STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	02/02/2012

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 30, 2012 and completed on February 02, 2012, the sample included two residents for complete review, eight residents for focused review, and one closed record for review. The sample included three additional residents to verify specific concerns during the survey.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, family interview, and staff interview, the	F 280	**F 280 Revising Care Plan** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #7's care plan was update to reflect Geri chair usage and appropriate incontinence management. Resident #7's meal tray card was updated to show the usage of a nosey cup. Resident #8's care plan was updated to show oxygen usage and denture usage. Resident #6's care plan was updated to include the usage of a	

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

Administrator 2-27-12

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 280	Continued From page 1 facility failed to review and revise the care plan for 4 of 10 sampled residents (Resident #1, #6, #7, and #8). Failure to revise the care plan as the residents' status changes has the potential to affect staff's understanding of the residents' problems/concerns and required interventions, limits staff's ability to communicate resident care issues, and may lead to lack of or inconsistency in cares provided. Findings include: - Observations of Resident #7 during the survey included: * On 01/30/12 at 5:20 p.m. in a geri chair at the dining room table * On 01/31/12 at 7:48 a.m. in a geri chair at the dining room table being fed thickened liquids with a nosey cup (a cup with a cut out area on the rim) * On 01/31/12 at 9:40 a.m. certified nurse assistants (CNAs) (#2 and #5) transferred the resident from geri chair to bed with a Hoyer (total) lift to check her incontinent brief Review of Resident #7's medical record occurred January 30 - February 2, 2012. Resident #7's current quarterly Minimum Data Set (MDS), dated 12/27/11, identified the need for total assistance of two for bed mobility, transferring, locomotion on unit, eating, toileting, and always incontinent. Resident #7's bladder assessment, dated 12/27/11, identified "check and change" and "always incontinent." An occupational therapy evaluation for Resident #7, dated 12/17/10, identified "to use a sip cup [with] nosey for drinking."	F 280	full resident lift. Resident #1's care plan was changed to include using a plate guard. Resident #1's meal tray card was changed to show usage of a plate guard Completed by 3-8-12 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Director of Nursing Services (DNS)/Designee reviewed the care plans of all residents checking for any inconsistencies between how we provide care and information written in the resident care plan. Corrections to the care plans were made as needed. Completed by 3-8-12 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All members of the Care Team were trained on care plan review process and the need to constantly update care plans to reflect the actual care provided to residents Over the next quarter all resident care plans will be audited using the care plan audit tool.	

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F 280	Continued From page 2 An interdisciplinary assessment and summary review, dated 07/06/11, identified Resident #7 "changed to full body lift on 03/14/11." During an interview, on 01/31/12 at 3:45 p.m., Resident #7's family member (#1) stated the facility obtained a geri chair during the past year to improve positioning for the resident. Review of Resident #7's comprehensive care plan, dated 01/04/12, failed to identify the use of nosey cups as a plan/approach for the problem of alteration in nutrition. The care plan failed to identify the use of a geri chair for the problem of mobility impairment. One of the plans/approaches included for the mobility impairment problem identified "enc. [encourage] to propellh [sic] own w/c [wheelchair]." The care plan identified the problem of alteration in elimination with one of the plans/approaches "toilet Q2H [every 2 hours]." As identified in the MDS, Resident #7 required total assistance with activities of daily living and was always incontinent, therefore, not capable of self propelling her wheelchair or toileting. - During initial tour of the facility on 01/30/12 at 1:45 p.m., Resident #8 stated he saw the dentist several times because of problems with dentures not fitting. The facility identified Resident #8 as interviewable. Observations of Resident #8 on 02/01/12 at 2:05 p.m. and on 02/02/12 at 9:30 a.m. showed the resident in his room in his recliner utilizing nasal oxygen per concentrator.	F 280	Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Social Worker will submit a monthly report on the results of the care plan audit tool to the Continuous Quality Improvement Committee (CQI Committee). The reports will continue for 3 months and then as directed by the CQI Committee. Completed by 3-8-12	

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Review of Resident #8's medical record occurred February 1-2, 2012 and identified dental appointments related to denture adjustments on 11/22/11, 12/02/11, 12/15/11 and 01/19/12. The medical record also identified a physician order, dated 12/21/11, for oxygen for a diagnosis of shortness of breath. On 01/05/12 a physician note identified a diagnosis of pneumonitis.

