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	355100	A. BUILDING _____ B. WING _____	12/18/2014

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 12/15/14 and completed on 12/18/14, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000	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 the provisions of Federal and State Law require it. For the purposes of any substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with ND State Health Department.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 procedure, and staff interview, the facility failed to implement policies and procedures prohibiting abuse of residents, for 1 of 1 sampled resident (Resident #5) involved in resident to resident abuse. Failure to investigate a resident to resident altercation, notify the resident's responsible party and physician, and implement corrective action placed all residents at risk of injury and may have resulted in a second altercation involving Resident #5. Findings include: Review of the facility policy, "Abuse and Neglect," occurred on 12/18/14. This document, revised September 2013, stated "PURPOSE, To assure that staff are knowledgeable regarding the	~~F 224~~ F-224	F 224 1. Resident #5's individual needs have been met by notifying the physician and family of the resident to resident altercation. Care plan interventions have been reviewed and updated to include diversional activities	1/22/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan E Bjelland — TITLE: Administrator — (X6) DATE: 1-20-15

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 224	Continued From page 1 reporting and investigative process of abuse and neglect allegations in the center. POLICY, The resident has the right to be free from verbal . . . physical . . . abuse . . . Residents must not be subjected to abuse by anyone, including . . . other residents . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. . . . If the alleged or suspected violation is verified, appropriate corrective action will be taken." Review of the facility procedure, "Abuse and Neglect," occurred on 12/18/14. This document, revised June 2014, stated "PURPOSE, . . . To ensure that residents are not subjected to abuse by anyone, including . . . other residents . . . To prevent future injuries. To ensure that complete review of existing incidents is documented. . . . PROCEDURE . . . 2. The charge nurse or licensed nurse will be notified immediately . . . and complete an initial investigation . . . 4. Notification procedures: . . . d. Notify the physician and family . . . inform them that an investigation is in progress. Record this notification. . . . 6. The investigation team . . . will review all incidents no later than the next working day following the incident. . . . 7. The investigation team will determine whether further investigation is needed. . . ." Review of Resident #5's medical record occurred on December 15-18, 2014. The facility admitted the resident in November 2013. Current diagnoses included Alzheimer's disease and dementia. The annual Minimum Data Set (MDS), dated 11/22/14, identified short and long term memory problems, moderately impaired daily	F 224	such as plays cards, rummages in a bucket of bolts, provide redirection when wandering into resident rooms and frequent checks on his location throughout the day. 2. All residents have the potential to be affected in this area. All allegations of resident to resident altercations will have an incident report started and the staff will start an investigation. The family, physician, DNS, and administrator will be notified as part of the incident report. The investigation team will complete the investigation the next business morning and ensure the care plan gets updated.	

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F 224	Continued From page 2 decision making abilities, extensive assistance of one person for walking in room and hall, did not demonstrate wandering, and did not exhibit behaviors during the seven day assessment period. The quarterly MDS, dated 08/23/14, identified wandering occurred one to three days during the seven day assessment period. The quarterly MDS, dated 02/22/14, identified physical, verbal and other behaviors directed toward others occurred one to three days during the seven day assessment period, and wandering occurred four to six days during the seven day assessment period. Resident #5's monthly nursing documentation, dated 12/03/14, identified a history of wandering into other resident's rooms and a history of hitting other residents. Resident #5's current care plan, dated 02/25/14, identified potential for elopement and use of a wanderguard. The care plan failed to identify a potential for wandering into other residents' rooms or physical altercations with other residents and interventions for staff regarding these issues. Resident #5's nursing Progress Notes, for the period February 02, 2014 to May 02, 2014, showed 17 episodes of Resident #5 wandering into other resident rooms or spaces. These episodes included the following: *03/10/14, 9:10 a.m. - "Resident wandered into another resident's room et [and] was drinking a soda that had been left on the other resident's dresser. Other resident saw this et appraoched [sic] this resident et began to swing et hit this	F 224	3. Education was provided on the procedure, "Abuse and Neglect". An all staff meeting on 1-14-15 was held to review the need to be aware of all resident to resident altercations and to start an incident report and investigation when residents have resident to resident altercation they need to make sure the physician, family, DNS, and administrator are informed. The investigation team will review all incidents the next working day following the incident and ensure the proper steps were taken and that the care plan was updated as needed. 4. An audit tool will be developed to monitor if an incident report was completed (including	

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F 224	Continued From page 3 resident. This resident swung his hands in attempts to get the other resident away from him. This resident was removed from the other resident's room. This resident has a bruise on his right ear where the other resident had a hold of. This resident also has a scratch to his right elbow et right bicep. Measures being taken to avoid this resident from wandering in the other resident's room. Will continue to monitor." *04/09/14 - Resident #5 wandered into another resident's room and touched the resident's personal belongings. The other resident struck Resident #5. Staff separated the residents. The facility staff provided the investigations of incidents of 03/10/14 and 04/09/14 at the surveyor's request. The investigations identified the following: *03/10/14 - Staff notified the social worker and administrator. The record lacked notification of the physician and Resident #5's responsible party. "Corrective Action: Removed" is identified. The investigation failed to identify why Resident #5 may have wandered into the resident's room, how it may have been prevented, possible corrective action other than "Removed," and failed to identify careplanning changes or communication to staff. *04/09/14 - Staff notified the social worker, administrator, physician, and Resident #5's responsible party. The investigation failed to identify why Resident #5 may have wandered into the resident's room, how it may have been prevented, possible corrective action, and failed to identify careplanning changes or communication to staff. The medical record showed Resident #5's history of wandering and behaviors. The care plan failed	F 224	notification to the family, physician, DNS, and administrator). The audit will monitor if staff started the investigation, filled out the incident report, and if the investigation team completed the investigation the next business day. The investigation team will ensure that the care plan was updated to prevent the reoccurrence of the altercation and monitor whether the physician, family, DNS, and Administrator was informed. The audit will be completed by the HIM director, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next	

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F 224	Continued From page 4 to address these issues. Failure to ensure a thorough investigation on 03/10/14 and implement corrective actions may have contributed to the altercation on 04/09/14. During interview, on 12/18/14 at 9:30 a.m., an administrative nursing staff member (#1) confirmed the facility's investigations regarding Resident #5's altercations were incomplete.	F 224	two months. If concerns are identified corrective action will be implemented. All results of the audits will be reported to the QA committee for further recommendations and/or the need for additional audits. In addition, the QA committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on two sample meal trays, review of Resident Council meeting minutes, review of policy and procedure, resident group interview, resident interview, and staff interview, the facility failed to act upon resident grievances regarding palatability of meal items and timely meal service for 7 of 11 residents (Resident A, B, C, D, E, F, and G) who attended the group interview and 1 of 1 confidential resident interview (Resident H). Failure to act upon food palatability issues voiced by residents since July 2014 (six months) and ensure timely meal service resulted in a reduced dining experience and placed the residents at risk of decreased meal intake and increased nutritional risk.	~~F 244~~ F-244	F-244 1. The vegetables are being cooked according to the recipe and temperature guidelines. The "Food	1/22/15

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F 244	Continued From page 5 Findings include: Review of the facility policy and procedure "Substitutes and Alternatives at Meal Times" occurred on 12/18/14. This document, dated February 2013, stated, "PURPOSE: To ensure residents have substitutions when they do not like the main entree. POLICY: Food substitutions of comparable nutritional value will be available to residents who refuse food served. PROCEDURE: 1. The substitutes for refused foods will be pre-planned and approved by the director of dietary services (DDS) and/or the registered dietitian (RD). 2. The dietary staff is responsible for preparing food substitutes. 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. 4. If a resident refuses the prepared substitute and requests an item that is usual/customary for the center, the item will be provided. 5. Residents will receive their request within 15 minutes of their request, whenever possible. . . . b. Offer alternatives for the current meal that can be provided in 15 minutes. . . . 7. The DDS will visit with residents who have consistent complaints." - Review of the Resident Council meeting minutes occurred on December 15-18, 2014. The minutes, dated December 05, 2014, included ". . . New Business . . . One resident reported wanting . . . less soup. . . ."	F 244	Substitution" policy list was reviewed with dietary staff to remind them of the need to provide substitution of equal nutritional value and this was posted in each kitchen. A "Resident Choice Menu" is posted in the dining room for residents to see what food alternatives that are available in the kitchen and an additional list of food items that are available 24 hours per day will be posted for residents outside of the kitchen and each nursing stations. The center menu has been changed to include more hot dishes, 50% less soup, and spaghetti will be added one more time in a 4 week period as requested. 2. All resident have the potential to be affected in this area. The social worker will invite the DDS	

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F 244	Continued From page 6 During the resident group interview, on 12/16/14 at 10:45 a.m., Resident A, B, C, E, and F reported the facility served too much soup, specifically, at evening meals, and stated the alternate choice at meals was usually soup. They further stated there is a "long wait time for meals to be served," and "meals never start on time." Review of the facility's scheduled menus, for a four week period, occurred on December 15-18, 2014. These menus, provided by the facility staff on 12/15/14 at approximately 3:30 p.m., showed the period December 14-20, 2014 as the third week. The period December 14-20, 2014 showed the entree for five of seven supper meals as soup or chili with a sandwich. The four week, 28 day cycle showed soup and sandwich as the entree for 14 of 28 supper meals. Observation on December 15-18, 2014 showed the "Resident Choice Menu," posted at the entrance to the dining room. Facility staff and residents identified this menu was the alternative menu for the scheduled menu. The "Resident Choice Menu" identified the following selections: *SANDWICH - Ham, Roast Beef, or Turkey *CHOICE OF SOUP *SALAD WITH DRESSING *COTTAGE CHEESE *CHOICE OF FRUIT CUP *CHOICE OF PUDDING CUP *CHOICE OF JELL-O CUP The scheduled menu showed soup and sandwich as the entree for half of the evening meals. The alternative menu entree was limited to soup and sandwich. The alternative menu did not provide residents a substitute of comparable nutritional value.	F 244	to the monthly resident council meeting to discuss meal and menu concerns. The DDS or designee will attend the meetings as time allows. The DDS will generate a list of residents, at least bi-monthly, who are at risk of weight loss and this will be reviewed by the interdisciplinary team for follow up and then will be documented as necessary. **3.System changes:** A. The social worker will invite the DDS to the monthly resident council meeting to discuss meal and menu concerns. The DDS or designee will attend the meetings as time allows. The follow up will be documented on the council meeting minutes and reviewed with the residents. B. A resident choice meal of the month will be started.	

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F 244	Continued From page 7 During an interview on 12/17/14 at 3:30 p.m., a dietary management staff member (#2) confirmed the scheduled menus included frequent soups and the alternative menu is limited. This staff member (#2) also confirmed the alternative menu did not offer substitutes of comparable nutritional value. This staff member (#2) reported she did not attend Resident Council meetings and was not aware of resident concerns. Review of the facility's Resident Council meeting minutes for the period July 03, 2014 through December 05, 2014 occurred on December 15-18, 2014. The meeting minutes included the following comments regarding the facility's meal service: *July 03, 2014 - ". . . A couple of the residents reported concerns with wanting the meal to be served hotter. . . . [Administrative staff member (#4)] is aware of these requests and is in charge of the Dietary Department at this time. . . ." *September 04, 2014 - ". . . One resident complained of the macaroni salad that was served was awful. This resident discussed her multiple dietary concerns afterwards with [administrative staff member (#4)]. . . ." *October 02, 2014 - ". . . We discussed multiple concerns from three different residents regarding food being served cold. . . . [Dietary management staff member (#2)] will be made aware of this. . . ." *November 06, 2014 - ". . . One resident had concerns with the vegetables not being cooked and soups being served cold. [Dietary management staff member (#2)] is aware of this and is addressing it. . . ." *December 05, 2014 - ". . . One resident reported having food served to her that is cold. [Dietary	F 244	Resident council members agreed to pick the first resident choice meal. The first resident choice meal will be in February on 2-14-15. The residents requested polish sausage, sauerkraut, and baked beans. C. The alternatives available for meals have been updated and posted in the dining room. This is called the "Resident Choice Menu". D. An additional posting will be created and displayed outside of the kitchen and by the nursing stations titled, "Food Items Available 24 Hours per Day". 3. Education was provided to the dietary staff on 12-30-14, and to all staff on 1-14-2015 to review from the procedure titled, "Substitutes and Alternatives at Meal Time" and to focus on the need to offer appropriate alternatives and substitutes for residents. Offers or requests for	

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F 244	Continued From page 8 management staff member (#2)] was notified of this. . . ." During the resident group interview on 12/16/14 at 10:45 a.m., 7 of 11 residents (Resident A, B, C, D, E, F, and G) reported meats are tough, 7 of 11 residents (Resident A, B, C, D, E, F, and G) reported meal items are not hot enough, and 5 of 12 residents (Resident A, B, C, E and F) reported cooked vegetables are raw. During a confidential resident interview on 12/16/14 at 10:20 a.m., Resident G indicated: * "Too many meals of soup and sandwiches." * "The alternate is usually always soup and sandwiches, and the soup is salty." * Many times the hot food is cold. "You can ask staff to microwave the food, but it dries the food out too much." * "It seems like they have cut back to one meat per meal and the alternate choice does not include a meat." * Food service is very slow at most of the meals, and never starts at the posted times. * Has brought these issues up at Resident Council meetings many times, but nothing ever changes. * No one addresses or updates us on any of the previous Resident Council food concerns. - For information regarding meal observations, tray line service, and timeliness of meal service, refer to F362 - For information regarding sample trays and palatability of meals, refer to F364. - For information regarding alternative meals and adequacy of substitutes, refer to F366.	F 244	substitutes will be provided to residents within 15 minutes. 4. An audit tool will be developed to monitor resident council meeting minutes for resident concerns and complaints on food and follow up. An audit tool will also check to see if staff is offering substitutes of comparable nutritional value and texture consistence at meals to residents that request alternatives and if the alternative was received within 15 minutes. The audit will be completed by the Social Worker or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be implemented. All results of the audits will be reported to the QA committee for further recommendations and/or the need for additional audits. In addition, the QA committee will review the 2015 state survey	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	~~F 280~~		

