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

PRINTED: 10/19/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 10/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/05/09 and completed on 10/08/09, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 5 residents added to verify specific concerns during the survey.	F 000		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the most recent life-safety survey results were available for examination by residents for 4 of 4 days (October 5 - 8, 2009) of survey. Findings include: Observation on October 5 - 8, 2009, showed a designated binder containing past survey results located on a table in the entrance of the facility. Review of the binder indicated the facility did not include the most recent life-safety survey results dated 07/20/09.	F 167		

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

Administrator 10-30-09

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 10/05/09 and completed on 10/08/09, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 5 residents added to verify specific concerns during the survey.	F 000	**This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.**	
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the most recent life-safety survey results were available for examination by residents for 4 of 4 days (October 5 - 8, 2009) of survey. Findings include: Observation on October 5 - 8, 2009, showed a designated binder containing past survey results located on a table in the entrance of the facility. Review of the binder indicated the facility did not include the most recent life-safety survey results dated 07/20/09.	F 167	**F 167** **1. The 2008 Life Safety Code was not posted due to the 2008 Life Safety audit resulted in no deficiencies or areas of correction. The 2008 Life Safety report was posted immediately once the ND State Surveyor verbalized concerns regarding the code not being posted.** **2. Any resident or individual with access to the facility's Life Safety Code would have the potential to be affected.** **3. Per facility protocol, Elim Rehab & Care Center will post the Life Safety Code results each year, even if no citations are made by the examiner.**	

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F 167	Continued From page 1 During interview on 10/07/09 at 8:00 a.m., a management staff member (#6) verified the facility failed to post the most recent life-safety survey results.	F 167	**4. The Director of Social Services will audit the information packets that are placed at the entrance of the facility quarterly to verify the Life Safety Code if posted. The Director of Social Services will take immediate corrective action if concerns are identified. The Director of Social Services will submit a report to the Quality Assurance Manager, Betsy Boyle, quarterly.**	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to assess factors/circumstances contributing/causing the aggressive behavior and failed to establish/implement preventative interventions for 1 of 1 sampled resident (Resident #9) identified as exhibiting aggressive behavior toward other residents, and failed to establish a specific plan/criteria for implementation of punitive measures in response to behavior exhibited by 1 of 1 sampled resident (Resident #15) in the secure dementia unit. Findings include: -Review of Resident #9's medical record occurred October 5-8, 2009, and showed the facility admitted the resident to the secure dementia unit on 03/14/07, and diagnoses included: dementia, depressive disorder, and anxiety state. A significant change Minimum Data Set (MDS) completed 12/19/08 and an annual MDS review completed 03/19/09, showed Resident #9	F 250	**5. See "Completion Date" column.** **F250** **1. For resident #9, further interventions will be created and reflective in resident's medical record that assess factors/ circumstances contributing to aggressive behaviors and further establishment of preventative interventions to prevent/minimize the occurrence of aggressive behavior.** **For resident #15, the removal of resident's TV for purpose of behavior modification is no longer utilized. The resident's guardian had requested the TV removal intervention be used as a behavior**	11/12/09

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F 250	Continued From page 2 exhibited physically abusive behavior during both assessment periods. Resident #9's nurses notes included the following: *06/14/09 - " . . . aggressive behaviors noted toward other resident, unable to re-direct. PRN [as needed] Ativan given with fair results." *06/16/09 - " Resident grabbed another female resident by the hair this am, unable to redirect. Resident let go almost instantaneously." *07/02/09 - " Struck out at another resident and pulled her hair. Removed from area." *07/06/09 - " . . . Resident was then in the lounge area and went and sat on couch next to another female. She then began slapping her, moved to another area of living room. . . ." *07/12/09 - " . . . Got into an argument with another resident and struck her on the arm. Staff attempted to redirect resident to her room but were unsuccessful, Resident again aggressively went toward the other resident. Resident removed from situation and PRN Ativan administered. . . . " *07/18/09 - " . . . Thought another resident had her sweater on, and was going to get it off her. . . ." *08/01/09 - " Resident resistive to cares and very combative towards staff and residents. Resident was slapping, punching, swinging blankets at people and spitting on people. Resident was screaming at staff and residents as well. PRN Ativan given." *08/26/09 - " . . . Grabbing onto other residents, and yelling at them. Staff intervened but resident could not be redirected. Grabbed onto several residents a couple different times. . . . PRN Ativan IM [intramuscular] given with some relief." The record lacked evidence of assessment of the	F 250	**modification technique, although the IDT has determined this is not an effective behavior modification invention. Education has been provided to the guardian. The removal of resident's TV for behavioral modification is not long a part of resident's plan of care.** **2. All residents have the potential to be affected by aggressive behaviors of other residents and the potential for punitive consequence.** **3. Nursing staff will be in-serviced regarding aggressive behavior and the creation/establishment of preventative interventions to minimize the occurrence of aggressive behavior and managing behavior without the use of punitive consequences on November 2, 2009. Further education opportunities will be ongoing. The Nursing Department will be educated on appropriate charting, assessment and implementation of preventative interventions regarding aggressive behaviors. The sited behavior modification technique has been revoked. The dementia care unit**	

