STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

(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 The standard Medicare/Medicaid recertification survey, started on 01/10/20 and concluded 01/13/20.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY CONDUCTED ON	F 657	1. It is the practice of the facility to review and revise comprehensive care	3/19/20

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

Electronically Signed | 03/10/2020

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F 657	Continued From page 1 02/02/19 Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure staff reviewed and revised comprehensive care plans to reflect the residents' current status for 5 of 26 sampled residents (Resident #32, #92, #100, #101, and #121) reviewed. Failure to review and revise the care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 02/13/20. This policy, dated February 2018, stated, ". . . The comprehensive care plan will describe, at a minimum . . . services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. . . ." - Review of Resident #32's medical record occurred on all days of survey and identified diagnoses of anxiety and vascular dementia with behaviors. Review of the progress notes from December 2019 through February 2020 indicated the resident ambulated frequently, ambulated up and down the hall, and/or wandered the hall. The quarterly Minimum Data Set (MDS), dated 12/01/2019, identified the resident wandered daily. Resident #32's current care plan failed to include a problem, goals, or interventions to address the	F 657	plans to reflect the residents□ current status as it relates to wandering, behaviors, contact precautions, macular degeneration, type 2 diabetes and use of anti-coagulants. On 3/4/2020, resident #32□s care plan was updated to include wandering as a focus area as well as goals and interventions. (On 2/17/2020, the quarterly MDS assessment dated 9/1/19 was correctly coded for wandering and then submitted on 2/18/2020.) On 2/11/2020, resident #92□s care plan was updated to include contact precautions as an intervention for MRSA. On 2/12/2020, resident #100□s care plan was updated to include macular degeneration as a focus area as well as goals and interventions. On 2/18/2020, resident #101□s care plan was updated to include signs and symptoms of type 2 diabetes. On 2/13/2020, resident #101□s care plan was updated to include the use of an anti-coagulant as well as signs and symptoms of bleeding. The care plan was then revised on 3/4/2020, to include history of blood clot formation as a focus area. On 2/13/2020, resident #121□s care plan was updated to include behaviors as a focus area as well as goals and interventions. On 2/15/2020, nursing staff were re-educated on the importance of	

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F 657	Continued From page 2 wandering behavior. - Observation throughout the survey showed a cart with isolation supplies in the hall outside Resident #92's room and a sign to check with the nurse before entering the resident's room. During an interview the morning of 02/11/20, a nurse supervisor (#1) stated the resident was on contact isolation. Review of Resident #92's medical record occurred on February 11-13, 2020. Diagnoses included cellulitis to the lower leg, with methicillin resistant staphylococcus aureus (MRSA) infection. A physician order, dated 01/15/20, stated to change dressings to bilateral lower extremity wounds daily. Resident #92's current care plan stated, "I have a Skin infection, Cellulitis/soft tissue/wound infection indicated by: (1) physician dx [diagnosis], positive wound cultures, MRSA . . . Administer prn [as needed] comfort meds [medications] as per standing order. Medication/treatment as ordered. . . ." The care plan failed to include a problem, goals, or interventions for contact precautions. During an interview on 02/13/20 at 12:16 p.m., an administrative nurse (#2) agreed contact precautions should be included on Resident #92's care plan. - During an interview on 02/11/20 at 8:35 a.m., Resident #100 stated she is legally blind, needs help reading the menu, activity calendar, and her mail. The resident stated she loves to read but is	F 657	updating care plans to reflect a resident□s current status. On 3/3/2020, care managers were re-educated on the importance of updating care plans to reflect a resident□s current status. 2. All resident that wander, exhibit behaviors, are in contact precautions, have a dx of macular degeneration and/or type 2 diabetes and resident that are prescribed anti-coagulants have the potential to be affected by this practice. 3. Re-education will be provided to all staff on 3/11/2020 and will include importance of updating care plans to reflect residents□ current status including wandering, behaviors, contact precautions, macular degeneration, type 2 diabetes and use of anti-coagulants. 4. A quality audit will be conducted to ensure all care plans reflect residents' current status. The audits will be conducted by the Quality and Learning Coordinator and/or designees. Five audits well be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	

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F 657	Continued From page 3	F 657		

unable to do so anymore. Observation showed the resident had glasses and a magnifying glass on her bedside table.