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F 280 SS=E	Continued From page 9 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 01/23/14, 01/16/13, AND 02/02/12. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 6 of 11 sampled residents (Resident #4, #5, #6, #7, #8, and #10). Failure to ensure care plans reflected the residents' current status and needs limited staff's ability to ensure consistency and continuity of care.	~~F 280~~ F 280	once a quarter for the first year to assure continued compliance. F 280 1.Resident # 4's care plan was updated to include her current mobility status of one assist with mechanical lift for transfers. Resident # 5's care plan was updated to include his wandering and interventions added to address the wandering. Resident # 6's care plan was updated to include pain medications, antianxiety medications, and antipsychotic medications, the potential medication side effects, or potential negative reactions for these medications. (Resident expired 1-19-15)	1/22/15

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F 280	Continued From page 10 Findings include: Review of the facility policy "Care Plan" occurred on 12/18/14. This document, dated September 2012, stated "POLICY . . . Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. . . . This plan of care will be modified to reflect the care currently required/provided for the resident." - Resident #4's medical record, reviewed on December 16-18, 2014, identified the resident sustained a fractured left hip on 08/26/14. The resident's current mobility care plan, revised 09/15/14, stated, "TRANSFER: Resident requires 1 staff participation with transfers. Uses stand aide [sit to stand lift] for transfers."A "Mobilization Support Data Collection Tool," dated 11/28/14, identified the resident required limited assistance of one staff member for transfers and ambulation. The form did not identify use of a lift for Resident #4. Observations showed the following: * 12/16/14 at 9:15 a.m.: a CNA (#6) assisted Resident #4 to transfer from her recliner and ambulate to the bathroom using a gait belt. * 12/16/14 at 11:38 a.m.: the CNA (#6) assisted the resident to transfer from the recliner to her wheelchair then to the toilet using a gait belt. * 12/17/14 at 10:25 a.m.: a CNA (#7) transferred the resident from her recliner to the bathroom using a sit to stand lift.	F 280	Resident #7's care plan was updated to include a lipped plate and plate guard. Resident # 8's diet card was updated to include her dislike of pork. A vision care plan was initiated due to poor vision from one of her eyes. Resident #10's diet card and care plan was updated to puree texture diet and nectar thickened liquids. The special instructions of "For lunch and Dinner add liquid to food so it is consistency of hot cereal and put in bowels" was discontinued. 2.All resident have the potential to be affected in this area. All care plans will be reviewed due to a change of condition. This may include the need to update the care plan for residents that wander, display physical or verbal behaviors, use of psychoactive drugs and list potential side	

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F 280	Continued From page 11 During an interview on 12/17/14 at 4:20 p.m. an administrative nurse (#1) stated staff should transfer Resident #4 with a gait belt and agreed staff have not revised the resident's care plan to include the current mode of transfer. Failure to revise Resident #4's care plan to identify the appropriate mode of transfer resulted in staff utilizing inconsistent transfer techniques for Resident #4. - Resident #7's dietary card, dated 09/29/14, stated, "Adaptive Equip [equipment]: Lip Plate with plate guard." Observations of breakfast and the noon meal on 12/16/14 and 12/17/14 showed the resident received her food on a lipped plate with a a plate guard. Resident #7's current care plan failed to identify use of the lipped plate and plate guard. During an interview on 12/18/14 at 8:00 a.m. a dietary manager (#2) confirmed Resident #7 had no dietary care plan. - Resident #8's medical record, reviewed on December 17-18, 2014, identified diagnoses including retinal vascular occlusion and dry macular degeneration. A clinic referral form, dated 07/30/14 identified the resident as blind in the right eye. A Care Area Assessment (CAA), 02/06/14, stated, "Resident has moderately impaired vision. Resident able to see large objects, however misses details. . . ." The CAA indicated staff would proceed to care planning regarding the resident's vision. Resident #8's current care plan failed to include a problem or	F 280	effects and negative reactions of these medications, special instructions for dietary needs such as thickened liquids, cut up meat, adaptive eating equipment, and the need to follow the physicians ordered diet. 3.Education was provided to the nursing staff on 12-30-2014 to educate staff on the procedure titled "Care Plans" with a focus on the need to update care plans when a resident has a change of condition. This may include the need to update the care plan for residents that wander, display physical or verbal behaviors, use of psychoactive drugs, list potential side effects and negative reactions, adaptive eating equipment, special instructions for meal assistance with thickened liquids and cut up food by dietary staff, and the need to follow the physicians ordered	

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F 280	Continued From page 12 interventions regarding her impaired vision. During an interview on 12/17/14 at 5:30 p.m. an administrative nurse (#1) confirmed Resident #8 is blind in her right eye and stated the resident's care plan needed revision. Observation at 12:25 p.m. showed a CNA (#14) served Resident #8 her meal which included a large slice of ham and cherry crisp. Resident #8 stated she did not eat pork and would like turkey instead. The CNA (#14) then took the plate back to the serving window and requested an alternative. Resident #8's dietary card, dated 12/10/14, stated, "Dislikes: Orange Juice, Pork, Lots of Macaroni, and Cherries." Review of Resident #8's care plan failed to identify a dietary care plan addressing the resident's preference not to eat pork or cherries. During an interview on 12/18/14 at 8:00 a.m. a dietary manager (#2) stated she was aware Resident #8 did not eat pork and confirmed Resident #8's care plan lacked dietary interventions, including the resident's food preferences. - Review of Resident #5's medical record occurred on December 16-18, 2014 and identified the resident wandered in the facility and into other residents' rooms. A quarterly Minimum Data Set, dated 08/23/14, identified the resident wandered one to three days during the seven day assessment period. Resident #5's current care plan, revised on	F 280	diet. Food preferences will be updated and listed on the tray card. 4.An audit tool will be developed to monitor the timely updating of care plans due to a change in the resident condition. The audit will focus on the need to update care plans residents that wander, display physical or verbal behaviors, use of psychoactive drugs and list potential side effects and negative reactions associated with these medications, adaptive eating equipment, special instructions for meal assistance thickened liquids and food items that the kitchen cuts up and the need to follow the physicians ordered diet. The audit will be completed by the DNS 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two	

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F 280	Continued From page 13 09/03/14, failed to identify wandering as a problem area and failed to provide interventions to address the wandering. - Review of Resident #6's medical record occurred on December 16-18, 2014. Physician's orders included the following medications: *Morphine Sulfate (narcotic pain medication) *Ativan (an antianxiety medication) *Geodon (an antipsychotic medication) Resident #6's current care plan, revised 11/18/14, failed to identify the use of pain medications, antianxiety medications, and antipsychotic medications, the potential medication side effects, or potential negative reactions and staff interventions for these medications. - Review of Resident #10's medical record occurred on December 17-18, 2014. Physician's orders, dated 11/16/12, included a puree texture diet and nectar thick liquids. Resident #10's diet card showed "Special Instructions: . . . For Lunch and Dinner add liquid to food so it is consistency of hot cereal and put in bowls." Resident #10's current care plan, revised 11/05/14, failed to identify a mechanically altered diet, thickened liquids, the special instructions on the diet card, interventions, or precautions for facility staff to monitor related to this diet.	F 280	months. If concerns are identified corrective action will be implemented. The results of the audits will be reported to the QA committee for further recommendations and/or the need for additional audits. In addition, the QA committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281 ~~F 281~~	F 281 1.Resident # 7 individual needs have been met as staff is no longer crushing the Metoprolol XR. Resident #1's individual needs have been met as a physician order for the TRIAD cream TID and PRN has been obtained. 2.All residents on Metoprolol XR or receiving TRIAD cream have the potential to be affected in this area. A revised	1/22/15

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F 281	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, and staff interview, the facility failed to ensure staff followed professional standards regarding medication administration for 2 of 11 sampled residents (Resident #1 and #7). Failure to obtain a physician's order prior to administering medication (Resident #1) and crushing an extended release medication (Resident #7) placed the residents at risk of an adverse reaction to the medications. Findings include: Nursing 2015 Drug Handbook, 35th Edition, Wolters, Kluwer, Philadelphia, Pennsylvania, Page 937-938 stated, "metoprolol succinate . . . INDICATIONS & DOSAGES: Hypertension [high blood pressure] . . . ADMINISTRATION: . . . Extended-release tablets may be cut in half on scored line, but never crushed or chewed. . . ." Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice, 9th Edition, Pearson, Boston, Massachusetts, Page 850-851, stated, "Medication Orders: A physician usually determines the client's medication needs and orders medications . . . Essential Parts of a Drug Order: . . . * Name of the drug to be administered * Dosage of the drug * Frequency of administration * Route of administration . . ." - Observation of medication administration for Resident #7 occurred on 12/16/14 at 7:45 a.m.	F 281	list of residents on Metopolol XR or TRIAD cream will be generated. All residents on Metopolol XR will be reviewed to ensure staff are not crushing this medication during medication pass audits. All residents with physician orders for TRIAD cream will be generated to ensure each resident has a physician order for the use of the TRIAD cream. System change: A list of medications that should not be crushed was provided by the consultant pharmacist and shared with staff that passes medications. Also a copy of the do not crush list is at each nurses station and each nurse will receive a copy of the list of medications at the inservice. 3.Education was provided to the nursing staff on 12-30-2014 to instruct staff on the	

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F 281	Continued From page 15 The licensed nurse (#13) obtained a metoprolol succinate ER [extended-release] tablet for Resident #7. The nurse then crushed the tablet, mixed it in pudding, and administered it to Resident #7. During an interview on 12/16/14 at 4:30 p.m. an administrative nurse (#1) agreed nurses should not crush the extended release metoprolol tablets. - Review of Resident #1's medical record occurred on December 16-18, 2014. Nursing progress notes identified the following: * 08/09/14 (Saturday) at 11:48 a.m.: "Resident has opening to coccyx. Will apply Triad [barrier cream] TID [three times a day] and PRN [as needed]. Fax drafted for physician in regards to opening. Will fax on Monday." * 08/11/14 (Monday) at 12:47 p.m.: "Fax rec. [received] and obs. [observed] re [regarding]: New Order, TRIAD TID and PRN." The record indicated staff applied the Triad for two days before requesting and obtaining a physician's order for the medication. During an interview on 12/17/14 at 4:30 p.m. an administrative nurse (#1) stated the facility does not have standing orders in place for the Triad and staff need to obtain a physician's order for the medication before using it.	F 281	need to NOT crush Metoprolol XR tablets and that we must have physician orders for TRIAD cream before it is applied. 4.An audit tool will be developed to monitor the medication pass to ensure the list of non-crushable medications is available and no meds on the list are crushed, including Metoprolol XR and that residents using TRIAD cream have physicians orders for its' use. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	corrective action will be implemented. The results of the audits will be reported to the QA committee for further recommendations and/or the need for additional audits. In	

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F 314	Continued From page 16 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 01/23/14 AND 01/16/13. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to promote healing of pressure ulcers and prevent new ulcers from developing for 4 of 4 sampled residents with current pressure ulcers (Resident #1, #2, #3, and #10). Failure to implement a repositioning program and promptly notify the dietary department of the ulcer resulted in Resident #1's ulcer progressing to a stage 3 and delayed healing. Failure to accurately monitor the ulcers (Resident #1, #2, #3, and #10) limited the staff's ability to assess the effectiveness of current interventions and determine the need for changes in treatment. Failure to re-apply a dressing and ensure correct wheelchair seating placed Resident #2 at risk for further skin damage and discomfort. Findings include: Review of the facility policy "Pressure Ulcers" occurred on 12/18/14. The policy, dated September 2012, stated, "PURPOSE: To provide appropriate assessment and prevention of pressure ulcers as well as treatment when	~~F 314~~ F314	addition, the QA committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. F-314 1.Resident # 1's individual needs have been met by having a current wound data collection tool completed daily by the licensed nurse and having a current wound assessment completed weekly by the RN until the pressure ulcer is healed. The care plan has been updated to include turning and repositioning with pressure relieving devices of a knee wedge and a side wide to keep him off of his back. Resident #2's individual needs have been met by having a current wound data collection tool completed daily by the licensed nurse and having a current wound assessment completed weekly by the RN	1/22/15

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F 314	Continued From page 17 necessary. POLICY: Based on the resident's comprehensive assessment, the center will use prevention and assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. . . ." Review of the facility policy "Pressure Ulcer Practice Guidelines" occurred on 12/18/14. The policy, revised June 2014, stated, "PURPOSE: To provide current information on prevention and management for pressure ulcers. . . . INITIAL SKIN OBSERVATION/ASSESSMENT . . . Documentation should include the presence of existing Stage I to IV pressure ulcers . . . INITIAL RISK ASSESSMENT . . . Prevention strategies should be developed and implemented at the time of admission based upon the initial assessments of the causative factors that contribute to the resident's risk for skin breakdown. Prevention strategies are ongoing and will be individualized based on the areas or the level of risk determined. Include these prevention strategies on the resident's care plan. . . . INITIAL WOUND ASSESSMENTS: If during the skin observation areas are identified, then the following documentation is recommended . . . Type of wound . . . Location . . . Measurements . . . General appearance/presence of healing. . . . Drainage . . . signs of infection . . . Pain . . . ONGOING SKIN ASSESSMENTS . . . Residents at risk for pressure ulcer development and those with pressure ulcers/wounds should be monitored daily for changes in their skin condition. . . .	F 314	until the pressure ulcer is healed. OT completed a wheel chair assessment and she has been placed in a different wheelchair which fits her better. The care plan was updated to include a knee wedge and a side wedge to keep her off of her back. Resident # 3's individual needs have been met by having a current wound data collection tool completed daily by the licensed nurse and having a wound assessment completed weekly by the RN until the pressure ulcer is healed. The care plan has been updated. Resident has been started on beneprotein due to skin risk. Resident # 10's individual needs have been met by having a current wound data collection tool completed daily by the licensed nurse and having a wound assessment	

