STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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 Fro the standard Medicare/Medicaid recertification survey started on 05/22/17 and completed on 05/25/17, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		7/6/17

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

Electronically Signed | 06/22/2017

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F 278	Continued From page 1 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 7 of 13 sampled residents (Resident #1, #2, #4, #8, #10, #11, and #13). Failure to code the MDS correctly related to turning/repositioning and constipation does not provide an accurate assessment of a resident's current status and needs. Findings include: TURNING AND REPOSITIONING The Long-Term Care Facility RAI User's Manual, revised October 2016, pages M 38-39 stated, ". . . M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., [example given] reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ." - Review of Resident #1's medical record occurred on all days of survey. The annual MDS,	F 278	F278 Assessment Accuracy-E 1. Residents #1, #2, #4, #8, #10, #11, and #13 will have current MDS coded with accurate corrections and resubmitted related to turning/repositioning and/or constipation to have an accurate assessment of the resident's current status and needs. 2. All other residents in the facility affected by this same practice at the time of the survey will have current MDS coded with accurate corrections and resubmitted related to turning/repositioning and/or constipation to have an accurate assessment of all resident's current status and needs. 3. Licensed nurses completing the MDS will be trained and review the MDS definitions for accurate coding to turning/repositioning and constipation and refer to The Long-Term Care Facility RAI 3.0 User's Manual for any questions regarding accurate coding of an MDS item on 6/20/17 by the Director of Nursing. 4. Audits will be completed initially by 7/03/17 by the MDS nurse to ensure that of the MDS assessments at the time of survey are coded accurately regarding	

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F 278	Continued From page 2 dated 03/27/17, identified extensive assistance of one for bed mobility and on a turning/repositioning program. The current care plan stated, ". . . Bed Mobility: Assist of 1 . . . Repositioning: assist with repositioning every 2 hours and as needed. . . . unable to ambulate . . . Transfer: Hoyer mechanical lift and 2 staff assist. . . ." Resident #1's medical record failed to identify an individualized repositioning program. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 04/06/17, and the annual MDS, dated 01/06/17, identified extensive assistance required for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Repositioning: 1-2 assist q [every] 2-3h [hours] and PRN [as needed] - does refuse. If refuses, try again, if still refuses report to nurse." Resident #2's medical record failed to identify an individualized repositioning program. - Review of Resident #4's medical record occurred on all days of survey. The admission MDS, dated 04/12/17, identified extensive assistance required for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Repositioning: 1 assist." Resident #4's medical record failed to identify an individualized repositioning program. - Review of Resident #8's medical record occurred on all days of survey. The quarterly MDS, dated 05/01/17, and the annual MDS, dated 02/01/17, identified total assistance for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Bed Mobility and Repositioning: 1 assist, q 2 hours; Requires staff	F 278	turning/repositioning and/or constipation. Audits will then be completed monthly for one year by the MDS nurse. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly. The MDS Nurse will follow up on further education/training on an as needed basis. 5. July 6, 2017	

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F 278	Continued From page 3	F 278		

assist and standing PAL [sit to stand mechanical lift] for transfers in and out of bed. Body pillow for repositioning d/t [due to] muscle/body alignment . . ." Resident #8's medical record, including the "24 Hour Repositioning Record," failed to identify an individualized repositioning program which included the use of the body pillow.

- Review of Resident #10's medical record occurred on May 24-25, 2017. The quarterly MDS, dated 04/06/17, identified extensive assistance for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Bed Mobility and Repositioning: 1 assist, q2hr and PRN; 2 assist PRN; Heel protectors on at all times." Resident #10's medical record failed to identify an individualized repositioning program.

- Review of Resident #11's medical record occurred on May 24-25, 2017. The significant change MDS, dated 05/17/17, and the quarterly MDS, dated 02/17/17, identified extensive assistance for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Positioning: self at times and assist of 1." Resident #11's medical record failed to identify an individualized repositioning program.

- Review of Resident #13's medical record occurred on May 24-25, 2017. The quarterly MDS, dated 03/11/17, identified extensive assist of two required for bed mobility and on a turning/repositioning program. The care plan stated, ". . . Repositioning: q2h and PRN . . . resident to change positions at least every two hours due to history of skin breakdown. . . ." Resident #13's medical record failed to identify

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F 278	Continued From page 4 an individualized repositioning program. CONSTIPATION The Long-Term Care Facility RAI User's Manual, revised October 2016, page H-12, stated, "Definition: CONSTIPATION: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements [BM] their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). * Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. * Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Clostridium difficile (C. diff). The admission MDS, dated 04/12/17, identified constipation. Resident #4's BM records showed more than two BMs during the 7-day assessment period. During an interview on 05/24/17 at 4:10 p.m., an administrative staff member (#2) confirmed Resident #4 did not experience constipation during the assessment period.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		7/6/17