Review of Resident #8's comprehensive care plan, dated 12/21/11, failed to identify the use of oxygen for Resident #8. The care plan also identified a problem self care deficit with plans/approaches which included "Res [resident] has no teeth or dentures."

- Observations of two staff providing extensive assistance, including checking and changing Resident #6's incontinent brief, occurred on 01/31/12 at 10:10 a.m., 11:30 a.m., 2:25 p.m., and 4:10 p.m.

Review of Resident #6's medical record occurred January 30 - February 2, 2012. Resident #6's current significant change MDS, dated 10/23/11, identified the need for extensive assistance of two for bed mobility, transferring, toileting, and frequently incontinent .

During an interview, on 02/01/12 at 8:45 a.m., a CNA (#5) stated staff have been utilizing the total Hoyer lift with Resident #6 since her stroke in October, 2011.

Review of Resident #6's comprehensive care plan, dated 12/21/11, identified a problem of potential for alteration in elimination related to occasional incontinence of urine with

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F 280	Continued From page 4 plans/approaches which included "assist of one w/ [with] gaitbelt for toileting." The facility failed to revise the care plan to indicate the resident's use of the Hoyer lift. - Observations on 01/31/12 at 7:50 a.m. and 01/31/12 at 12:10 p.m., showed Resident #1 using a divided plate (a plate divided in three sections) while eating. Review of Resident #1's medical record occurred from January 30 - February 2, 2012. Resident's diagnoses included peripheral neuropathy and blindness of right eye. The resident's admission assessment, dated 04/29/11, identified Resident #1 had very poor vision to her left eye and is blind in her right eye. Resident #1's MDS, dated 11/30/11, identified the resident with severely impaired vision and needing limited assistance with eating. Resident #1's care plan, dated 12/07/11, identified the problem of alteration in nutrition with the approach to use a plate guard and inform the resident of location and types of foods. Review of Resident #1's meal tray card identified a divided plate to be used at meals. The facility failed to revise the meal tray card to match the care plan. During interview with administrative nursing staff member (#6), on the morning of 02/02/12, she stated the CNA's hand held devices contain information, directly from the care plans, which directs the care the residents receive. Failure to revise the resident's care plan may result in a lack of/or inappropriate care.	F 280	**F 281 Services meet professional standards** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #1 has not received any iron supplement since it was discontinued on September 24, 2011. There were no known complications related to this medication error. The resident's physician was notified of the error on 10/9/11 and no intervention was needed. Completed by 3-8-12 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** During the end of the month medication record review, all resident medication records were checked to make sure they are consistent with current physician orders. This review was completed by the DNS/Designee and all problems were corrected. The monthly drug regimen review will be completed by the pharmacy consultant and part of the review	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 5 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, facility policy review, and staff interview, the facility failed to meet professional standards of quality regarding observing physician's orders for 1 of 1 sampled resident receiving hemodialysis (Resident #1). Failure to review the physician's orders prior to transcribing a discontinued medication to Resident #1's medication administration record (MAR) caused a resident with history of intolerance to iron to receive an iron supplement for 22 days. Findings include: Review of the facility policy titled "Physician's Orders" occurred on 02/02/2012. This policy, dated 09/2010, stated, "PURPOSE To provide a procedure that facilitates the timely and accurate processing of physician's orders . . . Introduction . . . Accurate processing and handling of physician's orders is important. The Nursing Services and Health Information Management departments each have responsibilities for processing physician's orders in a timely and accurate manner. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included end stage renal disease with hemodialysis three days a week, irritable bowel syndrome, chronic constipation, anemia	F 281	includes checking for medication discrepancies Completed by 3-1-12 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** All Licensed Nurses and Medication Aides were educated on physician orders and medication administration policies. Education included a written test. During month end medication record review any errors will be reported to the DNS for follow up. Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The DNS will submit a report to the Continuous Quality Improvement Committee (CQI Committee) on any errors found during the end of month medication record review. The reports will continue for 3 months and then as directed by the CQI Committee. Completed by 3-8-12	

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F 281	Continued From page 6	F 281		

associated with renal disease, gastroesophageal reflux disease, and chronic nausea/vomiting. Allergies noted on Resident #1's chart included iron.