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F 314	Continued From page 18 WOUND ASSESSMENTS . . . weekly documentation is recommended to provide a review of the pressure ulcer/wound. Weekly documentation should include the date observed and: Location with staging/depth . . . Measurements . . . exudate [drainage] . . . pain . . . Wound bed characteristics . . . Description of wound edges . . . Friction/Shearing: Friction is the mechanical force exerted on skin that is dragged across any surface. Shearing is the interaction of both gravity and friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches . . . causing tissue damage. . . . MOVEMENT OR MANAGEMENT OF TISSUE LOAD . . . Staff should implement resident-specific turning and positioning programs based upon an individualized assessment. This includes a consistent program for changing the resident's position and realigning the body. . . . Staff should collaborate with restorative nursing and therapy staff for residents presenting with positional challenges. Staff should . . . maintain head of bed less than 30 degrees (unless contraindicated) in an effort to prevent breakdown of skin integrity. . . . FOLLOW-UP ASSESSMENT/DOCUMENTATION . . . should include . . . the response to interventions directed at management of additional risk factors. The resident's care plan should be updated to reflect any changes in interventions. . . ." - Information provided by the facility on the afternoon of 12/15/14 identified Resident #1 had a new/worsened stage 3 (full thickness tissue loss) pressure ulcer on the left buttock.	F 314	completed weekly by the RN until the pressure ulcer is healed. The care plan has been updated to include a knee edge and protective booties prn. 2. All resident with pressure ulcers have the potential to be affected in this area. All residents will have their skin condition inspected daily during routine cares and weekly during bathing. Any unusual skin marks, open areas, or irritation will have the nurse inspect the skin and follow up with the physician as needed. 3.Education was provided to the nursing staff on 12-30-2014 to educate staff on the procedure titled "Skin Assessment and Pressure Ulcer Prevention" with a focus on the need to completed the entire wound data collection tool daily, the RN will	

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F 314	Continued From page 19 Resident #1's medical record, reviewed on December 16 -18, 2014, identified diagnoses including a cerebral vascular accident (CVA) with right hemiplegia (weakness) and diabetes mellitus (DM). A quarterly Minimum Data Set (MDS), dated 09/14/14, identified extensive assistance with bed mobility, transfers, and personal hygiene; always incontinent of bowel and bladder; no current pressure ulcers; and no turning/repositioning program. Resident #1's care plan identified a problem: "The resident has skin integrity impairment R/T [related to] DM, CVA, decreased mobility E/B [evidenced by] pressure sore to left buttock. Date Initiated: 10/24/14." Interventions included: "Monitor location, size . . . Report abnormalities, failure to heal, s/s [signs/symptoms] of infection, maceration [softening of skin due to moisture], etc. [et cetera] to health care provider. . . . Identify potential causative factors and eliminate/resolve where possible. . . . Resident needs pressure relieving mattress . . . to protect the skin while in bed . . . Date Initiated: 11/19/14. Turn and reposition in bed and when up in chair every 2 to 21/2 hours and PRN [as needed]. Date Initiated 12/27/13. . . .Weekly skin observation by licensed nurse. Date Initiated: 12/27/13. . . ." The Activities of Daily Living (ADL) care plan, revised on 12/27/13, stated, "Resident requires 2 staff participation to reposition and turn in bed. Use full body lift with med [medium] multipurpose sling when repositioning up in bed. . . ." Resident #1's nursing progress notes identified the following: * 08/09/14 at 11:48 a.m.: "Resident has opening to coccyx. . . ." The record lacked evidence staff measured or	F 314	complete the wound assessment weekly, and the need to care plan for pressure relieving devices and to reposition residents at least every two hours. 4.An audit tool will be developed to monitor pressure ulcer documentation daily with the wound data collection tool and weekly the RN wound assessment and to monitor if the care plans include pressure relieving devices and turning/reposition needs. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for next month, and then monthly for the next two months. If concerns are identified corrective action will be implemented. All results of the audits will be reported to the QA committee for further recommendations and/or the	

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F 314	Continued From page 20 regularly assessed this open area. A note dated 08/22/14 at 12:17 p.m. indicated the area was "healing." * 09/23/14 at 12:35 p.m.: "Sent fax to doctor in regaurds [sic] to 1 by 1 cm [centimeter] open area to left buttock." The record showed staff failed to complete the initial wound assessment form for this ulcer until 09/28/14 at 1:25 p.m. (five days later), at which time the ulcer had increased to 2 cm. by 2 cm. (no depth recorded). This form failed to identify the wound stage or include a description of the characteristics of the wound. The record showed staff documented the size of the wound weekly on the Wound Data Collection form, but failed to complete the sections assessing the depth and all wound characteristics (tissue type, drainage, assessment of wound margins and surrounding skin, and tunneling or undermining). On 10/22/14 at 1:23 p.m. the record showed the wound had increased to 3 cm by 2 cm with no depth or wound characteristics assessed. A nurse's note, dated 11/24/14 at 11:05 a.m., stated, "Correction from prior wound UDAs [user defined assessments]. Pressure sore to Left Buttock would be considered a Stage 3 per wound consultant nurse." This note lacked a description of the wound. A Wound Data Collection form, dated 11/25/14 at 1:44 p.m. showed the wound measured 1.6 cm by 2 cm with no depth, stage, or wound characteristics assessed. Observations during the survey showed the following: * 12/15/14 at 2:45 p.m.: Resident #1 resting in	F 314	need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. F314 Addendum- Nursing staff will be educated regarding the need to alert licensed staff when a dressing is not in place and needs to be replaced on a resident.	1/26/15

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bed on his back with the head of the bed elevated and a tube feeding infusing.
* 12/15/14 at 5:18 p.m.: Resident #1 resting in bed on his back with the head of the bed elevated. A sign on the wall stated, "Resident head of bed is to be at 45 degrees at all times."
* 12/16/14 at 8:45 a.m.: Certified Nursing Assistants (CNAs) (#6 and #8) provided incontinence cares. Following cares, the CNAs lifted Resident #1 using the soaker pad and positioned him on his back.
* 12/16/14 at 11:00 a.m.: A licensed nurse (#10) changed the dressing on Resident #1's left buttock. When asked if she planned to measure the wound, the nurse (#10) stated she did not usually do the treatments and did not know if the wound needed measurements completed that day. She then completed the dressing change without measuring the wound. Observation showed the wound dark pink and deeper at the center of the wound bed. Following the dressing change, the licensed nurse (#10) and a CNA (#8) positioned the resident by pulling him across the bed using a bath blanket.
* 12/16/14 at 1:55 p.m.: Two CNAs (#6 and #9) assisted the resident from the gerichair to his bed using a Hoyer lift and positioned him on his back in the bed.
* 12/17/14 at 10:20 a.m.: Resident #1 resting in bed on his back. A licensed nurse (#12) changed the dressing on his left buttock and measured the area at 1.8 cm by 1.6 cm The nurse did not measure the depth, but stated it was "about 0.3 cm" when measured "the other day." The record lacked evidence of this depth measurement.

A nutrition note, dated 10/09/14 at 10:55 a.m., stated, "Has fragile skin to (L) [left] buttock. Area noted to be pink and intact. Res [resident]

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continues to receive formula and MVI [multivitamin] with minerals daily which will promote halthy [sic] skin. Will continue to monitor." This note conflicts with the Wound Data Collection form dated, 10/06/14 at 1:43 p.m., which identified the resident had a 2.2 cm by 2 cm open area on his left buttock. A Wound Data Collection form, dated 10/15/14, identified the resident still had a 2.5 cm by 1.5 cm open area on the left buttock.

The record showed dietary staff failed to implement additional nutritional interventions to promote healing until 10/21/14 when the dietician recommended one scoop protein powder to be mixed with the gastrostomy (feeding tube) water flush twice a day.

A nutrition note, dated 11/25/14 at 2:43 p.m., stated, ". . . Area to (L) buttock is noted to be Stage III per wound consultant. . . . Sugest [sic] also to provide 1 Arginaid [a nutritional supplement] packet (9.2 g [grams]) daily to promote healing. Will continue to monitor."

An interview with a dietician (#3) occurred on 12/18/14 at 9:50 a.m. When asked about nutritional interventions, the dietician stated Resident #1 receives "what he needs to promote healing" from the tube feedings and the multivitamin. The staff member (#3) stated she first became aware of Resident #1's pressure ulcer on or about 10/09/14, but could not be sure of the date.

During an interview on 12/17/14 at 4:30 p.m. an administrative nurse (#1) agreed staff did not complete Resident #1's Wound Data Collection forms according to facility policy. When informed

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of the observations of the resident positioned on his back, the nurse (#1) stated staff should reposition Resident #1 according to his care plan. Record review showed the resident's care plan failed to identify individualized interventions to keep pressure off Resident #1's left buttock.

On 12/18/14 at 7:35 a.m., the administrative nurse (#1) stated staff are to use the Hoyer lift when repositioning Resident #1 in bed, as identified in his care plan.

Facility staff failed to assess and document the size, depth, and characteristics of the wound, as per facility policy; failed to appropriately reposition the resident in bed using a Hoyer lift; and failed to promptly notify the dietary department and implement nutritional interventions to promote healing of the ulcer. These failures resulted in Resident #1's ulcer progressing from a 1 cm by 1 cm "open area" on 09/23/14 to a 1.6 cm by 2 cm stage 3 pressure ulcer on 11/24/14.

- Review of Resident #2's medical record occurred on all days of survey and included diagnoses of diabetes and open wounds on the foot and buttock. An admission MDS, dated 10/22/14, identified extensive assistance with bed mobility, transfers, and personal hygiene; frequently incontinent of bowel and bladder; at risk for pressure ulcers, no current pressure ulcers; and no turning/repositioning program.

Resident #2's care plan identified a problem: "The resident has impairment to skin integrity R/T decreased mobility, failure to thrive E/B unstageable area to right heel. Date initiated: 11/08/14." Interventions included: "Monitor location, size . . . Report abnormalities, failure to

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heal, s/s of infection, maceration, etc. to health care provider . . . Identify potential causative factors and eliminate/resolve where possible. . . . Resident needs pressure relieving mattress, to protect the skin while in bed. Date initiated: 11/08/14. . . . Elevate heels off bed. Blue protective booties to be on at all times. Date initiated: 11/08/14.

Resident #2's care plan, dated 10/30/14, identified an "unstageable pressure sore to bottom" as a reason for the resident's indwelling foley catheter, but failed to identify interventions to promote healing of the unstageable pressure ulcer.

Resident #2's nursing progress notes identified the following:
* 10/16/14 at 1:29 p.m.: "Sent fax to [Physician] informing him that resident right heel is slightly red. . . ." Orders received for "hydrocolloid [dressing] to red heels for preventative measures."
* 10/30/14 at 6:13 p.m.: ". . . Resident has breakdown to right buttock. . . ."
* 11/05/14 at 8:08 a.m.: Fax sent to physician regarding "open areas to 1. Left [unidentified] 2. coccyx. . . ." The physician ordered a wound consultation.
* 11/08/14 at 11:50 a.m.: "Resident was found to have unstageable pressure sore to right heel. . . ."
* 11/23/14 at 3:31 a.m.: ". . . resident has silver dollar sized open sacral wound. wound clean with triad [cream] applied and open to air. . . ."
*12/06/14 at 1:23 a.m.: ". . . dressing to coccyx was entirely soiled . . . old dressing removed and new dressing placed. . . ."
* 12/11/14 at 2:44 a.m.: ". . . drsg [dressing] was soiled and partially coming off. Drsg was removed

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F 314	Continued From page 25 . . . New . . . drsg applied. . . ." Review of Resident #2's Wound Data Collection form showed: * Unstageable right heel ulcer assessments including measurements completed on 11/08/14 - initial measurement 3.5 cm x 3 cm, 11/18/14 - 5 cm x 4 cm, 11/24/14 - 5.4 cm x 4.4 cm, 11/26/14 - 4.5 cm x 3 cm, and 12/11/14 - 4 cm x 3.5 cm. The last two assessments failed to include any wound characteristics and more than two weeks elapsed without an assessment. * Left buttock ulcer initial assessment completed on 10/30/14 - 4 cm x 2.5 cm. * Central sacrum and right sacral ulcer assessment completed on 11/09/14 - 3 cm x 3 cm. * Coccyx ulcer assessment completed on 11/26/14 - 3 cm x 3 cm (failed to include any wound characteristics) and 12/10/14 - 2.3 cm x 2.4 cm. Two weeks elapsed without an assessment. Observation on 12/16/14 at 5:30 p.m. showed a CNA (#11) removed Resident #2's soiled brief, removed the soiled pressure ulcer dressing from the right buttock, and placed a new brief over the uncovered pressure ulcer. Two CNAs (#11 and #23) then transferred the resident with a total body lift from the bed to her wheelchair. The CNAs positioned the resident with her hips forward and partially sitting on top of the wheelchair's pommel cushion. The CNAs failed to correctly position the resident in her wheelchair and to notify the nurse to replace the dressing. Observation on 12/17/14 at 2:00 p.m. showed a nursing staff member (#12) changed Resident #2's dressing to her right heel unstageable	F 314		