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F 250	Continued From page 3 above described aggressive behaviors towards other residents, including assessment of patterns/trends (time, place, person(s) involved), mood/mental state prior to behavior, environmental factors, and unmet care needs. The lack of assessment of causative/contributing behavioral factors does not allow for planning and implementation of approaches/interventions to prevent/minimize the occurrence of the aggressive behavior, and does not provide sufficient information to establish the predictability of the behavior. Resident #9's current plan of care included the following: "Problem - Behavior problem r/t [related to] dementia, anxiety, and agitation - wandering - occasional verbal and physical aggression toward staff - occasional aggression toward other residents or her husband - disruptive behaviors, hollering out, noisiness - resisting cares. Goal - Resident will respond positively to redirection from staff when displaying behaviors. Approaches - . . . If resident is upset with another resident, attempt to redirect her away from situation. If unable to remove her, sit between residents, as she generally then will calm and will eventually walk away from situation on her own." The current plan of care included no approaches to prevent Resident #9 from exhibiting aggressive behavior towards other residents, nor did the plan of care include measurable goals to decrease/prevent the aggressive behavior from occurring, and prevent harm/injury to Resident #9 and other residents. An interview occurred on the afternoon of 10/06/09 with a social services staff member (#2) for purposes of requesting additional information	F 250	**will have additional training on behaviors that are commonly associated with residents in a secured special care unit during their quarterly meetings.** **4. The Director of Social Services will monitor resident #9 progress notes to ensure appropriate measures have been utilized (assessment, circumstances, interventions) if resident has demonstrated aggressive behaviors. The Director of Social Services will audit resident #9's progress notes every week x 6 months. A behavior team will also be created involving the IDT to review residents who are at risk for aggressive behaviors. The IDT will also review and discuss approaches to reduce behaviors without punitive consequences. This team will be created by October 30, 2009 and will meet weekly starting November 2, 2009. If concerns are identified, immediate corrective action will be implemented. The Director of Social Services will submit a report to the QA manager, Betsy Boyle.**	

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F 250	Continued From page 4 relative to assessment of Resident #9's aggressive behavior towards other resident's, including specific planned approaches to prevent/minimize the occurrence of the aggression. The facility did not provide additional information. -Observation at 11:45 a.m. on 10/06/09, showed Resident #15 enter the dining room, approach a certified nurse assistant (CNA) and ask, "Where's my TV?" The CNA replied, "I took your TV, you will get it back on Thursday." Resident #15 asked, "Why?" and the CNA replied, "Because you weren't very nice to me this morning." Resident #15 asked, "What did I do?" The CNA responded, "You said 'I don't give a damn,' and you weren't very nice to me." Resident #15 replied, "I said that?" The CNA responded, "Yes, so I took your TV, and you still haven't shaved your face." Observation of Resident #15's room at approximately 11:55 a.m. on 10/06/09, showed the resident's TV had been removed. An interview occurred with Resident #15 at 2:30 p.m. on 10/07/09. Resident #15 stated, "I like TV . . . I have a TV in my room, but they took it . . . I get it back tomorrow. . . they took it because I said 'I don't give a damn,' I was naughty, so, they took it. . .. they [staff] take it away lots of times, it makes me mad." Review of Resident #15's medical record occurred October 7-8, 2009, and showed the facility admitted Resident #15 to the secure dementia unit on 11/2007, and the resident's diagnoses included: mental retardation, dementia, depressive disorder, and mood disorder. Resident #15's most recent quarterly MDS, completed 08/26/09, identified the resident	F 250	**5. See "completion date' column.**	11/12/09

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F 250	Continued From page 5	F 250		

exhibited not easily altered persistent anger less than daily, and activity preferences included "watching TV."

Resident #15's current plan of care included: "Problem, Behavior problem r/t dementia, MR [mental retardation], depression, and mood disorder, socially inappropriate disruptive behavior, socially inappropriate hoarding/stealing other people's items, refusing to give back, swearing at staff, calling staff names. Goal: Resident will respond positively to redirection from staff when displaying behaviors. Approaches: . . . Niece has given guidelines for rewards and consequences to use for resident's behaviors. Consequences include taking away her TV for 3 days at a time. Remove TV from her room and inform her of why consequence is appropriate. 10 and 15 minute time-outs also offered as option. Rewards for good behavior include ice cream, a can of pop, posting her coloring pages on the fridge, and picking out a movie to watch."

Nurses notes included the following entry dated 07/30/09, "Received word from staff that niece [name] did not want to have TV taken away anymore as a consequence to negative behavior. Call was placed to [name of niece] to clarify. [name of niece] stated it is still okay to take the TV away for significant inappropriate behaviors, but she feels that if it is taken away too often for minor infractions, [Resident #15] will become accustomed to not having a TV and it won ' t mean anything anymore. Staff updated."

The record included no specific guidelines/criteria identifying specific circumstance and/or behavior for which the above consequences would be

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F 250	Continued From page 6	F 250		

imposed, what approaches would be utilized/implemented prior to removal of the TV, who had decision making authority to remove the TV, no evidence of Resident #15's involvement in the plan of care or understanding of the consequences associated with a clearly defined specific behavior, and no evidence of Resident #15's agreement to the plan of care. The above referenced plan of care included only staff related goals, and included no resident specific, measurable goals to minimize/prevent significant target behavior(s).

Nurses note dated 10/06/09 at 1:14 p.m. stated: "Resident had a lot of behaviors this morning. Resident took very long time to get ready as she was playing around in BR [bathroom]. Redirection unsuccessful. Another resident was waiting to use restroom but had difficulty getting resident out of BR. At lunch, resident was busy with posters instead of eating meal. Explained to her that she needed to eat, otherwise her TV would be removed from her room for 3 days. Resident continued with behaviors. TV removed from room."

Observation showed Resident #15's TV had been removed from her room prior to lunch on 10/06/09. Observation, on 10/06/09, also showed the following: Resident #15 shares an adjoining bathroom with Resident #9. At 10:15 a.m. on 10/06/09, observation showed a CNA (#1) entered Resident #9's room to assist Resident #9 to the bathroom. Observation showed Resident #9 asleep on her bed, and Resident #15 in the bathroom placing toiletry items into a washbasin. The CNA informed Resident #15 she needed to "get out of the bathroom so [Resident #9] could use it - You [meaning Resident #15] have been in

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here for an hour, and you haven't shaved your face yet this morning." (Resident #15 had been observed approximately 20 minutes earlier crawling on the floor in her room) Resident #15 responded verbally, however not loud enough to distinguish what she said. Resident #15 continued for 2-3 minutes to place toiletry items in the washbasin. The CNA (#1) then carried the washbasin into Resident #15's room, and Resident #15 left the bathroom. The CNA then awakened Resident #9, and assisted her to the bathroom.