Review of Resident #100's medical record occurred on all days of survey. Diagnoses included macular degeneration. The current care plan failed to include the resident's vision problem and interventions to address her impaired vision.

During an interview on the afternoon of 02/12/20, an administrative nurse (#2) agreed the Resident #100's vision problem should be included in the care plan.

- Review of Resident #101's medical record occurred on all days of survey and identified diagnoses of type 2 diabetes with hyperglycemia (high blood sugar level), ketoacidosis (a life threatening complication of diabetes), and acute embolism (obstruction of an artery by a blood clot)/thrombosis of deeps veins (DVT-a blood clot in a deep vein, usually legs) of a lower extremity. The record indicated the resident received scheduled Lantus (long acting) insulin and scheduled and PRN (as needed) Novolog (fast acting) insulin for the type 2 diabetes and received Eliquis (a blood thinner) for the DVT. A physician's order, dated 12/03/19, stated, ". . . NovoLOG . . . Inject 5 unit subcutaneously as needed for Hyperglycemia related to TYPE 2 DIABETES . . . Administer with PRN accu chek [sic] [use of a glucometer to test blood sugar levels] 500+ [blood sugar level of 500 or greater] with symptoms . . ."

Resident #101's current care plan failed to

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F 657	Continued From page 4 include signs/symptoms of hyperglycemia or ketoacidosis related to diabetes, and the signs/symptoms of blood clot formation and possible adverse reactions secondary to anticoagulant use. - Review of Resident #121's medical record occurred on all days of survey and identified diagnoses of Alzheimer's disease and dementia with behaviors. Observations of Resident #121 showed the following behaviors: * On 02/10/20 at 3:20 p.m., made loud nonsensical sounds/words while seated in the Westlyn lounge. Resident taken to the main dining room at 3:58 p.m. and continued the disruptive behavior. At 4:28 p.m. the behavior ceased after an unidentified CNA started to feed the resident. * On 02/11/20 at 4:22 p.m., made periodic nonsensical sounds/words while seated at the table in the main dining room. * On 02/12/20 at 8:05 a.m., many vocal sounds heard coming from the resident's room out into the Westlyn lounge. * On 02/12/20 at 9:08 a.m. through 9:52 a.m., during morning cares the resident became resistive to cares and very vocal. The CNA (#12) asked the resident to let go of her arm multiple times in order to complete the cares. Resident #121's current care plan failed to include a problem, goals, or interventions related to behaviors.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/19/20

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F 658	Continued From page 5 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 1 of 4 residents (Resident #11) observed during insulin pen preparation and administration. Failure to properly disinfect the insulin pen and administer insulin per policy/manufacturer recommendation may result in insulin contamination and the resident receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 02/13/20. This policy, dated 02/01/18, stated, ". . . 7. Attach safety pen needle: a. Remove the pen cap from the insulin pen. b. Wipe the rubber seal with an alcohol pad. . . . 10. Injecting the insulin: . . . d. Fully depress plunger until the dosing numbers count back to zero. e. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. . . ." The manufacturers instructions for the TRESEBIA® FlexPen®, found at www.nov-pi.com/tresibia.pdf, stated, ". . . Keep the needle in your skin after the dose counter shows '0' and slowly count to 6. . . . you will not get your full dose until 6 seconds later. . . ."	F 658	1. It is the practice of the facility to properly disinfect insulin pens and to administer insulin per policy/manufacturer recommendations. On 2/13/2020, at 3:20pm, a blood sugar check was completed for resident #11 and resident received her scheduled dose of insulin per physician orders and no follow was needed. Blood sugar checks are being completed twice a day every day. On 2/18/2020, nursing staff were re-educated on the importance of disinfecting insulin pens and proper administration of insulin. 2. All resident who receive insulin have the potential to be affected by this practice. 3. Re-education will be provided to all staff on 3/11/2020 and will include the importance of properly disinfecting insulin pens and properly administering insulin per policy/manufacturer recommendations. 4. A quality audit will be conducted for insulin administration per facility policy.	