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F 314	Continued From page 26 pressure ulcer. The nurse (#12) measured the heel's eschar - 3.5 cm x 4.2 cm. During interviews on 12/16/14 at 6:00 p.m. and on 12/17/14 at 2:30 p.m., an administrative nurse (#1) verified: * Resident #2's current pressure ulcers included the right heel and right buttock. * Nursing staff failed to accurately and consistently identify and assess Resident #2's current right heel and right buttock pressure ulcers. * The CNA failed to notify the nurse to replace the pressure ulcer dressing. * The CNAs incorrectly positioned the resident in her wheelchair. * Staff failed to have occupational therapy assess and train staff regarding proper positioning with the pommel cushion. Failure of facility staff to correctly identify and assess skin issues on a consistent basis prohibited staff from accurately tracking the pressure ulcers and evaluating the current treatments. Failure of staff to maintain pressure ulcer dressings and correctly position Resident #2 in her wheelchair may have caused further skin damage and increased discomfort to the resident. - Review of Resident #3's medical record occurred on all days of survey and included diagnoses of Cerebral Palsy and obesity. A quarterly MDS, dated 11/22/14, identified extensive assistance for bed mobility, total assistance for transfers and personal hygiene, always incontinent of urine, a Stage I pressure ulcer, and no turning/repositioning program. Resident 3's current care plan identified a	F 314		

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problem: "The resident has skin integrity impairment R/T Cerebral Palsy, Morbid obesity, and decreased mobility and transfers and stage 2 area to right buttock. Revision on: 06/05/14." Interventions included: "Use caution during transfers and bed mobility . . . Resident needs pressure relieving mattress and pressure relieving wheelchair cushion . . . Use lubriderm lotion to whole body daily on dry skin . . . Weekly skin observation by licensed nurse . . . Resident repositions self per motorized wheelchair. Date initiated 12/05/13 . . . Reposition every 2 to 2 1/2 hours and PRN when in bed. Date initiated: 12/04/13."

Resident #3's nursing progress notes identified the following:
* 10/30/14 at 3:32 p.m.: ". . . continues to have pressure area to (R) [right] buttock. . . ."
* 11/14/14 at 3:23 p.m.: ". . . continues to have a pressure are [sic] to (R) buttock. . . ."
* 12/05/14 at 11:55 a.m.: ". . . continues to have pressure area to coccyx. . . ."
* 12/11/14 at 2:24 a.m.: ". . . Right side of buttock has open area. Small amounts of bleeding. area that is open is scattered. Total intermittent area open 4 inches wide horizontal by 8 inches vertical. . . ."

Review of Resident #3's Wound Data Collection form showed:
* 04/05/14 - Initial assessment of right buttock pressure ulcer measuring 1 cm x 1 cm.
* 05/11/14 - Initial assessment of right buttock pressure ulcer measuring 1 cm x 1 cm.
* 11/17/14 - Assessment of coccyx pressure ulcer with no measurements
* 12/16/14 - Assessment of right buttock pressure ulcer with no measurements.

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F 314	Continued From page 28 Observation on 12/16/14 at 9:50 a.m. showed a nursing staff member (#10) applied Triad cream to Resident 3's buttocks. The nurse identified several open areas on the right buttock indicating possible Stage 2 areas. The left buttock and coccyx area showed no open areas. Observation on 12/16/14 at 1:55 p.m., showed Resident #3 sleeping in his room reclining back in his electric wheelchair. During an interview on 12/16/14 at 5:15 p.m., an administrative nurse (#1) indicated she failed to track the resident's pressure ulcers/wounds from the documentation completed by nursing. Nursing staff failed to complete initial assessments, follow through with consistent weekly assessments, and document when the pressure ulcer had healed/resolved. Failure of facility staff to correctly identify and assess skin issues on a consistent basis did not allow staff to accurately track the pressure ulcers, assess for improvements or worsening of the ulcers, and assess the effectiveness of current treatments for Resident #3. - Review of Resident #10's medical record occurred on December 17-18, 2014. The resident's current diagnoses included adult failure to thrive and history of pressure ulcer to the right ankle. The MDSs, quarterly dated 10/25/14, and significant change dated 08/20/14, identified one and two unstageable pressure ulcers, respectively. Resident #10's Pressure Ulcer CAA, dated 09/02/14, identified unstageable pressure ulcers	F 314		

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F 314	Continued From page 29 to the right lateral malleolus [ankle] and the right lateral foot. Resident #10's current care plan, initiated on 07/23/14 and revised on 10/02/14, stated "Focus, The resident has skin integrity impairment R/T decreased mobility, failure to thrive, hospice care E/B unstageable areas to right outer ankle and lateral foot. . . . Interventions, Monitor location, size and treatment of skin injury. . . ." Resident #10's medical record showed weekly documentation regarding the right ankle pressure areas. The documentation lacked weekly measurements and included statements such as "increased in size" and "decreased in size" and "healing" without objective criteria. The documentation identified the pressure ulcers healed on 11/26/14. A new area on the right foot developed on 12/17/14.	F ~~314~~ 315	F-315 1.Resident # 2's individual needs have been met as she is currently without signs and symptoms of a UTI. The care plan was updated to include the need to having the catheter bag positioned below the bladder at all times. 2.All residents with catheters have the potential to be affected in this area. A list of residents with catheters will be generated and each will have their care plan reviewed to ensure the drainage bags are kept below the level of the bladder during routine cares. 3.Education was provided to the nursing staff on 12-30-2014 to education staff on the procedure titled "Catheter Care " with a focus on the need to keep the catheter bag below the level of the bladder at all times.	1/22/15
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide appropriate	~~F 315~~		

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F 315	Continued From page 30 treatment and services to prevent urinary tract infections for 1 of 1 resident (Resident #2) observed with an indwelling catheter. Failure to keep the catheter drainage bag below the bladder during transfers and cares may result in urinary tract infections (UTIs). Findings include: Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice, 9th Edition, Pearson, Boston, Massachusetts, Page 1330, stated, "Urinary Cahterization . . . Keep the urine drainage bag below the level of the bladder. . . ." Review of Resident #2's medical record occurred on all days of survey and included diagnoses of chronic kidney disease Stage III and a UTI. The admission Minimum Data Set, dated 11/06/14, identified extensive assistance for bed mobility, transfers, and personal hygiene, indwelling catheter, and a UTI in the past thirty days. The current care plan identified a problem: "The resident has indwelling catheter R/T [related to] Skin breakdown E/B [evidenced by] unstageable pressure sore to bottom. Date initiated: 10/30/2014." Interventions included: "Monitor/document for pain/discomfort due to catheter . . . Monitor/record/report to health care provider for s/s [signs/symptoms] UTI. . . ." Resident #2's nursing progress notes identified antibiotic treatment for a UTI from 10/26/14 through 11/09/14. Observation on 12/16/14 at 5:30 p.m. showed two certified nursing aides (CNAs) (#11 and #23) transferred Resident #2 from the bed to her wheelchair with a total body lift. During the	F 315	4.An audit tool will be developed to monitor the level of catheter drainage bags during routine cares and bathing. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week the next month, and then monthly for the next two months. If concerns are identified corrective action will be implemented. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance.	

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F 315	Continued From page 31 transfer the CNAs hooked the catheter bag on one of the lift straps, at the same level as the resident's head. Further observation showed urine in the catheter tubing flowing backward. During an interview on 12/16/14 at 6:00 p.m., an administrative nurse (#1) verified the CNAs failed to keep the catheter bag below Resident #2's bladder to decrease the risk for UTIs.	F ~~345~~ 323	F-323 1.Resident # 7's individual needs have been met by updating the care plan and diet card to include the need to have a lid to cover hot beverages to prevent burns from spilling.	1/22/15
F 323 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent burns for 1 of 1 sampled resident (Resident #7) who obtained a burn from spilling a hot beverage. Failure to ensure staff provided hot beverages at a safe temperature and provided adequate supervision and assistive devices resulted in Resident #7's burn and may result in other residents experiencing burns from hot liquids. Findings include: Review of the facility policy "Meal Service/Dining	~~F 323~~	2.All resident have the potential to be affected in this area. All residents ~~will be~~ have been evaluated to ensure they are safe with hot beverages. If a resident is considered unsafe, a lid will be immediately applied and a physician order will be obtained as soon as possible. The care plan and dietary card will then be updated to include the addition of a lid for hot beverages. 3.Education was provided to the nursing staff on 12-30-2014 to education staff on the procedure titled, "Meal Service/Dining Assistive	1/22/15 4pm T.C. & adm Appr.

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F 323	Continued From page 32 Assistive Devices" occurred on 12/18/14. The policy, dated February 2013, stated, "PURPOSE: To provide assistive devices to maintain or improve the resident's ability to eat independently. . . . Use of these devices will be noted on the care plan and dietary card. . . ." Resident #7's medical record, reviewed on December 16-18, 2014, identified diagnoses including glaucoma, dementia, and arthritis. A quarterly Minimum Data Set (MDS), dated 10/04/14, identified short and long term memory problems and required supervision with eating. Resident #7's Activities of Daily Living care plan, dated, 01/15/14, stated, "Resident requires assist of one to eat PRN [as needed] . . ." A nurse's note, dated 07/06/14 at 2:15 p.m., stated, "at meal time resident refused staff assistance when offered due to resident was dropping food into lap while holding bowl of dessert and attempting to eat it. at the end of noon meal resident was meowing and yelling at staff. resident threw her cup of hot chocolate at staff, missing staff." Record review failed to identify interventions implemented following this incident to reduce the risk of Resident #7 spilling or throwing hot beverages. A nurse's note, dated 09/29/14 at 11:56 p.m., stated, "CNA [Certified Nursing Assistant] called for this nurse across dinningroom [sic] staing [sic] that resident spilled hot coffee on herself. This writer assisted CNA in removing resident's right arm from her sweatshirt. Resident's right arm noted to be bright red. Resident pleasant and cooperative with staff. Burn from spilt [sic] coffee noted just distal to antecubital on right arm. Redened [sic] area measures 3 x 1 inches. 1 cm	F 323	Devices" with a focus on the need to assess resident for safety with hot beverages and to provide assistive devices to maintain or improve the residents ability to eat independently. The care plan and dietary card will be updated as needed. The temperature of the coffee will be monitored routinely. 4.An audit tool will be developed to monitor if staff have checked the temperature of the coffee, and will monitor hot beverage service during meals, to check if all resident have been assessed for safety with hot beverages and a progress note has been written and if a lid is listed on the diet card and in the care plan if needed. The audit will be completed by the DDS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for two month additional months. If concerns are identified corrective action will be taken. All results of the audits will be	

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F 323	Continued From page 33 [centimeter] diameter blister noted in area. Resident is alert and oreineted [sic] to self and situation. She was pleasant and cooperative ith [sic] situation. Cool wash cloth applied to area while resident finished her supper. Sterile gauzed [sic] wrapped with kerlix applied after supper. Resident's [family member name] notified via phone at 1915 [7:15 p.m.] [Physician's name] notified via fax. Will continue to monitor." The record lacked evidence staff reassessed the burn or monitored for healing and failed to identify when the burn healed. An incident report, dated 09/29/14 at 5:46 p.m., identified the burn to the right antecubital and stated, "No unsafe conditions noted. Will continue to monitor." The report lacked evidence staff identified the safety risk of Resident #7 handling hot beverages without adaptive equipment. On the afternoon of 12/17/14, an administrative nurse (#1) provided minutes from an Interdisciplinary Meeting held on 10/07/14 at 8:15 a.m. The minutes stated, "Resident who had a coffee spill incident skin issue is no longer a problem -- covers are now used on her cups." It could not be determined from the minutes when staff implemented the covered cups. This meeting took place eight days after the resident sustained the burn and three months after the episode of Resident #7 throwing a hot beverage at a staff member. A nurse's note, dated 10/13/14 at 10:44 a.m., stated "Fax received back from [Physician's name] in regards to spilled hot coffee. Orders to place lids on hot beverages." The record lacked evidence staff attempted to contact the physician during the two week period from the time of the	F 323	reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance.	