Observation during the lunch meal on 10/06/09 showed Resident #15 seated at a table with seven other residents in the secure dementia unit. Upon being served her meal, Resident #15 indicated she did not want what she was served, but wanted "Soup." A CNA (#1) responded, "You like this, taste it, and if you don't like it I will get you soup." Observation showed Resident #15 began eating the meal as served, and at the time the surveyor left the dining room twenty minutes later, observation showed Resident #15 continuing to eat. Prior to the surveyor leaving the dining room, staff did not interact further with Resident #15.

An interview occurred at 4:20 p.m. on 10/07/09 with a social services staff member (#2) regarding the removal of Resident #15's TV, and to request additional information regarding specific guidelines/criteria for imposing the consequences of removal of Resident #15's TV. The staff member (#2) indicated she knew staff had removed Resident #15's TV 10/06/09, because the TV had been placed in his/her office. The staff member (#2) indicated the facility did not develop specific criteria/guidelines for staff to

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F 250	Continued From page 8 follow prior to, and upon removal of Resident #15's TV. The staff member (#2) stated, "At first, we only removed the remote control, but [Resident #15] would become angry and try to push the TV off the table, so we started to remove the TV." The lack of specific guidelines/criteria for imposing consequences in response to Resident #15's behavior, allows staff to impose punitive consequences for behavior commonly associated with residents who reside and require services in a secure special care unit. Failure to manage Resident #15's behavior without the use of punitive consequences does not allow the resident the opportunity to benefit from quality of life leisure/recreational activity, and does not allow the resident to fully maintain/attain her maximum over-all psychosocial well-being.	F 250		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, review of professional literature, information provided by a complainant, and staff interview, the facility failed to follow professional standards and facility policy for medication administration for 1 of 3 closed resident records (Resident #22) reviewed. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, and Practice," 8th Edition,	F 281	**F281** **1. Resident #22 is no longer at the facility.** **2. All residents, who are admitted, have the potential to be affected.** **3. All RN's, LPN's & TMA's will be in-served on November 2, 2009 regarding the policy "Medication Administration-General." This policy was reviewed with no changes noted. The current procedure for getting medication to the facility in a timely manner is being reviewed with the consultant pharmacist. If applicable, any**	

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F 281	Continued From page 9 dated 2008, page 850 stated, "Ten 'Rights' of Medication Administration . . . Right Documentation . . . If a medication is not given, follow the agency's policy for documenting the reason why. . . ." Review of the facility policy and procedure titled "Medication Administration- General" occurred on 10/08/09. The policy, dated May 2007, stated, "DOCUMENTATION: 1. The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. . . . 6. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. [such as] resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN [as needed] documentation. If two consecutive doses of a vital medication are withheld or refused the physician is notified." - Written correspondence from a complainant, received by the State Survey Agency on September 29, 2009, included an allegation that on the date of her admission, the facility "did not have all required meds [medications]" available for Resident #22.	F 281	**change(s) will be added to the "Pharmacy-Ordering and Receiving Medications" policy and all RN's, LPN's and TMA's educated as to those changes. Any changes in policy would be audited in the same manner.** **4. The Quality Assurance Coordinator will audit new admissions after November 2, 2009 to assure that policy is being followed and medications provided in a timely manner. She will conduct random audits for correct documentation and timeliness of receiving medications on new admissions weekly x1 month, monthly x 3 months and quarterly thereafter for one year. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to Quality Assurance Committee at each scheduled meeting.** **5. See "completion date" column.**	11/12/09

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(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 281	Continued From page 10 Resident #22's closed medical record, reviewed October 7-8, 2009, identified the facility admitted the resident on 05/11/09 with diagnoses including Churg Strauss syndrome, transient cerebral ischemia, renal failure, hypertension, hypothyroidism, asthma, and recent below knee amputation of the left leg. Physician's orders, dated 05/11/09, included the following medications and diagnoses: Prednisone 10 milligrams (mg) twice a day at 8 a.m. and 8 p.m. for asthma Azmacort inhaler four puffs twice a day at 8 a.m. and 8 p.m. for asthma Synthroid 100 micrograms daily at 8 a.m. for hypothyroidism Lisinopril 20 mg daily at 8 a.m. for hypertension Multiple vitamin with minerals one daily at 8 a.m. for generalized pain Potassium Chloride 10 milliequivalents daily at 8 a.m. for hypertension Demadex 10 mg daily at 8 a.m. for hypertension Vitamin E 400 units daily at 5 p.m. for generalized pain Lactulose 10 grams three times a day at 8 a.m., 2 p.m., and 8 p.m. for constipation Review of Resident #22's MARs identified the following: On 05/11/09: Vitamin E 5 p.m. dose and Prednisone 8 p.m. dose - initials circled as not given Azmacort and Lactulose 8 p.m. doses - initials circled, crossed out, and rewritten beside circled initials For the 05/11/09 medications, staff failed to record a reason for the missed doses or to clarify the crossed out and rewritten initials. On 05/12/09: Azmacort, Synthroid, Lisinopril, Multiple Vitamin,	F 281		