A written physician's order, dated 08/25/11, stated to discontinue Resident #1's ferrous gluconate (iron supplement). Resident #1 had a hospital stay from 08/26/11 to 08/30/11 and on readmit the physician again ordered to discontinue the ferrous gluconate. Review of the Resident's September MAR showed Resident #1 received 324 milligrams (mg) of ferrous gluconate daily from September 3 - September 24, 2011.

A form titled, Incident Details, identified a nurse filled out general information about the incident involving Resident #1 receiving the discontinued ferrous gluconate from September 3 - 24, 2011. The form further identified the administrator received notification of the incident on 10/08/11, and on 10/09/11, the physician received notification. The information completed on 10/08/11 stated, " . . . What type of assessment/evaluation and/or medical treatment was done as a result of the incident? . . .[no change] in resident status . . . What immediate interventions have been put in place to prevent this incident from happening again? . . . Education provided to transcribing GSS [Good Samaritan Society] staff . . ."

During an interview on 02/02/12 at 7:55 a.m., an administrative nursing staff member reported that a nurse had added the ferrous gluconate to Resident #1's MAR in September without having an order from a physician after the nurse noticed the medication that Resident #1 had received in

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F 281	Continued From page 7 the past was not being given. This staff member lacked awareness on why follow-up, including administrator and physician notification, had not been completed until two weeks after the medication had stopped being administered.	F 281	**F 360 Provide a diet to meet the Resident's needs** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #5 was assessed for any bowel regularity problems. The physician was informed of the results of the assessment and follow up was completed as directed by the physician. Completed by 3-8-12 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Dietary Manager/Designee reviewed all resident diet orders and meal tray cards to make sure matched physician orders. Care Plans were also checked to make sure any special diet orders were included on the care plan. Any problems were corrected and residents involved assessed for any complications or needed follow up. Completed by 3-8-12 **This is what the facility will do or changes it will make to the systems that**	
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's diet manual, review of facility policy and procedure, and staff interview, the facility failed to provide a well-balanced diet that met the special dietary needs of 1 of 1 sampled resident (Resident #5) ordered to have a high fiber diet. Failure to provide the proper diet placed the resident at risk of developing complications related to bowel regularity. Findings include: Review of the facility policy and procedure titled "Physician's Orders" occurred on 02/02/12. This document, dated 09/2010, stated "PURPOSE To provide a procedure that facilitates the timely and accurate processing of physician's orders . . . the following orders are required upon admission . . . diet . . . " Review of the facility policy and procedure titled	F 360		

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F 360	Continued From page 8 "Dietary/Physician Communication" occurred on 02/02/12. This document, dated March 2009, stated, "PURPOSE To promote effective communication between the dietary department and the physician . . . PROCEDURE . . .When the charge nurse receives the order, he or she will communicate the order to the [director of dietary services] or designee prior to the next meal. . . ." Review of the facility's "Diet Manual" occurred on 02/02/12. This manual, dated 2008, included "High Fiber diet . . . high fiber diet is for individuals who need additional fiber in their diets. The aging process, along with decreased activity, certain disease states . . . and certain medications, all may contribute to the problem of constipation . . . " Review of Resident #5's medical record occurred on January 30 - February 2, 2012. The facility admitted the resident on December 22, 2011. The resident's current diagnoses included chronic obstructive pulmonary disease (COPD), recent left hip and pelvic fracture, and bacterial pneumonia. Resident #5's physician orders, dated 12/23/11, included a high fiber diet. Resident #5's Nutritional Status Care Area Assessment (CAA), dated 01/04/12, stated, " . . . current diagnoses of COPD, general debility, and Bacterial Pneumonitis requiring to need extensive assistance with cares. She is ordered for a high fiber/regular diet . . ." The resident's current care plan, dated 12/22/11, stated "Problems . . . Alteration in nutrition r/t [related to] poor appetite m/b [manifested by] low BMI [body mass index] . . . Approaches . . .	F 360	**will prevent this problem from reoccurring in the future.** A new communication board has been installed next to the serving line in the kitchen. Nursing Staff have been educated to post a copy of all physician orders dealing with resident diets on the communication board. Nursing has also been educated to note on the 24 hour report any changes in diet order. On an ongoing basis, the Dietary Manager will review all 24 hour reports and report any problems where diet order changes are not communicated. Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Dietary Manager will select 10% of the residents per month and complete a diet order audit. The Dietary Manager will submit a monthly report on the results of the diet order audit to the Continuous Quality Improvement Committee (CQI Committee). The reports will continue for 3 months and then as directed by the CQI Committee. Completed by 3-8-12	