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F 323	Continued From page 34 burn to the time of the physician's response. Review of the resident's care plan failed to identify the risk of the resident throwing or spilling hot beverages and lacked interventions, such as placing lids on the cups (as ordered by the physician) to reduce the risk of Resident #7 spilling or throwing hot beverages. Review of Resident #7's dietary card identified adaptive equipment as "lip plate with plate guard." The card failed to identify adaptive equipment for hot beverages. During an interview on 12/17/14 at 3:30 p.m., a dietary management staff member (#2), reported the facility received a new coffee machine/dispenser since the incident involving Resident #7 on 09/29/14. The staff member (#2) reported the coffee machine/dispenser representative has reported the coffee temperature is "low as possible." The staff member (#2) reported she had not monitored and did not know the temperature of the coffee. During an interview on 12/17/14 at 4:32 p.m. an administrative nurse (#1) agreed the resident's record lacked evidence staff reassessed and monitored the burn in the days/weeks following the incident. She stated the physician examined Resident #7 on 11/01/14 during scheduled rounds and found the burn to be healed. An interview with a dietary manager (#2) occurred on 12/18/14 at 8:00 a.m. The staff member stated dietary staff implemented covered cups "right after" the incident on 09/29/14 and agreed Resident #7's care plan lacked interventions to address the risk of her spilling or throwing hot beverages.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 5 sampled residents (Resident #6) receiving as needed (prn) antipsychotic and prn antianxiety medications did not receive unnecessary medications. Failure to ensure adequate indications and attempt non-pharmacological interventions before using an antipsychotic (Geodon) and an antianxiety	F 329	F-329 1. Resident #6's individual needs have been met by updating her physicians order to include a yes or no question on the PRN Ativan and Geodon regarding if the nurse attempted non pharmacological interventions prior to administering the PRN Ativan or Geodon or not. Resident expired 1/19/15. 2. All residents on PRN psychoactive medications have the potential to be affected in this area. A list of residents on PRN psychoactive medications will be generated and each resident listed will be reviewed to ensure the physicians order has been updated with a yes or no question regarding if they have attempted non-medication interventions	1/22/15

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F 329	Continued From page 36 medication (Ativan) placed Resident #6 at risk of receiving unnecessary medications. Findings include: Review of the facility policy and procedure, "Psychopharmacological Medications and Sedative/Hypnotics," occurred on 12/18/14. This document, revised in June 2014, stated "PURPOSE, To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics . . . PROCEDURE, Non-Emergency Administration, 1. Before administration of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: a. Documentation . . . of mood symptoms or behaviors . . . and response to interventions used. . . ." Review of Resident #6's medical record occurred on December 15-18, 2014. The facility admitted the resident in October 2013. Current diagnoses included anxiety, dementia, and depression. The annual Minimum Data Set (MDS), dated 09/27/14, identified the resident usually made herself understood and understood others, had short and long term memory problems, did not exhibit behavior problems in the seven day assessment period, and received anti-depressant medication seven days in the seven day assessment period. Resident #6's physician orders included the following psychoactive medications: *Ativan (antianxiety) 0.5 milligrams (mg), every six hours (q6h), by mouth (po), prn for agitation and anxiety, initiated on 11/17/14 and	F 329	before administering PRN psychoactive medications. 3. Education was provided to the nursing staff on 12-30-2014 to education staff on the procedure titled "Psychopharmacological medications " with a focus on the need to provide non pharmacological interventions prior to administration of a PRN psychoactive medication and about the prompt to answer the yes or no question on theEMAR regarding if they attempted to offer non pharmacological interventions prior to the administration of a PRN psychoactive medications on the EMAR. 4. An audit will be developed to monitor PRN psychoactive medications and if non medication interventions were attempted before staff	

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F 329	Continued From page 37 discontinued on 11/28/14. *Geodon Solution 10 mg, intramuscularly (IM), prn for dementia, repeat every two hours, up to 40 mg in 24 hours, initiated on 11/17/14. Resident #6's current care plan, dated 11/18/14, stated "Focus, The resident has a behavior symptom R/T [related to] dementia E/B [evidenced by] hollers out frequently and is unable to express to others what is bothering her. . . . Interventions, Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Provide opportunity for positive interaction, attention. If reasonable, discuss resident's behavior. Explain/reinforce to resident why behavior is inappropriate and /or unacceptable. . . ." Resident #6's Nursing Progress Notes included the following behavior episodes, intervention, and administration of prn Ativan or Geodon: *11/20/14, 11:16 a.m. - "Yelling out, 'Help me.' " Ativan 0.5 mg *11/21/14, 12:30 p.m. - Geodon 10 mg, IM, no behaviors noted. *11/21/14, 2:22 p.m. - Geodon 10 mg, IM, no behaviors noted. *11/21/14, 7:55 p.m. - "Given to resident for relentless calling out and yelling after assessing basic needs." Geodon 10 mg, IM *11/23/14, 1:57 a.m. - "Resident aggitated [sic] about roommate [sic] crying. Was shouting out at roommate [sic]. 'Shut up' when asked to stop, resident persisted. Gave to resident to calm resident so resident could be peaceful." Ativan 0.5 mg *11/23/14, 4:33 a.m. - Geodon 10 mg, IM, no	F 329	administered the PRN psychoactive medications. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance.	

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F 329	Continued From page 38 behaviors noted. *11/27/14, 5:31 p.m. - Ativan 0.5 mg "effective." The medication administration record (MAR) identified the staff administered Ativan at 4:49 p.m. No behaviors were noted. *11/28/14, 9:35 a.m. - "Pt. [Patient] yelling, seems to be anxious." Ativan 0.5 mg *11/28/14, 1:05 p.m. - "Resident is highly anxious and restless. Is screaming 'Help, Help' but when [I] go into ask what she needs she cannot express what she wants. . . ." Geodon 10 mg, IM *12/15/14, 4:42 p.m. - Geodon 10 mg, IM "effective," no behaviors noted. The MAR identified the staff administered Geodon at 2:25 p.m. The Progress Notes and MARs lacked evidence of non-pharmacological interventions before using Ativan and Geodon. During interview, on 12/17/14 at 9:30 a.m., an administrative nursing staff member (#1) confirmed staff members should attempt non-pharmacological interventions before administering prn psychoactive medications.	F ~~329~~ 362	F 362 1. Resident #6's individual needs have been met by serving her meal within 30 minutes of the meal start time, and to give house supplements as indicated. Resident expired 1-19-15. 2. All residents that eat food by mouth or receive a nutritional supplement have the potential to be affected in this area. A list of resident that receive a nutritional supplement will be part of the random audits to ensure nutritional supplements. By ~~educating our staff~~	1/22/15
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, resident group interview, review of	~~F 362~~		

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F 362	Continued From page 39 facility policy and procedure, and staff interview, the facility failed to ensure sufficient staff for meal service in a timely manner for 2 of 2 observations (noon meals, December 16 and 17, 2014). Failure to serve resident meals in a timely manner did not enhance the dining experience for the facility's residents and may have contributed to Resident #6's weight loss. Findings include: Review of the facility policy and procedure "Frequency of Meals and Snacks" occurred on 12/18/14. This document, dated February 2013, stated, "POLICY, Three meals will be served each day at regular times comparable to normal mealtimes in the community. . . . PROCEDURE, 1. Mealtimes will be established and posted in the dining room. . . ." - During the entrance conference on 12/15/14 at approximately 2:00 p.m., the facility staff reported the residents' breakfast is "open," scheduled from 7:30 a.m. to 9:00 a.m. and their noon meal is served at 11:30 a.m. - During the resident group interview on 12/16/14 at 10:45 a.m., Resident A, B, C, E, and F reported there is a "long wait time for meals to be served," and "meals never start on time." - During a confidential resident interview on 12/16/14 at 10:20 a.m., Resident G indicated: * Food service is very slow at most of the meals, and never start at the posted times - Observation of the noon meal service on 12/16/14 showed residents in the dining room at 11:30 a.m. and staff beginning to serve residents	F 362	and auditing our meal delivery system we will ensure the meal service is completed within 30 minutes. 3. Dietary staff was educated on 1-6-2015 on the need to serve meals to all residents in the dining room within 30 minutes, except during open breakfast from 7:00-9:00 AM. All staff was educated on the need to serve residents within 30 minutes on 1-14-15. 4. An audit tool will be developed to monitor meal service times in the dining room for all three meals, and that the nutritional supplements need to be provided and	

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F 362	Continued From page 40 at approximately 11:35 a.m. Observation showed the last resident meal tray served in the dining room at 12:40 p.m., one hour and 10 minutes after the scheduled start of meal service. - Observation of meal service on 12/17/14 showed residents in the dining room at 11:30 a.m. and staff beginning to serve residents at approximately 11:40 a.m. Observation showed the last resident meal tray served in the dining room at 12:45 p.m., one hour and 15 minutes after the scheduled start of meal service. - Review of Resident #6's medical record occurred on December 15-18, 2014. The resident's current diagnoses included adult failure to thrive, anxiety, and dementia. The resident experienced a significant weight loss, weighing 124.8 pounds on 06/12/14 and 106.6 pounds on 12/10/14, a 18.2 pound loss (14.6%). Resident #6's Nutrition Care Area Assessment (CAA), dated 10/6/14, identified the resident's meal intake ranged from 0 to 50%. A dietary note, dated 10/03/14, identified Resident #6 was a "selective eater" and her average meal intake was 22%. Resident #6's current care plan, revised 11/18/14, stated "Focus, The resident has a behavior symptom R/T [related to] dementia E/B [exhibited by] hollers out frequently and is unable to express to others what is bothering her. . . . Interventions . . . Divert attention. . . . Provide opportunity for positive interaction, attention. . . . Focus, The resident has nutritional problem R/T dementia and failure to thrive E/B poor intake, weight loss and refuses meals frequently. . . . Interventions . . . Carnation Hot Chocolate and Magic Cup at all	F 362	consumed by the resident. The audit will be completed by the DDS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure	

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F 362	Continued From page 41 meals . . ." (Magic Cup is a high calorie supplement.) Observation of Resident #6's meal service identified the following: *12/16/14, 11:35 a.m. - Resident #6 seated at the dining room table for the noon meal. 12:15 p.m. - Resident #6 received her meal. *12/17/14, 7:30 a.m. - Resident #6 seated at the dining room table for breakfast. 8:25 a.m. - Resident #6 received a Magic Cup supplement with medication pass. 8:30 a.m. - Resident #6 received her breakfast. 11:30 a.m. - Resident #6 seated at the dining room table for the noon meal. 12:20 p.m. - Resident #6 received her noon meal. 12:40 p.m. - Resident #6 left the dining room, did not consume any meal items. During these meal observations Resident #6 attempted to propel her wheelchair from the dining room and facility staff convinced her to stay in the dining room for the meal service. Resident #6 repeatedly called out in a loud voice to express her displeasure with being in the dining room and waiting for her meals. Facility staff failed to offer Resident #6 hot chocolate, Magic Cup, early meal service, or another alternative to attempt to increase her intake and enhance her meal experience. During an interview on 12/17/14 at 3:30 p.m., a dietary management staff member (#2) reported the facility staff could offer Resident #6 supplements or meal items to enhance her dining experience, address her weight loss, and reduce her behaviors. This staff member (#2) agreed the meal service took too long.	F 362	continued compliance.	

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F 363 SS=E	Continued From page 42 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. 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 meet the nutritional needs of residents by serving incorrect portion sizes during 2 of 2 meal service observations (noon meals on December 16 and 17, 2014). Failure to use appropriate portion sizes placed residents at nutritional risk. Findings include: Review of the facility policy and procedure, "Portion Control," occurred on 12/18/14. This document, dated February 2013, stated "PURPOSE, To ensure nutrient needs of residents are met. To ensure that the menu is served in the quantity stated by the menu writer. POLICY, Standard portions will be served for all food items to ensure nutritional adequacy . . . PROCEDURE, 1. The portion sizes listed on the menu extensions will be followed. . . . 2. Standard portion control scoops and ladles will be used. . . . 4. The Portion Control Guidelines may be posted in the kitchen for reference by staff. . . ." At the surveyor's request, on 12/18/14 at 8:00	F 363 F 363	F 363 1. No specific resident was cited in this area. All meal service scoops are available for kitchen staff to use. Residents with physician orders for small meal portions are receiving their physician ordered diet for small portions. 2. All residents with physician orders for small portions have the potential to be affected in this area and all serving scoop sizes are available to the kitchen staff. Also residents with physician orders for small meal portions will be generated and the RD will review all residents with current physician orders for small portion meals to see if they can tolerate regular size meals. 3. Education was provided to dietary staff on 1-6-2015 and again at the all staff meeting on 1-14-2015 to review from the procedures titled, "Small and Large" and "Portion control" with a focus on the need for	1/22/15

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F 363	Continued From page 43 a.m., a dietary management staff member (#2) provided the following Small Portion Serving guidelines: *Protein: Same as regular portion *Vegetable: 1/3 cup (#12 scoop) *Starch: 1/3 cup (#12 scoop) - Observation of the noon meal service in the facility's dining room, occurred on 12/16/14 at 11:50 a.m. and on 12/17/14 at 11:55 a.m., and identified the following: *A dietary staff member (#5) served starches and vegetables for all resident diets, including small or regular portions and regular or mechanically altered texture, using a scoop identified as "#12" (1/3 cup) and a ladle identified as "3 ounce" (1/3 cup). Observation of diet cards identified residents with "small" and "regular" portion diets. Review of the facility diet roster, on 12/18/14, showed 41 of 45 residents (91%) receiving meals in the dining room should receive regular portion diets. During interviews, on 12/17/14 at 3:30 p.m. and 12/18/14 at 8:00 a.m., a dietary management staff member (#2) and a consultant dietary staff member (#3), respectively, reported they expected staff to provide residents the correct serving sizes for meals.	F 363	residents to receive small meal portions per physician orders. 4. An audit tool will be developed to monitor if the correct portion sizes are given. The audit will be completed by the DDS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	F 364 1. Hot food items are being served hot. 2. All resident have the potential to	1/22/15