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F 281	Continued From page 11 Potassium Chloride, Demadex 8 a.m. doses initials circled as not given Vitamin E 5 p.m. dose initials circled as not given Prednisone and Novolog insulin 8 a.m. doses initials circled, then rewritten directly over the circled initials For the 05/12/09 medications, staff failed to record a reason for the missed doses of medication or to clarify the rewritten initials. During an interview on 10/08/09 at 9:10 a.m., an administrative nurse (#15) stated when the facility admits a resident from a hospital, medications do not come with the resident and there may be times when the medication would not be immediately available for administration. Record review failed to identify the reason staff did not administer medications with the circled initials on the May 11 and 12, 2009. It could not be determined from the circled, crossed out, and rewritten initials if staff did or did not administer those medications.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM SURVEY COMPLETED ON 10/09/08	F 309	**F309** **1. For resident #11, as with all residents, BM's are monitored each shift. Review of past Medication Administration Records indicate minimal use of PRN laxatives/suppositories indicating little problem with the current plan or a need to change it. There were no other incidences of resident #1 requiring removal of stool or that stool was hard indicating this was an isolated event and bowel records show she resumed her normal bowel pattern**	

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F 309	Continued From page 12 Based on record review, staff interview, review of facility policy and procedure, and review of professional literature, the facility failed to ensure 1 of 2 sampled residents (Resident #11) with a diagnosis of constipation received effective interventions to maintain normal bowel elimination patterns to prevent constipation and the need for manual removal of stool. This failure resulted in Resident #11 experiencing discomfort related to manual extraction of a large quantity of hard formed stool. Findings include: Berman, Snyder, Kozier, Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th edition,Pearson Education, Inc., New Jersey, pages 1328-29, stated; "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . Many causes and factors contribute to constipation. Among them are the following: . . . Poor motility or slow transit, emotional disturbances such as depression or mental confusion, and medications such as opioids, . . . and antidepressants. Fecal impaction is a mass or collection of hardened feces in the folds of the rectum. . . . " Taylor, Lillis, LeMone, "Fundamentals of Nursing, The Art and Science of Nursing Care," 4th edition, J.B. Lippincott Company, Pennsylvania, pages 1185 and 1204, stated, ". . . Constipation is often a chronic problem for older adults . . . fecal impaction . . . can also result from physiologic or lifestyle changes . . . Most people have individual regular patterns or bowel elimination involving frequency . . Changes in any of these may upset a person's routine and lead to constipation. . . .	F 309	**following this. The Interdisciplinary Team determined no further interventions or changes in interventions were needed based on the BM record. It is important and worthy to note that in the "Summary Statement of Deficiencies" there are several sources quoted regarding constipation as it relates to fecal impaction. A true fecal impaction is defined by " . . . obtaining a hospital record indicating an x-ray or physician's statement pointing to a digital rectal exam. . . ." (See attachment). Therefore, there is no evidence to support the inference of fecal impaction.** **2. All residents have the potential to be affected by constipation.** **3. The current policy and procedure for "Bowel Management" and "Bowel and Bladder Assessment" were reviewed with no changes. All nursing department staff will be in-serviced regarding these policies on November 2, 2009. This in-service will also include education on constipation.**	

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F 309	Continued From page 13 Digital Removal of Stool: . . . If a patient with a fecal impaction cannot expel the fecal mass voluntarily, and oil and cleansing enemas fail to break up the mass, the impaction must be broken up manually. A physician's order is required. This procedure may cause great discomfort to the patient as well as irritation of the rectal mucosa and bleeding. . . ." The Merck Manual of Geriatrics, Chapter 110 "Constipation, Diarrhea, and Fecal Incontinence," some medications, low dietary fiber, inadequate hydration, and reduced caloric intake are common causes of constipation. Functional impairment from immobility, muscular weakness, some neuromuscular disorders, altered mental status or depression may also contribute to constipation. Dietary approaches begin with adequate hydration, a cornerstone to treating constipation. Review of the facility policy titled "Bowel Management Program" occurred on 10/08/09. This policy, dated August 2009, stated, ". . . Procedure: 1. Document bowel movement daily. Report any unusual characteristic to nurse. . . 3. If no bowel movement by 3rd day, consider suppository or fleets enema. 4. Nurse reviews and assess daily. 5. Bowel program, A. Notify Dietician, Increase fluid intake, Increase dietary fiber, Other interventions as deemed appropriate. . . . 6. Charge nurse and/or dietician need to care plan approach that is individualized per resident's likes and usual routine." Review of Resident #11's medical record on October 5-8, 2009, identified the facility admitted	F 309	**4. The Quality Assurance Coordinator will audit resident # 1's bowel pattern weekly x 1 month, monthly x 3 months and quarterly thereafter. All residents with a diagnosis of constipation will be audited with ten residents per audit to assure facility policy and procedures are being followed. These audits will be done in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to Quality Assurance Committee at each scheduled meeting.** **5. See "Completion Date" column.**	11/12/09

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F 309	Continued From page 14 the resident in August, 2007. Medical diagnoses included; dementia, Alzheimer's, constipation, esophogeal reflux, depression, and anxiety. Nurses notes, dated 07/18/09, stated, "Administered PRN [as needed] bisacodyl suppository to promote BM [bowel movement] at 0230 [2:30 a.m.]. Resident up to toilet at 0400 [4:00 a.m.], unable to pass stool. Manually removed large quantity of formed, hard BM. Resident tolerated poorly d/t (due to) discomfort. Assisted to lounge area and offered emotional support and snack. . . ." Resident #11's care plan, dated 04/23/09, stated, "alteration in elimination related to . . . History of occasional constipation." The care plan did not identify interventions to prevent constipation or another episode of constipation requiring manual extraction from occurring. A dietary nutritional assessment dated 08/13/09, failed to identify constipation as a relevant condition/diagnosis. Review of Resident #11's bowel record identified the resident had a moderate BM on 07/14/09, no BM on the 15th, 16th, or 17th. The resident received a suppository on 07/18 and required a manual extraction of hard fecal matter. Review of Resident #11's current physician's orders identified the resident is on Risperdal, Lortab, and Duragesic patch. Side effects of these medication include constipation. The orders identified Resident #11 received Senna S one tab twice daily since admit. The facility did not adjust Resident #11's bowel medications after manual extraction occurred. During an interview on 10/07/09 at 5:15 p.m., an	F 309		