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F 658	Continued From page 6 - Observation on 02/12/20 at 8:48 a.m. showed a licensed nurse (#5) attached a needle to two of Resident #11's TRESEBIA® insulin pens without cleansing the rubber seals. The nurse (#5) administered Resident #11's ordered 74 units of TRESEBIA® insulin, via the two separate pens, and removed the needle from the resident's skin after 1 second with both injections. During an interview on 02/13/20 at 03:39 p.m., an administrative nurse (#2) confirmed staff did not follow facility policy and practice professional standards with insulin pen preparation and administration for Resident #11.	F 658	The audits will be conducted by the Quality and Learning Coordinator and/or designees. Five audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy, and staff interview, the facility failed to provide adequate assistance for 2 of 3 sampled residents (Residents #45 and #125) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift placed Resident #45 and #125 at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include:	F 689	1. It is the practice of the facility to ensure proper use of the standing lift and to complete appropriate assessment for use of the standing or full lift. On 2/13/2020, nursing staff assessed lift use and updated plans of care for resident #45 and resident #125 to reflect the use of the full lift for transfers. On 2/18/2020, nursing staff were re-educated to assess any residents that are not tolerating the standing lift	3/19/20

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F 689	Continued From page 7 -Review of the facility policy titled "Mechanical Lifts" occurred on 02/13/20. This policy revised July 2018, stated, ". . . A stand lift . . . is used for residents capable of bearing weight . . . Follow operating instructions for the lift used . . ." The facility failed to provide the mechanical lift operating instructions. - Review of Resident #45's medical record occurred on all days of survey. The Quarterly Minimum Data Set (MDS), dated 12/15/19, identified extensive assistance of one or more staff is required for transfers. Observation on 02/12/20 at 1:49 p.m. showed a certified nursing assistant (CNA) (#3) transferred Resident #45 from the toilet to her wheelchair utilizing the sit to stand mechanical lift. The resident hung from the harness in a semi-seated position and failed to bear weight. As the harness straps pulled upward into Resident #45's axilla, her shoulders raised with her elbows extending horizontally. During an interview on 02/12/20 at 4:20 p.m., an administrative nurse (#2) confirmed facility staff should ensure residents bear weight when utilizing the stand lift and should ensure the harness is not pulling upward/putting pressure on their axilla. - Review of Resident #125's medical record occurred on all days of survey. The Admission MDS, dated 01/29/20, identified extensive assistance of two or more staff is required for transfers. The current care plan stated, ". . . I have ADL [activity of daily living] self care	F 689	(hanging, not bearing weight) and to change transfer type to a full lift if appropriate. 2. All residents that utilize the standing lift for transfers have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/11/2020 and will include proper use of the standing lift and review of appropriate assessment for use of the standing lift. 4. A quality audit will be conducted for residents that utilize the standing lift for transfers. The audits will be conducted by the Quality and Learning Coordinator and/or designees. Five audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	

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F 689	Continued From page 8	F 689		

performance deficits . . . TRANSFER: I require standing lift for transfers. . . ."

Observation on 02/10/20 at 11:23 a.m. showed two CNAs (#10 and #11) transferred Resident #125 from her wheelchair to the toilet utilizing the sit to stand mechanical lift. The CNA (#10) raised the lift and the resident hung from the harness in a semi-seated position and failed to bear weight. "Help I am slipping out!" shouted Resident #125 and staff lowered her onto the toilet. When exiting the bathroom, Resident #125 failed to bear weight with the harness straps pulled upward into the residents axilla (armpit) and caused her elbows to extend out horizontally. "I'm gonna fall, I'm gonna fall," Resident #125 repeated.