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F 364	Continued From page 44 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/23/14. Based on sampled test trays, resident interview, resident group interview, review of Resident Council meeting minutes, and staff interview, the facility failed to prepare and provide food items for residents that were flavorful, palatable, and at proper temperature, for 2 of 2 meal services observed (noon meals, December 16 and 17, 2014). Failure to provide meals at acceptable temperatures resulted in a reduced dining experience and may contribute to reduced meal intakes and increased nutritional risk. Findings include: - Review of the facility's Resident Council meeting minutes for the period July 03, 2014 through December 05, 2014 occurred on December 15-18, 2014. The meeting minutes included the following comments regarding the facility's meal service: *July 03, 2014 - ". . . A couple of the residents reported concerns with wanting the meal to be served hotter. . . . [Administrative staff member (#4)] is aware of these requests and is in charge of the Dietary Department at this time. . . ." *September 04, 2014 - ". . . One resident complained of the macaroni salad that was served was awful. This resident discussed her multiple dietary concerns afterwards with [administrative staff member (#4)]. . . ." *October 02, 2014 - ". . . We discussed multiple concerns from three different residents regarding	F 364	be affected in this area. If a resident complains of cold food the staff member will either microwave the food or ask for a new plate of food. System change: A posting will be place in the upstairs kitchen to ensure the staff knows what temperature the food needs to be cooked and served. 3. Education was provided on dietary staff on 1-6-2015 to review the procedures	

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F 364	Continued From page 45 food being served cold. . . . [Dietary management staff member (#2)] will be made aware of this. . . ." *November 06, 2014 - ". . . One resident had concerns with the vegetables not being cooked and soups being served cold. [Dietary management staff member (#2)] is aware of this and is addressing it. . . ." *December 05, 2014 - ". . . One resident reported having food served to her that is cold. [Dietary management staff member (#2)] was notified of this. . . ." - During the resident group interview, on 12/16/14 at 10:45 a.m., 7 of 11 residents (Resident A, B, C, D, E, F, and G) attending reported meats are tough; 7 of 11 residents (Resident A, B, C, D, E, F, and G) attending reported meal items are not hot enough; and, 5 of 12 residents (Resident A, B, C, E and F) attending reported cooked vegetables are raw. - During an interview, on 12/16/14 at 7:45 a.m., Resident A reported, "pork chops are tough, some meats [are tough]," and "vegetables are not tender." During an interview, on 12/16/14 at 8:30 a.m., Resident B reported, "vegetables are hard." During a confidential resident interview on 12/16/14 at 10:20 a.m., Resident G indicated: * Many times the hot food is cold. Residents can ask staff to microwave the food, but it dries the food out too much. - On 12/16/14 at 12:40 p.m., at completion of the noon meal service, at the surveyor's request, the dietary staff provided a sample meal tray. The	F 364	titled, "Food Temperatures" and "Palatability of Food" with a focus on the need to cook hot foods to 165 degrees and to serve foods no lower than 140 degrees. 3. An audit tool will be developed to monitor hot food meal temperatures, and if the food temperature is above 140 degrees at the end of the meal services. The audit will be completed by the DDS, or designee, 3-5 times per week	

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F 364	Continued From page 46 facility served all the prepared vegetable (cauliflower) to residents and no vegetables remained for sampling. The tray included the main entree, a chicken breast. Three of three surveyors who sampled the chicken breast found it to be tough, dry, and difficult to chew. On 12/17/14 at 12:50 p.m., at completion of the noon meal service, at the surveyor's request, the dietary staff provided a sample meal tray. The tray included the main entree, ham slices, sweet potatoes, peas, and the alternate entree, pork loin slice. Three of three surveyors who sampled the meal items agreed the ham was cool, the sweet potatoes were cool, the peas were hard and undercooked, and the pork loin was cool, tough, dry, and difficult to chew. Meal item temperatures included the following: ham - 104.6 degrees Fahrenheit (F), sweet potatoes - 127.5 degrees F, peas - 120 degrees F, and pork loin - 97.5 degrees F. During an interview, on 12/17/14 at 3:30 p.m., a dietary management staff member (#2) reported she did not attend Resident Council meetings. This staff member reported she was not aware of the residents' concerns voiced during Resident Council meetings. This staff member agreed the meal item temperatures obtained on 12/17/14 were not palatable. During an interview, on 12/18/14 at 10:00 a.m., a consultant dietary staff member (#3) also confirmed the meal item temperatures obtained on 12/17/14 were not palatable.	F 364	for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendatio ns and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS	~~F 365~~		

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F 365	Continued From page 47 Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/23/14. Based on observation, record review, resident interview, and staff interview, the facility failed to ensure each resident received food in a form designed to meet the individual resident needs during 2 of 2 observations of meal service. Failure to ensure Resident #4 and #10 received meals prepared to their individual needs contributed to Resident #4's reduced meal intake and may contribute to Resident #4's and #10's weight loss. Findings include: Review of the facility policy and procedure, "Texture Altered Diets," occurred on 12/18/14. This document, dated February 2013, stated "POLICY, The dietary department will provide texture-altered diets that are prescribed by the resident's attending physician. Texture-altered diets will be served attractively and prepared by methods that conserve nutritive value, flavor and appearance. . . . PROCEDURE . . . 4. Pureed foods will hold a "mashed potato" consistency and will be served on a regular plate. Divided plates will not be used for the function of separating pureed items . . . 7. When a dietary assistant or nursing assistant have a concern about a diet order, they should inform the charge nurse. . . . All diet orders	~~F 365~~ F365	continued compliance F 365 1. Resident #10's individual needs have been met by updating the diet card to remove the phrase "Add liquid to food so it is consistency of hot cereal and put in bowls", and she is receiving a puree diet. Resident #4's individual needs have been met by adding to her diet card the need for the kitchen staff to cut up the food and adding this as an intervention to the care plan. 2. All residents with special instructions,	1/22/15

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F 365	Continued From page 48 including consistency changes must have a physician's order. . . . 9. Liquefied diets require a recipe. . . . The RD [registered dietitian] will ensure that the liquefied diet meets the estimated needs of the residents." - Observation of the meal service, on 12/16/14 at 11:50 a.m., identified a dietary staff member (#5) placed a serving each of ground chicken, mechanically altered cauliflower, and fortified mashed potatoes in separate bowls. The staff member (#5) added ladles of gravy to each bowl and placed the bowls on a tray for service for Resident #10. Observation of the meal service, on 12/17/14 at 11:55 a.m., identified a dietary staff member (#5) placed a serving each of ground meat, mechanically altered peas, and fortified mashed potatoes in separate bowls. The staff member (#5) added ladles of gravy to each bowl and placed the bowls on a tray for service for Resident #10. Resident #10's current Diet Card, observed on 12/16/14, identified "Diet Level: 1 . . . Special Instructions: Cereal Bowls for side dishes. . . . For Lunch and Dinner add liquid to food so it is consistency of hot cereal and put in bowls. . . ." A sign above the tray line stated "LEVEL 1 - PUREED FOODS - MASH POTATO CONSISTENCY, NOT RUNNY FOODS." During interview, on 12/16/14 at 12:00 p.m., a dietary staff member (#5) reported she prepares Resident #10's meal this way instead of providing a pureed diet, indicating she followed Resident #10's Diet Card.	F 365	such as to serve pureed meals with thickened or thin liquids, to cut up food by the kitchen staff, and to serve small meal portions at meals have the potential to be affected in this area. A list of residents that receive pureed diets, who the kitchen staff needs to cut up the food for prior to serving, or small meal portions will be generated and care plan interventions will be updated to include any physician ordered special instructions. 3. Education was provided to the dietary staff on 1-6-2015 on the procedures titled, "Texture of Foods" with a focus on how to prepare and serve pureed food and the need for the kitchen to	

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F 365	Continued From page 49 Review of Resident #10's medical record occurred on December 17-18, 2014. The resident's current diagnoses included adult failure to thrive, esophageal reflux, and unplanned weight loss. Physician's orders, dated 10/21/13, included a pureed texture diet and nectar consistency liquids. The care plan failed to identify Resident #10's diet texture. During interviews, on 12/17/14 at 3:30 p.m. and on 12/18/14 at 10:00 a.m., a dietary staff member (#2) and a consultant dietary staff member (#3), respectively, reported they did not know why Resident #10's diet card included the Special Instructions. These staff members reported they expected dietary staff to serve Resident #10 the diet texture as ordered. - Information provided by the facility on the afternoon of 12/15/14 identified Resident #4 had experienced a weight loss in the past six months. Review of Resident #4's medical record occurred on December 16-18, 2014. A quarterly Minimum Data Set (MDS), dated 11/29/14, identified severely impaired cognition, required supervision and assistance of one person with eating, and a weight loss of 5% or more in the last month or 10% in the last 6 months, and not on a physician prescribed weight loss regimen. A physician's order, dated 09/01/14 stated, "Regular diet, regular texture . . . Cut solid foods into small pieces. . . ." Resident #4's dietary card, dated 09/08/14, stated, "Requesting soft foods and food cut into small pieces." The resident's current nutrition care plan, revised 10/08/14, failed to identify the intervention of cutting solid foods into small	F 365	cut up the resident's food per diet card. 4. An audit tool will be developed to monitor if the residents tray card and care plan interventions including residents with physician ordered special instructions, such as small food portions, pureed meal with thick or thin liquids, or if the kitchen staff needs to cut up the food. The audit will be completed by the DDS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA	

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F 365	Continued From page 50 pieces. Dining observations showed the following: *12/16/14 at 12:00 p.m.: Resident #4 received a whole chicken breast (not cut into small pieces), mashed potatoes with gravy, cauliflower, and chocolate pudding. A licensed nurse (#13) assisted the resident, but did not cut up the chicken. Observation showed the resident ate the pudding and drank part of a glass of cranberry juice, but consumed none of the chicken breast. *12/17/14 at 11:40 a.m.: Resident #4 received a slice of ham, cut into small pieces, peas, mashed potatoes with gravy, and cherry crisp. The resident fed herself the meal without assistance from staff and consumed several bites of the ham, and approximately half the potatoes and dessert. Resident #4 stated she did not eat much of the ham because "It's a little salty." The above observations showed, when staff cut the meat into small pieces, Resident #4 did consume a portion of the meat. An interview with a dietary manager (#2) occurred on 12/18/14 at 8:00 a.m. The staff member confirmed Resident #4's nutrition care plan lacked an intervention to cut solid foods into small pieces and agreed staff should have cut the chicken served at noon on 12/16/14 into small pieces, as identified on the resident's dietary card.	F 365	committee for further recommendations and/or the need for additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance	
F 366 SS=D	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.	F366 ~~F-366~~	F 366 1. Resident # 8's individual needs have been met as she is receiving a nutritionally balanced diet with alternatives food items of equally nutritional value and texture available if she refuses the food served. 2. All residents that request substitutions have the potential to be affected in this area. All residents that request	1/22/15

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F 366	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident, group, and staff interview, the facility failed to offer and provide substitutes of similar nutritive value for 1 of 1 sampled resident (Resident #8) who requested a substitute meal item. Failure to offer and provide substitutes and alternatives of similar nutritive value placed Resident #8 and all other residents at risk of reduced meal intake and nutritional risk. Findings include: Review of the facility policy "Substitutes and Alternatives at Meal Times" occurred on 12/18/14. This document, dated February 2013, stated "PURPOSE: To ensure residents have substitutions when they do not like the main entree. POLICY: Food substitutions of comparable nutritional value will be available to residents who refuse food served. PROCEDURE: 1. The substitutes for refused foods will be pre-planned and approved by the director of dietary services (DDS) and or the registered dietitian (RD). 2. The dietary staff is responsible for preparing food substitutes. 3. Staff will offer the prepared substitute (which has comparable nutritional value and texture consistency) to those residents who are refusing to eat . . . or who verbalize their dislike for a food served. . . ." - During the resident group interview, on 12/16/14 at 10:45 a.m., Resident A, B, C, E, and F reported	F 366	substitutions will be offered a substitute of equal nutrition value. 3. Education was provided for the dietary staff on 1-6-2015 on the procedure titled, "Nutritional Adequacy of Menus" and "Substitutes and Alternatives at Meal Times", and the "Resident Choice Menu List" with a focus on the need to provide residents that refused a food item offered substitutes of equally nutritional value. System Change: A. The Registered Dietician has assisted the DDS to update the "Resident Choice List" with additional items.	