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F 360	Continued From page 9 Therapeutic high fiber diet as ordered. . . ." The resident's current diet card, dated 01/27/12, lacked information related to the physician ordered high fiber diet. During interview, on 02/01/12 at 3:00 p.m., a supervisory dietary staff member (#4) reported facility staff provide juice with added fiber to residents on a high fiber diet and the diet card would reflect this. This staff member confirmed after checking Resident #5's physician's orders, that dietary staff failed to provide the physician ordered high fiber diet since admission.	F 360	**F 369 Assistive Devices- Eating equipment/utensils** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #1's meal tray card and care plan was updated to show the usage of a plate guard. Resident #1 was assessed for any weight related problems. Resident #6 was discharged. Completed by 3-8-12	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, review of policies/procedures, record review and staff interview, the facility failed to provide appropriately placed adaptive equipment for 2 of 3 sampled residents (Resident #1 and #6) requiring adaptive equipment for eating. Failure to provide adaptive equipment according to the resident's needs has the potential to contribute to possible weight loss and to negatively impact a resident's dignity related to spillage of food from their plate. Findings include: A Plate Guard is an assistive device used to	F 369	**This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** The Restorative Nursing Supervisor/Designee will review all residents to make sure appropriate adaptive eating utensils are being used for residents. The review will include checking meal tray cards and care plans. Completed by 3-8-12 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Residents who use plate guards will have usage instructions printed on	

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F 369	Continued From page 10 scoop food on to a utensil. The guard attaches to most plates and is commonly used by people who have controlled movement with only one hand. Food is pushed by a utensil against this wall-like device that curves along the edge of one side of the plate. Review of the facility policy titled, "Meal Service/Dining Assistive Devices," occurred on 02/02/12. This policy, dated revised 03/09, stated, "Purpose - To provide assistive devices to maintain or improve the resident's ability to eat independently. Policy - The center will provide special eating equipment and utensils for residents who need these items. Procedure 1. The rehabilitation nurse or designee, in conjunction with the director of dietary services, may make recommendations regarding resident use of assistive devices. 2. Every effort will be made to assist a resident in attaining/maintaining independence in eating. . . . 4. Assistive devices will only be used with the approval of the resident. . . . 7. Use of these devices will be noted on the care plan and dietary card. . . ." - Record review of Resident #6's medical record occurred January 30 - February 2, 2012 and identified the facility admitted Resident #6 in September 2011. Diagnoses for Resident #6 included cerebrovascular accident (CVA) with right sided hemiplegia (paralysis). Resident #6's current care plan, dated 12/21/11, identified a problem with alteration in nutrition related to diabetes manifested by a therapeutic diet and significant weight loss. Plans and approaches included "plateguard." The care plan also identified a problem with mobility impairment	F 369	his/her meal tray card. Nursing Department staff will be trained on appropriate usage of plate guards. Training will include a return demonstration using a meal tray card for guidance. Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Restorative Nursing Supervisor will complete a weekly audit that checks for appropriate adaptive eating utensils. The results of the weekly audits will be report on a monthly basis to the Continuous Quality Improvement Committee (CQI Committee). The reports will continue for 3 months and then as directed by the CQI Committee. Completed by 3-8-12	