Observation on 02/11/20 at 11:45 a.m. showed two CNAs (#13 and #14) attempted to transfer Resident #125 from her wheelchair to her bed using a sit to stand mechanical lift. Resident #125's shoes were not flat on the lift platform. The CNA (#13) raised the lift, "You are pulling my arms off," yelled Resident #125. The resident hung from the harness and failed to bear weight. The CNA (#13) lowered the resident back into her wheelchair. The CNAs verbalized they were going to use the full body mechanical lift, retrieved a lift from the hallway, applied a lift sling that was laying on the resident's bedside table, and transferred Resident #125 to her bed.

Observation on 02/12/20 at 3:35 p.m. showed two CNAs (#15 and #16) transferred Resident #125 from the toilet to her wheelchair. Resident #125 hung from the harness and failed to bear weight, the sling slid up to the back of her head, and she stated "This hurts my arms."

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F 689	Continued From page 9 During an interview on 02/12/20 at 3:45 p.m., a CNA (#16) stated sometimes Resident #125 is weak and we have to use the full body lift. During an interview on 2/13/20 at 2:02 p.m., an administrative nurse (#2) stated CNA's should not be assessing if a resident should be using a sit to stand or hoyer lift.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		3/19/20

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F 761	Continued From page 10 by: Based on observation, review of facility policy, and staff interview, the facility failed to label a multi-dose insulin pen and discard outdated medication devices for 2 of 6 medication storage areas (Oak Lane medication cart and Memory Lane medication room). Failure to label multi-dose pens with the date opened and discard expired medication devices increases the risk of residents receiving outdated medications with reduced medication efficacy and increases the risk of medication device failure. Findings include: - Review of the facility policy titled "Labeling of Medications and Biologicals" occurred on 02/13/20. This policy, dated May 2018, stated, ". . . Labels for multi-use vials must include . . . The date the vial was initially opened . . ." Observation of the Oak Lane medication cart occurred on the morning of 02/12/20. An insulin pen/pharmacy label did not contain a date when opened or an expiration date. During an interview on 02/13/20 at 11:03 a.m., an administrative nurse (#2) stated she expects staff to date insulin pens with open and expiration dates. - Review of the facility policy titled "Medication Storage" occurred on 02/13/20. This policy, dated June 2019, stated, ". . . To ensure all medications housed on our premises will be stored in . . . medication rooms according to the manufacturer's recommendations. . . ."	F 761	1. It is the practice of the facility to label all multi-dose insulin pens with the open and expiration date and to discard any expired saline flushes. On 2/12/2020, the insulin pen from the Oak Lane medication cart was discarded. The expired saline flushes from the Memory Lane medication room were discarded. On 2/18/2020, nursing staff was re-educated on dating all multi-dose insulin pens with an open and expiration date and to discard any expired saline flushes. 2. All residents who received multi-dose insulin and have orders for a saline flush have the potential to be affected by this practice. 3. Re-education will be provided to all staff on 3/11/2020 to label all multi-dose insulin pens with an open and expiration date and to discard any expired saline flushes. Nursing staff or designee will inspect all medication storage rooms and medication carts weekly for expired medications and supplies. 4. A quality audit will be conducted to check for labeling of insulin pens and expiration dates of all medications and supplies in medication storage rooms and medication carts. The audits will be conducted by the Quality and Learning	