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F 366	Continued From page 52 the facility served too much soup, specifically, at evening meals, and stated the alternate choice at meals was usually soup. . . ." During a confidential resident interview on 12/16/14 at 10:20 a.m., Resident G indicated the facility had cut back to one meat per meal and the alternate choice did not include a meat. - Resident #8's dietary card, dated 12/10/14, stated, "Dislikes: . . . Pork . . ." Observation of the noon meal, on 12/17/14 at 11:55 a.m., identified the scheduled entree of ham slices - indicated on the menu and a second choice of pork loin - not indicated on the menu. Observations showed the following: * 12:25 p.m.: a Certified Nursing Assistant (CNA) (#14) served Resident #8 her meal which included a large slice of ham. A CNA (#17) seated at the table spoke softly to the CNA (#14) and the CNA (#14) replied, "Oh, it's pork." The CNA (#14) then took the resident's plate back to the serving window and requested an alternative. Resident #8 stated she does not eat pork and would like turkey instead. * 12:30 p.m.: a dietary staff member (#5) informed a dietary manager (#2) of Resident #8's request. The dietary manager (#2) then went to the kitchen to prepare a turkey sandwich. Several minutes later, the manager (#2) called from the kitchen to inform staff the turkey was "outdated" and no other meat alternative was available. The dietary manager (#2) then prepared a bowl of tomato soup as an alternative for the ham. Observation at 12:40 p.m. showed a CNA (#15) served Resident #8 the tomato soup. During interview, on 12/17/14 at 3:30 p.m., a	F 366	B. A 24 hour a day available food list will be generated and displayed in the dining room of food items available for substitution. C. A copy of the policy regarding "Substitutes and Alternatives at Meal Times" has been posted in both kitchens. 4. An audit tool will be developed to monitor the availability of substitute foods for when residents refuse a food group to ensure it is replaced with an equally nutritional and texture substitute. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two	

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F 366	Continued From page 53 dietary manager (#2) agreed the tomato soup was not a comparable nutritional substitute for the ham served to Resident #8. This staff member (#2) stated other choices were available. When interviewed on 12/18/14 at 8:00 a.m. the dietary manager (#2) stated she was aware Resident #8 did not eat pork and stated staff could have substituted cottage cheese or a cheese sandwich for the ham.	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: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 2 of 2 kitchens (main floor and basement). Failure to ensure a clean environment, replace flooring, and ensure proper handwashing, placed residents, staff, and visitors consuming food items from the kitchens at risk for food borne illness. Findings include:	~~F 371~~ F-371	times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. F 371 1. The loose floor tile in the basement kitchen has been removed and is in the process of being replaced with a new floor. The can opener has been cleaned and placed on a routine cleaning	1/26/15

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F 371	Continued From page 54 Review of the facility policy and procedure, "Cleaning - Sanitation of Non-Food Contact Surfaces," occurred on 12/18/14. This document, dated February 2013, stated "PURPOSE, To provide guidelines for center non-food contact surfaces in the dietary department. . . . PROCEDURE . . . 8. Hoods and filters . . . b. Clean inside and out daily. c. Have a cleaning schedule in place for the hood either by a commercial company or the maintenance department. d. Schedule weekly cleaning of the filters, in the dishwasher or other method. . . . 10. Fans, a. Clean weekly or as needed. Place on scheduled cleaning program. . . . 14. Cabinets, drawers and counter tops, a. Clean and sanitize between uses and at the end of the day. . . . 15. Carts, a. Clean and sanitize at the beginning of the a.m. [morning] shift . . ." During the initial dietary tour, on 12/15/14 at 2:00 p.m., observation identified the following: - Basement kitchen - *Two areas of loose floor tile, irregularly shaped, approximately eighteen inches long and four inches wide, in the main traffic area. - Main floor kitchen - *A heavy stationary table mounted can opener with a large amount of dried debris on the opener. A dietary staff member (#24) reported "Don't know how long." since the staff used the can opener. *A floor fan with accumulated dust and debris on the blades, directed towards the food serving area. *Dishwasher area - a broken towel dispenser that required hand or arm contact to tear off the paper towel after handwashing. Observation on 12/16/14 at 10:25 a.m., in the	F 371	schedule, the fan on the floor was cleaned and placed on a routine cleaning, the broken towel dispenser has been fixed, the dishes are being air dried, and on the main floor a towel dispenser will be added near the sink to assist in proper hand washing. An outside company has been contracted to clean the exhaust hood above the stove. A cleaning company was hired to do a thorough cleaning of the kitchen cabinets and the convection oven. The upstairs kitchen nosey cups where rewashed, the plate rack was cleaned, the microwave oven was cleaned, the floor fan was cleaned, the towel dispenser was fixed, and the dishwasher ceiling vent was cleaned. The above listed items have been placed on a routine cleaning schedule.	

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F 371	Continued From page 55 dishwashing area, showed the following: *Dishes removed from the dishwasher, stacked, and ready for use per a dietary staff member (#24) - approximately ten wet plates, ten wet bowls, wet cups, and two plates with food debris. Observation on 12/17/14 at 12:30 p.m. in the main floor kitchen, showed the following: *A dietary staff member (#5) used the telephone, washed her hands at a sink, turned off the water with her bare hands, wiped her hands with a paper towel, dried her hands on her clothing, and donned gloves. The staff member (#5) resumed serving resident meals with utensils. Observation on 12/17/14 at 2:30 p.m., during the general dietary tour, identified the following: - Basement kitchen - *Exhaust hood above the stove - visible accumulated debris on the filters, palpable grease and debris on the hood above the stove. A dietary management staff member (#2) was uncertain of the cleaning schedule. *Cabinets throughout the kitchen - surfaces grimy to touch, accumulated material on the surfaces. *Convection oven - back of the oven covered with accumulated dust and debris *Two areas of irregularly shaped loose floor tile, as identified on the initial tour, on 12/15/14. - Main floor kitchen - *Six plastic nosy cups stacked, wet *Clean plate rack with plates ready for service, accumulated crumbs and debris on the rack *Microwave with dried material on the inside surface *Dirty fan directed toward the food serving area, as identified on the initial tour, on 12/15/14. *Dishwasher area - towel dispenser broken, as identified on the initial tour, on 12/15/14	F 371	2. All resident that eat meals at the center have the potential to be affected in this area. The facility will contract with a cleaning service two times per year to ensure thorough cleaning is completed. 3. System change: Cleaning sanitization lists have been updated to include the items identified above. Education was provided to the dietary staff on 1-6-2015. They were educated on the procedure titled, "Cleaning-sanitation of Non- food contact surfaces, Equipment sanitation, Cleaning schedules, Sanitation of Pots and Pans, and Dishwashing" with a focus on the need to have a clean kitchen. An All staff meeting was held on 1-14-2015 which included housekeeping	

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F 371	Continued From page 56 *Dishwasher area - ceiling vent above the clean dish area, with accumulation of dust and debris During interview, on 12/17/14 at 3:30 p.m., a dietary management staff member (#2), confirmed staff should not store dishes wet, turn off water with bare hands, or dry hands on their clothing. The staff member (#2) also confirmed staff should clean the areas and repair the flooring and towel dispenser.	F 371	and maintenance and they were educated on the items listed above in the upstairs and basement kitchens that were cited as needing to be cleaned. The DDS has developed a cleaning schedule for the items listed above to maintain kitchen sanitization. An outside company was contracted to replace the downstairs basement flooring. 4. An audit tool will be developed to monitor the cleanliness of the kitchen, including items cited above. The audit will be completed by the DDS, or designee, 3-5 times per week for one month, then one to two times a week for the next month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA	
F 428 SS=B	483.60(c) DRUG REGIMEN REVIEW, REPORT 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 pharmacist's drug regimen reviews, review of facility policy and procedure, and staff interview, the pharmacist failed to report drug regimen irregularities to the attending physician and director of nursing, for 1 of 1 sampled resident (Resident #5) with duplicate orders for an as needed (prn) anti-psychotic. Failure to report drug irregularities placed the resident at risk of receiving duplicate anti-psychotic medications.	~~F 428~~		

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F 428	Continued From page 57 Findings include: Review of the facility policy and procedure, "Pharmaceutical Services," occurred on 12/18/14. This document, dated September 2012, stated "PURPOSE, To provide appropriate and timely pharmacy service to residents. POLICY, Pharmacy services will be available at all times. These services will be provided to meet the needs of each resident . . . A licensed pharmacist will be employed or services obtained to: . . . 5. Report any irregularities to the attending physician or the director of nursing services or both. . . ." Review of Resident #5's medical record occurred on December 15-18, 2014. Current diagnoses included Alzheimer's disease and dementia. The resident's current physician orders included the following: *11/26/13, Haldol Solution (Haloperidol Lactate), "Inject 0.5 mg [milligrams] intramuscularly [IM] every 6 hours as needed for agitation . . . may give IM or PO [by mouth]." *01/25/14, Haloperidol Tablet, "Give 0.5 mg by mouth every 6 hours as needed for aggitation [sic] . . . May give IM or PO." Haloperidol (Haldol) is an anti-psychotic medication. Resident #5's medication administration record showed the facility did not administer the prn Haldol to the resident. During interview, on 12/17/14 at approximately 10:00 a.m., an administrative nurse (#1) provided the pharmacist's drug regimen reviews for the period January through November 2014. The medication reviews failed to identify the duplicate	~~F 428~~ F 428	committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. F-428- 1. Resident #5's individual needs have been met by discontinuing one of the duplicate PRN Haldol orders and the other order was decreased to one PRN Haldol order. The second was discontinued on 12-26-14. 2. All residents who receive medication have the potential to be affected in this area. The consultant pharmacist reviews each resident drug regiment every month. 3. Education will be provided to the nursing staff on 12-30-2014 to educate staff on the need to	1/22/15

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F 428	Continued From page 58 orders for the prn Haldol. During interview, on 12/18/14 at 9:30 a.m., an administrative nurse (#1) confirmed the drug regimen reviews failed to identify the duplicate orders.	F 428	look for the reminder pop up box in PCC that you are about to enter a duplicate medication order, to ensure we do not duplicate medication orders, especially PRN psychoactive medications. Education was provided to the pharmacy consultant on 12-24-14 on the citation and the need to not have duplicate physician orders. 4. An audit tool will be developed to review physician orders and/or EMAR for duplicate medications. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for one month, and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need for additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 59 (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: URINARY TRACT INFECTION: 1. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure staff followed infection control standards for 1 of 1 sampled resident (Resident #8) treated for a urinary tract infection without laboratory confirmation of an infection. Failure to ensure Resident #8 had an infection prior to initiation of antibiotic therapy placed the resident at risk of an antibiotic resistant infection. Findings include: The Long-Term Care Pocket Guide for Infection Control, January 2008, Health Care Compliance Company, Marblehead, Massachusetts, pages 13 - 21 stated, "Urinary tract infection (UTI) is a symptomatic infection that occurs anywhere in the urinary tract . . . Diagnosis: Because of the wide range of presenting symptoms, the misdiagnosis of UTI in the geriatric population ranges from approximately 20% to 40%. . . . A resident without an indwelling catheter should meet three or more of these criteria: * Fever (>38 [degrees] C [Centigrade]) or chills) * New or increased burning pain on urination	~~F-441~~ F-441	the first year to assure continued compliance. F-441 **Part 1 Urinary Tract Infection** 1. Resident #8's individual needs have been met as she is no longer having signs or symptoms of an active urinary track infection. 2. All residents with physician orders for a urine analysis and urine culture have the potential to be affected in this area. A list of residents with physicians orders for u/a's will be generated and reviewed to ensure the culture results are received back before starting a resident on an antibiotic. System change: A. A lab book has been established to record all lab orders and the HIM will check the book M-F to ensure a urine analysis and urine culture report is received back to the center on a timely basis. B. The lab that we frequently use was	1/22/15

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F 441	Continued From page 60 * New flank or suprapubic pain or tenderness * Changes in character of urine, and worsening mental function . . . All long-term care facilities should develop, adopt, and adhere to an evidence-based policy for identifying and managing potential urinary tract problems. . . . Reporting to the physician: Notifying the physician of laboratory values is the responsibility of the long-term care facility. Do not assume the laboratory will make physician notifications. . . ." Review of the facility policy "Urogenital Tract Infections" occurred on 12/18/14. The policy, dated June 2012, stated, "PURPOSE: To provide information on urogenital tract infections. . . . Signs symptoms: * Suprapubic pain * Urethral burning * Urgency * Frequency * Dysuria (painful urination) * Fever, chills or sweats in severe infections * Confusion * Change in behavior * Falls . . ." Review of Resident #8's medical record occurred on December 17-18, 2014. A quarterly Minimum Data Set, dated 10/25/14, identified the resident required extensive assistance with toilet use and personal hygiene and had occasional incontinence of urine. A "FAX Communication To Physician," dated 10/12/14, stated, "Resident reports increased incontinence. C/O [complains of] buttocks itching. Providing more incontinence cares & [and] applying protective ointment. Resident having	F 441	contacted and they will change their procedure of communicating with us to assist us. 3. Education was provided to the nursing staff on 12-30-2014 to educate staff on the procedures titled "Urogenital Tract infection" with a focus on the need to physician orders for urine analysis and urine culture is received back before staff start antibiotic therapy. 4. An audit tool will be developed to monitor urine lab testing to ensure urine analysis and urine culture lab results are returned before starting antibiotic therapy. The audit will be completed by the HIM, or designee, 3-5 times per week for one month, then one to two times a week for next month, and then monthly for two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of	

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F 441	Continued From page 61 increased confusion/forgetfulness. Please Advise. . . ." The physician's response, dated 10/13/14, identified orders for Doxycycline (an antibiotic) and to send a urinalysis (urine sample) to the lab. The record showed the orders signed as "received and observed" on 10/14/14 at 1:46 p.m. Record review failed to identify results of the urinalysis. Resident #8's nursing progress notes identified the following: 10/16/14 at 2:18 a.m.: "resident is afebrile [no fever]. Resident started antibiotic doxycycline 100 mg [milligrams] po [orally] bid [twice a day] for the next week for UTI. Resident has not reported any voiding concerns. Staff has not reported any foul odor or clarity problems with urine. Antibiotic and UA [urinalysis] ordered due to increased incontinence and confusion. UA was obtained this pm [afternoon] but needed to be discarded due to CNA [Certified Nursing Assistant] dropping it and possible contamination. Will pass on for am [morning] shift to obtain UA with micro [microscopic] and send to the lab." 10/16/14 at 9:32 p.m.: "Resident continues on antibiotic doxycycline for UTI. Resident has not voiced any voiding concerns and staff has not reported any foul odor or clarity problems with urine. Unable to get urine sample this shift do [sic] to resident 'just peed' and couldn't go again, then the lab was closed." The record lacked evidence staff obtained the urine sample or informed the physician that staff had not sent a urinalysis to the lab and that the resident had no symptoms of a UTI (such as burning, frequency, fever, chills, etc). During an interview on the morning of 12/18/14,	F 441	additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. **Part II Wound Care and Dressing Changes** 1. Resident #2's dressing change is being done per procedure with a clean surface for the extremity to sit on during the dressing change. 2. All residents with wound care or dressing changes has the potential to be affect in this area. A list of resident with a wound or dressing change will be used for random audits on staff regarding their performance of providing a barrier during wound or dressing changes. 3. Education was provided to the nursing staff on 12-30-2014 to educate staff on the procedures titled,	