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F 369	Continued From page 11 related to a stroke manifested by hemiparesis (muscle weakness). Plans and approaches included "Be aware of R) [right] side hemiparesis when assisting." An Inter-Department Communication form from occupational therapy, dated 10/03/11, stated, "Please add plateguard at meals. It helps & [and] she likes. . . ." Observations of Resident #6 during meals identified the following: * On 01/31/12 at 8:05 a.m. - nursing staff member (#1), sitting at Resident #6's left side, positioned the opening of the plate guard to the resident's right (affected) side and repositioned the plate guard a few minutes later with the opening at the top of the plate (10 o'clock to 2 o'clock). * On 01/31/12 at 11:45 a.m.- certified nurse assistant (CNA) (#2), sitting at Resident #6's left side, positioned the opening of the plate guard with the opening at the top of the plate. * On 01/31/12 at 6:07 p.m. - staff positioned the plate guard with the opening at the top of the plate. * On 02/01/12 at 12:05 p.m. - staff positioned the plate guard with the opening to the resident's right (affected) side. At this meal, during an interview with a nursing staff member (#3), she confirmed the plate guard should be positioned with the opening to the resident's left side. The staff failed to consistently position the opening of Resident #6's plateguard to accommodate the use of her dominant hand. During an interview on 02/01/12 at 12:10 p.m., an	F 369		

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F 369	Continued From page 12 administrative dietary staff member (#4) stated the opening of the plate guard "should be open to the side the resident is able to use." - Record review of Resident #1's medical record occurred from January 30 - February 2, 2012. Resident's diagnoses included peripheral neuropathy and blindness of right eye. The resident's admission assessment, dated 04/29/2011, identified Resident #1 had very poor vision to her left eye and is blind in her right eye. Resident #1's Minimum Data Set, dated 11/30/11, identified the resident with severely impaired vision and needing limited assistance with eating. Resident #1's care plan, dated 12/07/11, identified the problem of alteration in nutrition with the approach to use a plate guard and inform the resident of location and types of foods. Review of Resident #1's meal tray card identified a divided plate to be used at meals. The facility failed to have consistency between the care plan and the tray card. - Observation on 02/02/12 at 8:45 a.m. showed Resident #1 in her room eating food off of a flat plate which lacked a plate guard. Resident #1 tried to scoop pieces of food onto her fork and pushed food onto her bedside table. The resident used her fingers to pick up the food off of the table and ate the food. The facility staff failed to provide a plate guard to Resident #1 during her meal which contributed to her food being pushed off the plate onto the bedside table.	F 369	**F 371 Store/Prepare/Serve food in a sanitary manner** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** The sewer line was appropriately capped by maintenance staff. An additional inspection of all kitchen areas show no other uncapped sewer lines. Completed by 2-1-12 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents could have been affected by this practice but by capping the sewer line and inspecting to make sure no more uncapped lines exist, they will all be protected. Completed by 2-1-12	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 13 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store food under sanitary conditions in 1 of 2 kitchen areas (lower level main preparatory kitchen). Failure of the facility to properly plug a sewer line after removing a dishwasher allows for food stored next to the sewer line to become contaminated and increases risk of illness to facility staff, family, and residents who eat at the facility. Findings include: - During a tour of the facility's main preparatory kitchen on 02/01/12 at 9:20 a.m., observation showed a sewer drainage pipe sticking horizontally out of a wall and protruding into a cupboard. The pipe lacked a proper cover and contained a dish cloth pushed into it. The cupboard containing the pipe stored four Angel food cake mixes, a box of lemon bar mix, six boxes of bread crumbs, and two plastic containers that contained bread crumbs and corn meal.	F 371	**This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** The Environmental Services Supervisor was educated on the need to properly cap all sewer/drain lines. The Environmental Services Supervisor completed an audit of the building to make sure there are no other uncapped sewer or drain lines. Any new remodeling projects will include as part of the final inspection prior to use, checking for uncapped sewer and drain lines. Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** Any time the facility is remodeling a drain/sewer line the Director of Environmental Services will be responsible to inspect drain/sewer line work to make sure any unused lines are capped. A report of the inspection will be given to the CQI Committee for any follow up. This process will continue on an ongoing basis. Completed by 3-8-12	

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F 371	Continued From page 14 During an interview on 02/01/12, an administrative maintenance staff member (#9) agreed the pipe lacked a proper cover which increased the risk that sewer gas and sewage could back up into the kitchen and contaminate food and food prep areas.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F 441 Infection Control** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #5's nebulizer mask was properly cleaned. Resident #5 was assessed for any infections and was found free of infections related to use of a nebulizer mask. Resident #9's nebulizer mask was properly cleaned. Resident #9 was assessed for any infections and was found free of infections related to use of a nebulizer mask. Nursing staff have been educated on proper cleaning of nebulizer masks. Completed by 3-8-12 **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All other residents who use a nebulizer mask had his/her mask cleaned and the resident was	