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F 309	Continued From page 15 administrative dietary staff member (#7) stated she had not been informed or notified Resident #11 had a manual extraction of stool as per facility policy. The facility failed to develop and implement interventions to promote normal bowel elimination patterns to prevent further manual stool removal for Resident #11, who had a diagnosis of constipation. The facility failed to comprehensively look at the resident's care regime and did not adjust scheduled bowel medications accordingly after experiencing manual removal of hard stool. In addition, this resident experienced significant pain during the manual stool extraction which could have been avoided in a more dignified manner.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE 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 and record review, facility staff failed to provide adequate perineal cleansing following bowel and bladder incontinence to prevent a potential urinary tract infection (UTI) for 2 of 4 sampled residents (Resident #5 and #16) observed receiving incontinence care in the secure dementia unit.	F 315	**F315** **1. Residents #5 and #16 will receive peri-care as per facility policy.** **2. All residents who are incontinent have the potential to be affected.** **3. The policy titled, "Perineal Care" was reviewed with no changes needed. All nursing staff will be in-serviced regarding this policy and urinary tract infections on November 2, 2009.**	

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F 315	Continued From page 16 Findings include: -Review of Resident #16's medical record on October 7-8, 2009, showed the resident experienced a decline in bowel and bladder continence from continent of bowel and bladder at the time of an annual Minimum Data Set (MDS) completed 01/16/09, to frequently incontinent of bladder and occasionally incontinent of bowel at the time of a quarterly MDS review completed 07/21/09, and a significant change MDS completed 08/17/09. The record showed Resident #16 experienced UTIs since the decline in urinary and bowel continence as follows: *07/16/09 - Resident #16 began antibiotic treatment for a UTI (organism - Escherichia coli, bacteria present in fecal material). * 09/29/09 - Resident #16 began antibiotic treatment for a UTI (organism - Corynebacterium species). Observation of two caregivers (#4 and #5) assisting Resident #16 to the bathroom at 3:30 p.m. on 10/07/09, showed Resident #16 had been incontinent of both urine and a moderate amount of loose/liquid feces. The caregivers (#4 and #5) completed cleansing of Resident #16's perineal area by wiping the resident's perineal area from front to back three times, turning the cloth/wipe between each cleansing. At the conclusion of the third cleansing, the cloth/wipe continued to show the presence of fecal material. The caregivers did not provide further cleansing. -Review of Resident #5's medical record occurred on October 5-8, 2009, and showed diagnoses included a history of UTIs. Resident #5's annual	F 315	**4. The Quality Assurance Coordinator will audit perineal care on residents #5 and #16 weekly x 1 month, monthly x 3 months and quarterly thereafter. The Quality Assurance Coordinator will also audit other residents identified as incontinent of bowel and/or bladder in the same manner with a minimum of 8 residents per audit. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will submit a report of the monitoring results to the Quality Assurance Committee at each scheduled meeting.** **5. See "Completion Date" column.**	11/12/09

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F 315	Continued From page 17 MDS completed 09/01/09, showed the resident experienced occasional incontinence of bowel, a decline from continent of bowel at the time of a quarterly review completed 06/01/09. Both MDS assessments identified Resident #5 as frequently incontinent of bladder. Observation of a caregiver (#1) assisting Resident #5 to the bathroom at 9:45 a.m. on 10/06/09, showed Resident #5 had been incontinent of bladder. After assisting Resident #5 from the toilet, the caregiver (#1) cleansed Resident #5's perineal area using a cloth/wipe, and wiping through the resident's perineal area from front to back, turning the cloth/wipe and repeating the described cleansing three times with the same wipe. At the conclusion of the third wiping through the resident's perineal area, fecal material remained visible on the cloth/wipe. The caregiver did not provide additional cleansing of Resident #5's perineal area prior to applying a clean brief. Failure to provide complete/adequate perineal cleansing/care, placed Resident #5 and Resident #16 at risk for avoidable urinary tract infection.	F 315		
F 425 SS=F	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425	**F425** **1. Residents #2, #25, #26, #28, #17, #27, #29 and #8 will have medications prescribed for their use administered per facility policy. Resident #28 is deceased.**	

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F 425	Continued From page 18 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide routine medications to residents on 5 of 5 resident care units (1st, 2nd, 3rd, and 4th Street, and Cherished Lane). Failure to ensure medications are available places residents at risk of not receiving necessary medications and has the potential to adversely affect each resident's status. Findings include: Review of the facility policy titled "Medication Administration-General" occurred on 10/08/09. The policy, dated May 2007, stated "PURPOSE: 1. Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so . . . ADMINISTRATION . . . 9. Medications supplied for one resident are never administered to another resident . . . DOCUMENTATION 1. The individual who administers the medication dose records the administration on the resident's Medication Administration Record [MAR] directly after the	F 425	**2. All residents who receive routine and controlled medications have the potential to be affected.** **3. The policy, "Medication Administration – General," was reviewed with no changes needed. All RN's, LPN's and TMA's will be in-serviced regarding how to administer medications to the residents using only that resident's supply. There will be specific emphasis placed on the importance of following facility policy, "Medication – Controlled," with controlled drugs. The consultant pharmacist will review the controlled drug count records when they are returned to the pharmacy to ensure correct distribution of each individual resident's medications is occurring. The residents indicated in #1 of this tag will have a review done to ensure proper billing was done for any doses not administered to them.**	