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F 441	Continued From page 62 an administrative nurse (#1) stated staff did not obtain an second urine sample after discarding the first sample. Failure to obtain a second urine sample and continuing the antibiotic therapy without confirmation of an infection placed Resident #8 at risk of obtaining an antibiotic resistant infection. WOUND CARE/DRESSING CHANGE 2. Based on observation, record review, review of facility procedure, and staff interview, the facility failed to ensure staff followed infection control procedures for 1 of 1 sampled resident (Resident #2) observed during a pressure ulcer dressing change. Failure to ensure wound drainage did not spread to Resident #2's pressure reducing boot and bed comforter resulted in contamination of those items. Findings include: Review of the facility's procedure titled "Wound Dressing Change" occurred on 12/18/14. This procedure, dated September 2012, stated, ". . . Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. . . ." Review of Resident #2's medical record occurred on all days of survey and included diagnoses of open wound to foot. The December 2014 Medication Review Report identified a foam dressing change to the right heel every three days. Observation on 12/17/14 at 2:00 p.m. showed a nursing staff member (#12) changed Resident	F 441	"Wound Dressing Change" with a focus on the need to provide a barrier when performing wound care or dressing changes. 4. An audit will be developed to monitor if staff are providing a barrier when performing Wound Care or dressing changes. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for one month, and then monthly for two month additional months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the	

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F 441	Continued From page 63 #2's right heel pressure ulcer dressing while the resident remained in bed on her left side. Without placing a barrier beneath the right heel, the nurse: * Lifted the right foot and removed the soiled dressing * Placed the right foot on top of the blue pressure reducing boot on the resident's left foot (with the open wound), disposed of the dressing, and performed hand hygiene. Bloody drainage from the ulcer stained the blue boot. * Placed the right foot behind the resident's left foot and on top of the bed's comforter where a small smear of bloody drainage stained the comforter. * Lifted the right foot, cleansed, and measured the wound. Dried skin surrounding the wound area sloughed off and dropped onto the resident's comforter. * Completed the dressing change, placed a clean blue boot on the left foot, and called for a CNA to transfer the resident to her wheelchair. During an interview on 12/17/14 at 2:30 p.m., an administrative nurse (#1)indicated nursing staff failed to place a towel or soaker pad barrier under Resident #2's right foot to prevent drainage or debris from contaminating the blue boot and comforter. HAND HYGIENE 3. Based on record review, review of facility procedure, and staff interview, the facility failed to ensure staff followed infection control procedures for 1 of 1 sampled resident (Resident #2) observed during the resident's personal care. Failure to ensure staff perform proper hand hygiene increases the risk of infection to	F 441	first year to assure continued compliance. **Part III Hand Hygiene** 1. Resident #2's individual needs have been met as staff are washing hands according to procedure. 2. All resident have the potential to be affected in this area. By reviewing our procedures and educating our staff will prevent other residents from being affected in this area. 3. Education will be provided to the nursing staff on 12-30-2014 to educate staff on the procedures titled, "Perineal Care" with a focus on the need for staff to remove gloves, and wash hands and then change their gloves during the provision of perineal care, and again after they pull up resident pants. Staff will wash their hands	

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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 441	Continued From page 64 residents and staff. Findings include: Review of the facility's procedure titled "Perineal Care" occurred on 12/17/14. This procedure, dated November 2013, stated, ". . . 3. Perform hand hygiene and put on gloves. (If additional supplies are needed during perineal care, remember to remove soiled gloves, wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care.). . . ." Review of the facility's procedure titled "Hand Hygiene and Handwashing" occurred on 12/17/14. This procedure, dated November 2014, stated, ". . . use an alcohol-based hand rub for routinely cleaning your hands: . . . After removing gloves. . . ." Review of Resident #2's medical record occurred on all days of survey. An admission MDS, dated 10/22/14, identified extensive assistance with bed mobility, transfers, and personal hygiene and frequently incontinent of bowel and bladder. Observation on 12/16/14 at 5:30 p.m. showed a CNA (#11) entered Resident #2's room and: * Washed hands and donned clean gloves * Positioned the resident on her right side and proceeded to remove the soiled brief and the soiled pressure ulcer dressing from the right buttock * Cleansed the area with pre-moistened wipes * Removed the dirty gloves and without performing any hand hygiene, donned a clean pair of gloves * Placed a clean brief on the resident	F 441	again before leaving the resident's room. 4.An audit tool will be developed to monitor if the nursing staff did proper hand washing between perineal care and redressing. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for next month and then monthly for the next two months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. F-507 1. Resident #8's individual needs have been met as	F-507 1/22/15

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F 441	Continued From page 65 * Removed her gloves * Pulled the residents pants up * Donned a new pair of gloves * Emptied and tied up the trash bag * Removed her gloves and then used hand sanitizer During an interview on 12/17/14 at 2:30 p.m., a nurse administrator (#1) verified staff should perform hand hygiene after removing gloves during resident personal care.	~~F 441~~	the resident is without signs and symptoms of a urinary tract infection. 2. All residents with physician order for urine analysis and culture have the potential to be affected. All identified residents will be reviewed to ensure the lab results have been received by the facility. System change: A lab book has been created to track the date the lab was ordered and the date the results were received back. 3. Education was provided to the nursing staff on 12-30-2014 to educate staff on the need to track urine analysis orders and the date the report was received back to the facility. 4. An audit will be developed to monitor that if staff are tracking in the lab book the date of the physician order and the date the results were received back to the facility. The audit will be	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on record review and review of professional reference, the facility failed to ensure staff promptly filed results of laboratory tests ordered by the physician on the medical record for 1 of 2 sampled residents (Resident #8) with a history of urinary tract infections. Failure to promptly obtain and file culture results placed the resident at risk of obtaining an antibiotic resistant infection. Findings include: The Long-Term Care Pocket Guide for Infection Control, January 2008, Health Care Compliance Company, Marblehead, Massachusetts, pages 13 - 21 stated, "Urinary tract infection (UTI) is a	~~F 507~~		

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F 507	Continued From page 66 symptomatic infection that occurs anywhere in the urinary tract . . . Reporting to the physician: Notifying the physician of laboratory values is the responsibility of the long-term care facility. Do not assume the laboratory will make physician notifications. . . ." - Review of Resident #8's medical record occurred on December 17-18, 2014 and identified, 09/02/14, the physician ordered a urinalysis (urine test) for symptoms of vaginal itching for the past 4 days. The record showed, on 09/05/14, the physician ordered Cipro (an antibiotic) 250 milligrams twice a day for three days for "Urinary Tract Infection." A urinalysis report, dated 09/05/14, showed 20-50 white blood cells (an indication of an infection). However, a urine culture, dated 09/11/14, showed "Mixed uro-genital flora," an indictor of possible contamination of the urine sample. The record showed the lab faxed the culture results to the facility on 11/13/14 (two months after completion of the testing). The record lacked evidence facility staff contacted the lab at any time during those two months to obtain the culture results.	F 507	completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for one month, and then monthly for the next months. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F-514 1. Resident #8's individual needs have been met as documentation indicates she has had no residual injuries and has returned to baseline since the fall on 9-14-2014. Resident #6's individual needs have been met by RD	1/22/15

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F 514	Continued From page 67 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete and accurate clinical records for 2 of 2 sampled residents (Resident #6 and #8) with inaccurate records. Failure to accurately record Resident #6's weights limited the facility's ability to determine the severity of weight loss and effectiveness of interventions. Failure to include information regarding Resident #8's fall limited the facility's ability to track and trend falls and monitor the resident's status. Findings include: - Review of Resident #6's medical record occurred on December 15-18, 2014. Current diagnoses included adult failure to thrive and weight loss. Resident #6's weight records showed a continued weight loss from 152 pounds on 10/09/13 to 106.6 pounds on 12/10/14. The records show weights of 114.4 pounds on 10/13/14 and 103.6 pounds on 10/23/14, a 10.8 pound loss (9.4%) in ten days. The medical record did not identify an acute illness or an attempt to re-weigh the resident on 10/23/14. During interview, on 12/18/14 at 9:30 a.m., an administrative nurse (#1) agreed Resident #6's weight record showing a 10.8 pound weight loss	F 514	review of her meal intake and nutritional status and a progress note indicating review and updated status. Resident expired 1/19/15. 2. All residents with incident/accident or with significant weight loss have the potential to be affected in this area. Any incident or accident will have an incident report started and documentation will be completed on the incident. A list of residents with significant weight loss was generated. The Registered dietician will make a progress note on their nutritional status and reason for weight loss. 3. Education was provided to the nursing staff on 12-30-2014 on the completion process for incidents and for the need to start neuro checks according to procedure if a resident hits their head. The incident report will identify the location or circumstances of the fall, the resident's vital signs at that time, or that the resident had hit her head	

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F 514	Continued From page 68 (9.4%) in ten days was questionably accurate and the staff should have re-weighed the resident. - Review of Resident #8's medical record occurred on December 17-18, 2014. A "FAX Communication to Physician," dated 09/04/14 at 10:00 p.m., stated, "Resident fell to floor @ [at] 2045 [8:45 p.m.] transferring self. No apparent injuries - Doing neuros [neurological checks] due to report of hitting head - All WNL [within normal limits]. VS [vital signs] WNL. Will obs. [observe]." Review of nursing progress notes for 09/04/14 failed to identify any documentation regarding the fall or the resident's possible head injury. When requested, during an interview on 12/18/14 at 9:00 a.m., an administrative nurse (#1) provided an incident report (not part of the medical record), dated 09/04/14, which identified Resident #8 had an unwitnessed fall on 09/04/14 at 8:45 p.m. The report failed to identify the location or circumstances of the fall, the resident's vital signs at that time, or that the resident had hit her head during the fall.	F 514	during the fall. Incident documentation will be completed by staff Neuro checks will be completed according to facility procedure. And residents with significant weight loss will have a food first approach for nutritional supplement, ie fortified foods. 4. An audit tool will be developed to monitor incident/accident reports documentation to ensure it includes the location or circumstances of the fall, the resident's vital signs at that time, or that the resident had hit her head during a call and that follow up documentation needed. Neuro checks will be completed per procedure. An audit tool will also be developed to monitor residents with significant weight loss to ensure a progress note has been written by either the registered dietician or DDS to address the weight loss and nutritional needs. The audit will be completed by the DNS, or designee, 3-5 times per week for one month, then one to two times a week for one month, and then monthly for the next two months. If concerns are	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	~~F 520~~		

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F 520	Continued From page 69 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to ensure 1 of 2 required members (a physician) actively participated as a member of the Quality Assurance (QA) committee, failed to ensure the QA committee identified and addressed quality issues, and failed to develop and implement plans of action to correct deficient practice and sustain compliance with federal requirements as evidenced by repeat citations at F280, F314, F364, and F365. Findings include: When interviewed, during the entrance conference on 12/15/14 at 2:00 p.m., a QA staff member (#16) stated "it's been a struggle" to get the physician to attend QA committee meetings. On 12/18/14 at 12:30 p.m. the staff member (#16) stated the physician has not attended QA	F 520 F 520	identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance. F-520 1. Resident individual needs were affected in F 280, F 314, F 364, and F365 and interventions were documented in those tabs. 2. All residents have the potential to be affected in this area. Staff will be educated on regulation F 520, Quality Assurance and Improvement. This will ensure the safety and quality of care for our residents. A Quality Assurance meeting will be held next on 1-22-2015 and the required members will be present including the medical director. 3. Education was provided to all staff on 1-14-2015 and to the quality members on 1-22-2015 to educate staff on the Quality Assurance process and the need to complete audits that are assigned, the need to ~~identify issues utilizing the root~~	1/30/15

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F 520	Continued From page 70 meetings for the past year. Failure to effectively implement the QA program resulted in the facility not sustaining compliance with the following repeat deficiencies: F280: reviewing and revising residents' care plans F314: preventing and healing pressure ulcers F364: palatable food at proper temperatures F365: food prepared in a form to meet individual needs	F 520	cause analysis process for improvement. Education was provided by an [redacted] RN from the Good Samaritan National Campus to the DNS, Adm., and social services director on the Quality Meeting Members requirements with a focus on the need to have the medical director present at least 4 quarterly meetings per year. The administrator or DNS will meet with Medical Director [redacted] on 1-22-15 on his scheduled rounds to review the Quality Assurance physician requirements of the need to attend 4 meeting per year. The committee will also continue to look at survey audit results at least quarterly for the first year to assure continued compliance. Changes will be made as needed to correct any deficit practices found. 4. An audit tool will be developed to monitor the required meeting members, including the medical director, DNS, and at least three other staff members are present at least quarterly. The meeting agenda and minutes will be audited monthly for one year to ensure quality issues are addressed and plans of actions are implemented and the need to prevent the reoccurrence of repeat deficiencies. The QA meeting agenda and minutes will be audited monthly for one year, the audit will be completed by the QA coordinator, or	1/23/15 1020 c adm JO 1/23/15 1020 c adm JO

designee. If concerns are identified corrective action will be taken. All results of the audits will be reported to the QA committee for further recommendations and/or the need of additional audits. In addition, the QA committee will review the 2015 state survey once a quarter for the first year to assure continued compliance.

F-371

Addendum to F-371

1/22/15

Staff member #5 and all dietary staff were educated on proper handwashing procedures on 1-6-15. Staff were again educated at an All Staff meeting regarding proper handwashing on 1-14-2015. In addition, a towel dispenser was added to the sink area.