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F 441	Continued From page 15 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to properly clean the nebulizer device for 2 of 2 residents (Resident # 5 and #9) observed receiving nebulizer treatments. Failure to follow facility procedure and infection control guidelines may lead to the development and transmission of disease and infection. Findings include: Review of the facility policy and procedure "Nebulizer" occurred on February 2, 2012. The policy, revised September 2010, stated, " . . . Procedure . . . Cleaning Nebulizers 1. Wash hands. 2. Disconnect nebulizer from tubing. 3. Rinse under hot tap water to remove any residual after each use. 4. Air dry parts on clean paper towels. 5. Wash hands. . . ." - Record review for Resident #5 occurred on all days of survey. The resident's orders include Duonebs at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. The facility identified resident #5 as interviewable. On 01/31/11 at 4:30 p.m. Resident #5 went to the emergency room and returned in the evening with orders for Levaquin and Prednisone for a diagnosis of exacerbation of	F 441	assessed for any signs or symptoms of infection. Completed by 3-8-12 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** Licensed Nursing Staff and Medication Aides were educated on the use and cleaning of a nebulizer mask. Education included a written test. All residents who use nebulizer masks have the masks stored in a sanitary container. The mask is cleaned and returned to the container after each use. Nebulizer masks are changed out for new masks every three weeks and PRN. The Licensed Nurse/Medication Aide who assists with the nebulizer treatment documents the cleaning in the mediation administration record. The record will also track when the date the mask was put into service. Completed by 3-8-12 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The Director of Nursing Services/Designee will audit, on a monthly basis, the medication	

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F 441	Continued From page 16 chronic obstructive pulmonary disease (COPD) with patchy infiltrates. Observations of Resident #5's nebulizer treatments identified the following: * 01/31/12 at 7:45 a.m., showed Resident #5 seated in her room with a nebulizer mask around her neck. At 7:55 a.m., a nurse (#10) removed the nebulizer from around the resident's neck and placed it on her bedside table. At 8:15 a.m. the same nurse moved the nebulizer and tubing from the bedside table to a plastic graduated cylinder on Resident #5's television stand. The nurse failed to rinse the nebulizer and place on paper towels to dry. The nebulizer and tubing remained in the plastic container at 10:00 a.m. and at 1:50 p.m. * 02/01/22 at 3:55 p.m., a staff nurse (#11) entered Resident #5's room, obtained the nebulizer mask and tubing from the plastic graduated cylinder which had a plastic bag overtop of it. The nurse administered the nebulizer treatment to Resident #5, and at 4:05 p.m., the staff nurse (#11) placed the nebulizer mask and tubing back into the plastic container without cleaning. * 02/02/12 at 9:20 a.m., nebulizer mask and tubing lying on resident's bed with water droplets dried on the mask. - Record review for Resident #9 occurred on February 1-2, 2012. The resident's orders included the nebulizer of bromide inhalation solution four times daily. Observation on 02/01/12 at 3:50 p.m. showed a staff nurse (#11) obtain the nebulizer and tubing from a plastic container that had a plastic bag	F 441	administration records of residents who use nebulizers. The audit will check to make sure the nebulizer mask was documented as cleaned after each usage and how long the mask was used. Any concerns found during the audit will be followed up immediately. A monthly report of the audits will be submitted by the DNS/Designee to the Continuous Quality Improvement Committee (CQI Committee). The reports will continue for 3 months and then as directed by the CQI Committee. Completed by 3-8-12	

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F 441	Continued From page 17 over top of it. After administering the nebulizer, the nurse (#11) placed the nebulizer and tubing back into the plastic container without cleaning. During interviews on 02/01/12 at 4:05 p.m., the staff nurse (#11) reported the nebulizer gets cleaned at the end of the night, and at 4:10 p.m., Resident #5 confirmed she sees staff clean the nebulizer daily, but not after every treatment. During interviews the morning of 02/02/12, the administrative staff nurses (#6 and #13) stated expectations of staff would be to cleanse the nebulizer after each treatment and follow the facility procedure for cleaning the nebulizer.	F 441		