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F 425	Continued From page 19 medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. . . ." Review of controlled drug reconciliation records for all units occurred on 10/08/09. The records stated the following: * Resident #2-Fentanyl 100 milligrams (mg) (sic)/ (per) hour (hr) 1) 09/28/09 8:00 p.m. "[one] top [topical] borrowed for [resident initials]" 2) 09/29/09 "[one] returned" * Resident #25-Hydrocodone 5/500 1) 04/17/09 "Borrowed for [resident initials]" 2) 08/06/09 12:00 a.m. "[one tab] Borrowed" 3) 08/06/09 4:00 a.m. "[one tab] Borrowed" 4) 08/20/09 8:30 p.m. "[one tab] Borrowed 4 [for] [resident initials]" 5) 08/21/09 1:00 a.m. "[one tab] Borrowed 4 [resident initials]" 6) 08/22/09 1:00 p.m. "[one tab] Borrowed for [resident initials]" * Resident #28-Morphine Sulfate 2.5 mg (1.25 milliliters) 1) 10/01/09 8:30 p.m. "2.5 ml borrowed [resident name]" * Resident #17-Lortab 5/500 1) 09/18/09 "Borrowed for [resident name]" * Resident #27-Ativan 0.5 mg 1) 06/04/09 11:30 a.m. "[one] Borrowed for [resident name]" 2) 06/04/09 1:30 p.m. "returned 1" 3) 06/17/09 1:30 p.m. "borrowed [one] for [resident name]"	F 425	**4. The Quality Assurance Coordinator will audit the controlled drug records of residents in #1 except resident #28 weekly x 1 month, monthly x 3 months and quarterly thereafter for 1 year. The consultant pharmacist will also review all controlled drug count records upon return to pharmacy for accurate completion. The consultant pharmacist will report any discrepancies to the Director of Nursing immediately. The Director of Nursing will notify the Quality Assurance Coordinator of findings. Random audits of controlled and routine medications will also be conducted in the same manner by the Quality Assurance Coordinator. Results will be immediately reported immediately to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to Quality Assurance Committee at each scheduled meeting.**	

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F 425	Continued From page 20 * Resident #27-Ambien 10 mg 1) 08/02/09 "Borrowed for [resident name] * Resident #26-Alprazolam 0.25 mg 1) 08/14/09 2:15 a.m. "borrowed to [resident name]" * Resident #29-Ativan 0.5 mg tab 1) 09/08/09 5:00 p.m. "[one] returned to [resident name]" * Resident #8-Ativan 0.25 mg 1) 05/14/09 12:05 a.m. "[one] Borrowed for [resident name]" During an interview on 10/08/09 at 9:05 a.m., an administrative nursing staff member (#18) confirmed borrowing medications from other residents is against facility policy and staff should not be doing so. The facility failed to provide routine medications to the residents at all times which placed the residents at risk for complications. This practice resulted in staff members borrowing medications from other residents and not consistently replacing the medication, which caused the resident to pay for a medication they did not necessarily receive. A high potential exists for the resident's medications to be misappropriated by staff and/or not available for the resident's use. During routine pharmacy reviews, the pharmacist failed to address the practice of staff borrowing medications for different residents.	F 425	**5. See "Completion Date" column.**	11/12/09
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW 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	F 428	**F428** **1. The Mid-Level and Physician were consulted regarding resident #3 and the allergy to Lasix. The allergy was discontinued on October 6, 2009. After review, it was**	

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F 428	Continued From page 21 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to ensure the consultant pharmacist identified and reported drug irregularities to the attending physician and the director of nursing regarding a medication allergy for 1 of 1 sampled resident (Resident #3). Failure to identify and report a medication which has been ordered by the physician and for which an allergy has been identified, placed the resident at risk for an allergic reaction. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding drug regimen review. Medication regimen review (MRR), identification of irregularities stated, "The pharmacist's review considers factors such as: whether the physician and staff have identified and acted upon, or should be notified about, the resident's allergies and/or potential side effects and significant medication interactions." Review of Resident #3's medical record, on October 5-8. 2009, identified the facility admitted the resident in January 2009. The resident's current diagnoses included congestive heart failure, urinary tract infection, hypertension, and aspiration pneumonia. The resident's list of	F 428	**revealed that the resident had a rash in the past when receiving this drug. She had no rash while receiving the drug at this facility. The consultant pharmacist was made aware and updated on October 6, 2009 regarding the lasix allergy for resident #3 and that it had been discontinued. It was removed from both the facility and pharmacy computer software and removed from the resident chart.** **2. All residents who have allergies have the potential to be affected.** **3. All residents identified as having allergies will be assessed to assure these are entered into both the facility and pharmacy computer software. Those residents not using the consulting pharmacy will also be assessed to be sure allergies are identified in their software or by another manner. All resident charts will also be audited for allergy stickers for those with allergies.**	

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F 428	Continued From page 21 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility failed to ensure the consultant pharmacist identified and reported drug irregularities to the attending physician and the director of nursing regarding a medication allergy for 1 of 1 sampled resident (Resident #3). Failure to identify and report a medication which has been ordered by the physician and for which an allergy has been identified, placed the resident at risk for an allergic reaction. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding drug regimen review. Medication regimen review (MRR), identification of irregularities stated, "The pharmacist's review considers factors such as: whether the physician and staff have identified and acted upon, or should be notified about, the resident's allergies and/or potential side effects and significant medication interactions." Review of Resident #3's medical record, on October 5-8. 2009, identified the facility admitted the resident in January 2009. The resident's current diagnoses included congestive heart failure, urinary tract infection, hypertension, and aspiration pneumonia. The resident's list of	F 428	**All nursing staff will be in-serviced on November 2, 2009 regarding allergy postings and alerts.** **4. The Quality Assurance Coordinator will audit all new residents admitted after November 2, 2009 for allergies to assure that information is documented and communicated to staff and pharmacies. Audits will be done weekly x 1 month, monthly x 3 months and quarterly thereafter. A current list of all residents with allergies in the facility will be sent to the consulting pharmacist, or other pharmacies as needed to confirm that allergies have been identified and are a permanent part of the resident record. The Quality Assurance Coordinator will audit the resident allergy list with the resident chart for this same purpose. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action**	

