed them each in a separate plastic bag. She removed her gloves, but did not perform hand hygiene. CNA (#24) retrieved a clean pair of pants and a new pull-up from the resident's closet. She put on a new pair of gloves

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F 441	Continued From page 52 and assisted the resident in putting on clean pants and a new pull-up. She then cued the resident to stand, and performed pericares. She cleansed the resident's buttocks, but did not cleanse her upper leg area which had come into contact with her wet clothing. The CNA (#24) finished adjusting the resident's clothing/pull-up, removed her gloves, and washed her hands with soap and water. Facility staff failed to completely cleanse the resident after an incontinent episode, and failed to wash her hands with soap and water after providing pericare. During an interview on 02/25/10 at 10:30 a.m., an administrative nursing staff member (#22) stated she expected staff to wash their hands with soap and water after assisting with toileting and after providing pericares.	F 441		