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F 761	Continued From page 11 Observation of the Memory Lane medication storage room occurred on 02/13/20 at 8:03 a.m., with a staff nurse (#6) identified the following expired medication devices: * 27 0.9% Sodium Chloride Injection 10 ml (millimeter) syringes expired 1/5/2020. * 30 0.9 % Sodium Chloride injection 10 ml syringes expired 12/28/19. During the observation, the staff nurse (#6) agreed the above items had expired and needed to be discarded.	F 761	Coordinator and/or designees. Audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	
F 770 SS=B	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to discard expired laboratory supplies for 2 of 2 medication rooms (Friendship Lane and Memory Lane). Failure to discard expired laboratory supplies increased the risk of staff utilizing outdated laboratory supplies with reduced efficacy. Findings include: - Observation of the Friendship Lane medication storage room on the afternoon of 02/12/20 with a licensed staff nurse (#4) identified the following	F 770	1. It is the practice of the facility to discard expired laboratory supplies. On 2/12/2020, all expired vacutainers from the Friendship Lane medication room were discarded. On 2/10/2020, all expired vacutainers and luer lock devices from the Memory Lane medication room were discarded. On 2/18/2020, nursing staff were re-educated to discard any expired lab supplies.	3/19/20

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	355079	A. BUILDING _____ B. WING _____	02/13/2020

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F 770	Continued From page 12 expired laboratory collection tubes (vacutainers): * Blue top vacutainer- 12 expired on 01/31/20 * Gray top vacutainer- 1 expired on 04/30/19 1 expired on 06/20/19 12 expired on 07/31/19 14 expired on 01/31/20 * Yellow top vacutainer- 3 expired on 11/30/19 10 expired on 01/3/20 During an interview on 02/13/20 at 11:03 a.m., an administrative nurse (#2) agreed the above items had expired and staff needed to discard the items. - Observation of the Memory Lane medication/supply storage room on 02/13/20 at 8:03 a.m. with a staff nurse (#6) identified the following expired laboratory collection tubes and supplies: * Yellow top vacutainer - 10 expired on 1/31/20. * Vacutainer luer lok access devices (used for blood collection) - 9 expired on 12/31/19 During an interview on 02/13/20 at 8:15 a.m., a staff nurse (#6) agreed the supplies had expired and needed to be discarded.	F 770	2. All residents have the potential to be affected by this practice. 3. Re-education will be provided to all staff on 3/11/2020 to discard any expired lab supplies. Nursing staff or designee will inspect all medication storage rooms for expired lab supplies weekly. 4. A quality audit will be conducted for any expired lab supplies in the medication rooms. The audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by:	F 807		3/19/20

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F 807	Continued From page 13 Based on observation and resident and staff interview, the facility failed to provide drinks at bedside for 1 of 1 sampled resident (Resident #10) who voiced a desire to have fluids at bedside. Failure to provide fluids at bedside based on Resident #10's request, may affect the resident's ability to maintain adequate hydration status. Findings include: During an interview on 02/10/20 at 12:12 p.m., Resident #10 stated she is thirsty and does not get enough to drink. "I often don't have water on my tray [over bed table in room]. . . It happens a lot." Review of Resident #10's medical record occurred on all days of survey and indicated the resident is at risk for aspiration and is cognitively intact. A nutritional assessment, dated 02/10/20, stated, ". . . Interviews: . . . 6. Fluid Availability: Asked if she was getting enough to drink: 'No.' Asked if staff are good about offering fluids: 'No they're not just the nurses are.' . . . Followed up with nsg [nursing] about fluids. . . . Risk Assessment: . . . 5e. Comments . . . She does prefer to have fluids indep. [independent] in her apt [room] to allow for indep. [independent] and freq. [frequent] fluids. [Resident] aware of risks. She receives . . . honey thick liquids. . . . 9a. comments: She is able to make her dietary needs [known] to staff. . . ." Resident #10's electronic medication administration record showed the nurses/medication aids provided the resident 240 cc of fluids three times a day with medication pass.	F 807	1. It is the practice of the facility to provide fluids at bedside to all residents unless care planned otherwise. On 2/13/2020, staff caring for resident #10 were re-educated on resident□s request to keep fluids at bedside. 2. All residents have the potential to be affected by this practice. 3. All residents will be provided with fluids at bedside unless care planned otherwise. Education will be provided to all staff on 3/11/2020 to offer fluids at beside to all residents unless care planned otherwise. 4. A quality audit will be conducted to ensure there are fluids available for residents at bedside. The audits will be conducted by the Quality and Learning Coordinator and/or designees. Audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	