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F 428	Continued From page 22 allergies include: clindamycin, compazine, furosemide (Lasix), Levaquin, OxyContin, penicillin, salicylates, Sulfatrim, and sulfonylureas. Review of a physician's order identified Lasix 20 mg (milligrams) orally every day was ordered for congestive heart failure on 03/24/09. Review of physician progress notes and pharmacy notes failed to address Resident #3's allergy to Lasix before or during the time the resident received the medication. Review of Resident #3's medication administration record for the months of June, July, August, and September 2009, identified the facility staff administered Lasix 20 mg on a daily basis. Resident #3's monthly drug regimen review by the consulting pharmacist identified "no irregularities."	F 428	**will be taken. The Quality Assurance Coordinator will report results to Quality Assurance Committee at each scheduled meeting.** **5. See "Completion Date" column.**	11/12/09
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policies and staff interview, the facility staff failed to follow infection control practices for 1 of	F 441	**F441** **1. Residents #6, #2 and #7 will receive optimal care when changing dressings according to the facility "Standard Precautions" policy. Resident #6 will wear a trach mask when in public areas.** **2. All residents with dressing changes and tracheostomies have the potential to be affected.** **3. The current policies for "Dressing Change – Sterile," "Dressing Change – Unsterile"**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 23 1 sampled resident (Resident #6) with a tracheostomy positive for Methicillin resistant Staphylococcus aureus (MRSA) and during 6 of 6 observations of dressing changes (Residents #2, #6, and #7). Failure to follow infection control practices could result in the spread of multidrug resistant organisms within the facility. Findings include: Review of the facility policy titled "Standard Precautions" occurred on 10/08/09. The policy, dated August 2009, stated ". . . Standard Precautions apply to all patients and in all situations, regardless of diagnosis or presumed infection status. Because all residents can serve as reservoirs for infectious agents, adherence to Standard Precautions during the care of ALL residents is essential to interrupting the transmission of microorganisms. Standard precautions also intend to protect residents by ensuring that healthcare personnel do not carry infectious agents to residents on their hands or via equipment used during resident care . . . PROCEDURE: Standard Precautions are used with ALL patients, regardless of diagnosis or isolation status. The required elements include: Adequate hand hygiene at all appropriate times . . . Disinfection of surfaces and equipment between patient uses, Appropriate use of Personal Protective Equipment (PPE) for reasonably anticipated contact with body substances or contaminated equipment. The symptoms, condition, and expected interaction with each patient must be critically assessed when determining what type of PPE use is appropriate . . . Respiratory hygiene and cough etiquette. . . ." Review of the facility policy titled "Dressing	F 441	**and "Tracheostomy – Routine Cares" have been reviewed and additions/changes made. The "Standard Precautions" policy was reviewed with no changes needed. All nursing staff will be in-serviced regarding the dressing change policies and the use of personal protective equipment for staff and residents on November 2, 2009.** **4. The Quality Assurance Coordinator will audit residents #6, #2 and #7 for dressing changes following facility policy weekly x 1 month, monthly x 3 months and quarterly thereafter. Other residents in the facility who receive dressing changes will be audited in the same manner. Resident #6 will be audited to assure a trach mask is in place when he is in a Common Area in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality**	

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F 441	Continued From page 24 Change-Sterile" occurred on 10/08/09. The policy, dated August 2008, stated "PURPOSE: 1. To protect open wound from contamination . . . 3. To prevent infection and skin irritation . . . PROCEDURE: 1. Wash your hands. 2. Gather equipment and take to bedside . . . 7. Open sterile dressing. 8. Pour prescribed solution onto gauze to be used for cleaning. 9. Put gloves on. 10. Remove soiled dressing and discard in plastic bag, along with gloves. 11. Put on sterile gloves. 12. Cleanse wound with prescribed solution and sterile gauze . . . 14. Apply sterile dressings and secure with tape. 15. Remove sterile gloves and dispose of in bag . . . 18. Wash your hands. . . ." Review of the facility policy titled "Dressing Change-Unsterile" occurred on 10/08/09. The policy, dated August 2008, stated " . . . PROCEDURE: 1. Wash hands . . . 7. Put gloves on . . . 10. Remove dressing . . . 12. Dispose of soiled dressings in bag-remove gloves. 13. Open clean gauze and supplies and place within working area. 14. Put on non-sterile gloves . . . 16. Clean wound with prescribed solution. 17. Use gauze to dry wound or incision line. 18. Apply ointment if prescribed. 19. Remove gloves and dispose of properly. 20. Use tape over dressing to secure. 21. Dispose of all supplies and close bag. 22. Wash hands. . . ." - Review of Resident #6's medical record occurred on October 05-08, 2009. Review of the current quarterly Minimum Data Set (MDS), dated 07/23/09, identified the resident with a tracheostomy and an ostomy. A culture taken on 04/16/09 identified "Methicillin Resistant S. Aureus [MRSA]" in Resident #6's respiratory flora. The current plan of care for Resident #6 stated "MRSA in trach [tracheostomy]" dated 04/20/09,	F 441	**Assurance Coordinator will report results to Quality Assurance Committee at each scheduled meeting.** **5. See "Completion Date" column.**	11/12/09

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F 441	Continued From page 25 and "Bring out of room twice a day to lounge to increase stimulation, place trach mask over trach." Observation on 10/06/09 at 10:10 a.m. showed facility staff failed to place a trach mask over Resident #6's tracheostomy before placing him in the commons area. A licensed nurse (#14) stated "Right now [Resident #6] does not have MRSA in his trach." Record review provided no evidence Resident #6 was free of MRSA. Observation at 11:55 a.m. revealed Resident #6 still in the commons lounge area without a trach mask over his tracheostomy. At this time, a number of residents sat in the commons area in close proximity to the resident. A family member visited Resident #6 during this time and sat in a chair close to him while his tracheostomy remained uncovered. During an interview on 10/08/09 at 7:55 a.m., an administrative nursing staff member (#3) stated she expected staff to always place the trach mask over his tracheostomy when he is out of his room and in public areas. The facility's failure to place a trach mask over Resident #6's tracheostomy when in public areas has the potential to result in the spread of infections to other residents, visitors, and staff within the facility. - Observation of two dressing changes for Resident #6 occurred on 10/06/09 at 8:00 a.m. A licensed nurse (#14) washed her hands, donned gloves, and removed the dressing around the resident's gastrostomy tube. While continuing to wear the same gloves, the licensed nursing staff member (#14) cleansed the site and applied a	F 441		

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F 441	Continued From page 26	F 441		

new dressing. The licensed nurse (#14) then removed the gloves, cleansed the bedside table with an alcohol pad, applied new gloves without washing her hands, and removed the soiled dressing around Resident #6's tracheostomy. The dressing contained a moderate amount of tan sputum. While continuing to wear the same gloves, the licensed nurse (#14) poured a mixture of half hydrogen peroxide and half sterile water into a sterile container, she removed the inner cannula of the tracheostomy with the same gloves, and dropped it into the container of hydrogen peroxide/sterile water. Without removing the contaminated gloves, the licensed nurse (#14) donned a pair of sterile gloves over the soiled gloves. The licensed nurse (#14) then proceeded to clean and replace the inner cannula, cleanse around the site, apply a new dressing around the tracheostomy, remove gloves, and wash her hands.

The nursing staff member failed to wash her hands in-between the two different dressing change sites, failed to change gloves after removing the soiled dressings, and failed to remove the contaminated gloves before donning sterile gloves.

- Review of Resident #7's medical record occurred on October 05-08, 2009. Review of the current quarterly MDS, dated 09/03/09, identified the resident with three stage two ulcers and one stage three ulcer (three of the four being pressure ulcers); and application of ointments/medications and dressings to ulcers. A culture taken on 05/22/09 identified "Methicillin Resistant Staph aureus [MRSA]" in Resident #7's coccyx and right leg wounds. The current plan of care for Resident #7 stated "Long hx [history] of decubiti and

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F 441	Continued From page 27 MRSA+ in wounds. Wound culture positive for pseudomonas 08/12/09." Observation of two dressing changes for Resident #7 occurred on 10/06/09 at 9:50 a.m. A licensed nurse (#14) donned gloves and removed the soiled dressings on the right lower leg/heel. Without changing gloves, the licensed nurse (#14) cleansed the wounds, applied silver nitrate as ordered, and put on the new dressings. The licensed nurse (#14) then removed the contaminated gloves without washing her hands. The nurse (#14) then donned a new pair of gloves and removed the contaminated dressing on the right buttock. Without changing gloves, the nurse (#14) cleansed the wound, applied Santyl cream as ordered, applied a new dressing to the right buttock, removed gloves, and washed her hands. The nursing staff member failed to wash her hands in-between changing the dressings on the two different wounds, and failed to change gloves after removing the soiled dressings. Failure to follow infection control practices could result in the spread of multidrug resistant organisms within the facility. During an interview on 10/08/09 at 7:55 a.m., an administrative nursing staff member (#3) stated she expected staff to change gloves after removing contaminated dressings, and to wash their hands in-between dressing changes on different wounds. - Resident #2's medical record, reviewed October 05-08, 2009, identified a stage 2 pressure ulcer to the resident's coccyx. Observation on 10/05/09 at 5 p.m. identified	F 441		

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F 441	Continued From page 28 Resident #2 incontinent of a large amount of soft stool. With the resident lying in bed, two certified nursing assistants (CNAs) (#5 and #12) provided incontinence cares. When turned on her side, observation revealed a dressing on her coccyx, soiled with stool. A CNA (#12) left the room and returned with a licensed nurse (#13). The nurse donned gloves and removed the soiled dressing from Resident #2's coccyx. Observation showed an open area approximately two by two centimeters with a yellow wound bed. Without changing her gloves, the nurse (#13) cleansed the resident's wound. The nurse then removed her gloves, and without washing her hands, applied a clean dressing on the wound and secured in place. Observation on 10/06/09 at 8:30 a.m. identified Resident #2 lying in bed. A CNA (#16) lowered Resident #2's brief to expose the wound, revealing the resident incontinent of urine. A licensed nurse (#14) donned gloves and removed the soiled dressing. Observation showed the dressing saturated with pale yellow liquid. Without changing her gloves or washing her hands, the nurse (#14) cleansed the wound, applied ointment, and applied a clean dressing on the wound. During an interview on the morning of 10/07/09, an administrative nurse (#15) agreed the nurses should have changed gloves between removing the soiled dressings and cleansing the wound and applying a clean dressing. The nurse stated the facility recently provided education on dressing change technique. During an interview on 10/08/09 at 8:20 a.m. an infection control nurse (#17) stated the facility provided education regarding dressing changes in August 2009;	F 441		

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F 441	Continued From page 29 however staff continue to follow incorrect infection control practices.	F 441		