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F 807	Continued From page 14 Observations on all days of survey showed no water cup/mug in Resident #10's room and no fluids offered by staff with the resident's cares. During an interview on 02/13/20 at 12:00 p.m., an administrative nurse (#2) confirmed the dietician should have relayed to the facility staff Resident #10's wishes for water at her bedside.	F 807		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/19/20

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F 880	Continued From page 15 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 1 of 4 sampled residents (Resident #11) observed during insulin administration and 1 of 1 plastic intravenous (IV) start basket containing IV supplies. Failure to follow standard infection control practices/ensure a safe sanitary environment may result in the spread of infections and communicable diseases. Findings include: Review of the facility policy titled "Standard Precautions" occurred on 02/13/20. This policy, reviewed November 2019, stated, ". . . All Residents at Villa Maria will be cared for using standard precautions for prevention of infections . . . All employees will routinely use appropriate precautions to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. . . . Resident care equipment that is to be re-used will be: . . . Cleaned and disinfected before re-use, as appropriate. . . ." - Observation on 02/12/20 at 8:48 a.m. showed a licensed nurse (#5) prepare two separate TRESEBIA® insulin FlexPens® (one with 4 units and one with 70 units of insulin). The nurse attempted to lay both insulin pens on the foot of Resident #11's bed when the insulin pen with the 70 units fell into the resident's garbage can. The nurse retrieved the pen from the garbage can and stated, "Now I will have to go out and swap out the needle." The nurse (#5) took the insulin	F 880	1. It is the practice of the facility to follow standard infection control practices when handling and administering insulin and for storage of IV start kits in a clean/sanitary location. On 2/12/2020, resident #11□s insulin pen was sanitized. On 2/13/2020, the IV start kit in the Memory Lane medication room was placed in a clean location. On 2/18/2020, nursing staff were re-educated to sanitize insulin pens when needed prior to administration and/or storage in the medication cart and to keep items stored off of the floor in the medication rooms. 2. All residents receiving insulin and all resident requiring an IV start have the potential to be affected by this deficient practice. 3. Re-education will be provided to all staff on 3/11/2020 to sanitize insulin pens when they become unsanitary prior to administration and/or storage in the medication cart and to keep items stored off the floor in the medication rooms. Education will be provided to all staff on 3/11/2020 to establish a clean field when administering injections at bedside. Our Standard Precautions policy was updated to include this information	

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F 880	Continued From page 17 pen back to the medication cart, and without sanitizing the pen, replaced the needle. The nurse then administered the insulin from both pens, removed/disposed the needles, and placed both insulin pens back into the medication cart. The nurse failed to disinfect the contaminated insulin pen prior to the needle replaced, the insulin administrated, and pen placed back into the medication cart. - Observation on 02/13/20 at 8:13 a.m. showed a plastic IV start basket, containing IV supplies located on the floor of the Memory Lane medication/supply storage room. During an interview on 02/13/20 at 8:15 a.m. a staff nurse (#6) agreed the IV start basket should not be stored on the floor. The facility failed to store the IV start supply basket in a clean/sanitary location.	F 880	4. A quality audit will be conducted to ensure insulin pens are sanitized when needed prior to administration and/or storage and to ensure that no items are being stored on the floor in the medication rooms. The audits will be conducted by the Quality and Learning Coordinator and/or designees. Five audits will be conducted weekly for 4 weeks, then monthly for 3 months, and continued auditing will be scheduled per discretion of the quality assurance committee. Audits will be reviewed by the quality assurance committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by 3/19/2020.	