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F 281	Continued From page 5 (i) 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 reference, and staff interview, the facility failed to ensure staff assessed the response to as needed (PRN) medications for 2 of 13 sampled residents (Resident #3 and #12) who received PRN medications (pain medication and cough suppressant). Failure to assess the residents' response to PRN medications in a timely manner limited the staff's ability to assess the effectiveness of the medications and may result in the resident experiencing unrelieved pain and/or cough. Findings include: "Nursing 2017 Drug Handbook, 37th edition (ed.), Wolters and Kluwer, Pennsylvania, pages 75, 214, and 726, stated, ". . . acetaminophen [Tylenol] . . . Analgesic . . . peak [highest level of pain relief at] 1/2 - 2 hr [hour] . . . benzonatate [Tessalon] . . . Antitussives . . . suppresses the cough reflex . . . Onset 15-20 min [minutes] . . . Norco [hydrocodone] . . . Analgesic . . . peak 1/2 to 2 hr . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1106 and 1109, stated, ". . . NONOPOID ANALGESICS/NSAIDS [nonsteroidal anti-inflammatory drugs] FOR MILD PAIN - *Acetaminophen OPIOID ANALGESICS FOR MODERATE PAIN- * Hydrocodone . . . Assess pain prior to and 60 minutes after	F 281	F281 Professional Standards 1. Resident #3 and #12 will have appropriate documentation and follow up documentation of prn medication administrations including responsiveness to treatment documented in a timely manner and use of 0 to 10 pain scale assessment with administration of prn analgesics on the MAR. 2. All residents who receive a prn medication will have appropriate medication documentation and follow up documentation of prn medication administrations including responsiveness to treatment in a timely manner and use of 0-10 pain scale assessments with administration of prn analgesics on the MAR. 3. Policy and procedure for Administering Pain Medications and Documentation of Medication Administration were reviewed. All licensed individuals who administer medications will be educated on the policy and procedure for Administering Pain Medications (including using of 0-10 pain scale and documentation in timely manner of responsiveness to prn analgesics) and Documentation of Medications (including documentation of response to prn medications) by the Director of Nursing on 6/20/17. 0-10 pain scales for reference purposes will be available on each medication cart by 6/21/17.	

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F 281	Continued From page 6 administration. . . . Evaluate the effectiveness of pain control measures used through ongoing assessment. . . ." Review of the facility policy titled "Pain Assessment and Management" occurred on 05/25/17. This policy, revised March 2015, stated, ". . . 'Pain management' is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident . . . Monitoring for the effectiveness of interventions . . ." Review of the facility policy titled "Pain Management" occurred on 05/25/17. This policy, dated April 2014, stated, "Each resident will be provided with a constant, accurate and timely comprehensive assessment of resident's comfort level as related to acute, chronic or suspected pain. . . . The pain assessment will also include the use of a pain scale to describe the resident's pain and amount of pain relief. . . . A pain scale of 0 to 10 can be used . . . Monitor and document effectiveness of pain control methods . . . The resident's response to the PRN pain medication will be documented on the residents Medication Administration record with: A pain scale rating at time of adminstration. A pain scale rating one hour later. Monitoring for side effects." - Review of Resident #3's medical record occurred on May 22-25, 2017. Diagnoses included left hip and pelvic fracture, osteoporosis, and knee pain. The admission Minimum Data Set (MDS), dated 04/13/17, identified presence of frequent pain rated 10 on a scale from 0 to 10 (0 is no pain and 10 is the worst pain imaginable). The current care plan stated, "Pain . . .	F 281	4. Audits will be completed initially by 7/03/17 by the Nurse Managers and/or Director of Nursing to ensure all residents who receive prn medications have appropriate documentation of follow up documentation pf prn medications including responsiveness to treatment being documented in a timely manner and use of 0 to 10 pain scale assessments with administration of prn analgesics. Audits will then be completed weekly for one month and then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Nurse Managers and/or Director of Nursing will follow up on further education/training on an as needed basis. 5. 07/06/17	

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F 281	Continued From page 7 Administer medications . . . PRN as ordered. Evaluate/record/report effectiveness using pain scale as appropriate and any adverse side effects. . . . Update physician if pain management is not effective . . ." The physician's orders, medication administration record (MAR), and progress notes for May 01-23, 2017 identified the following: * "Acetaminophen OTC [over the counter] 1000 milligrams (mg) give three times a day PRN for pain." The staff administered Acetaminophen four times, assessed Resident #3 on two occasions over two hours after administering the pain medication, and failed to assess for pain relief on one occasion. * "Hydrocodone-acetaminophen 5-325 mg give one tablet every four hours PRN for moderate pain." The staff administered Hydrocodone-acetaminophen 20 times. On four occasions staff assessed Resident #3 two hours after administering the pain medication and on two occasions staff failed to assess his/her pain relief. * "Oxycodone 5 mg give one tablet every four hours PRN for severe pain." The staff administered Oxycodone 27 times, assessed Resident #3 on eight occasions two to three hours after administering the pain medication, and failed to assess for pain relief on two occasions. The medication administration notes for May 01-23 2017 identified PRN medications administered 54 times and on 29 occasions the facility staff failed to document a follow up time and on 51 occasions the facility staff failed to document an initial pain level and follow up pain	F 281		

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F 281	Continued From page 8 level on a scale from 0 to 10. - Review of Resident #12's medical record occurred on May 22-25, 2017. Diagnoses included upper respiratory infection. The current care plan stated, ". . . has potential for complication, including SOB [shortness of breath] . . . administer medications: as ordered/evaluate/record/report effectiveness/adverse side effects. . . ." The physician's orders, MAR, and progress notes for May 05-07, 2017 identified "Benzonatate 100 mg QID [four times a day] q [every] 8hrs [hours] as needed for cough." The staff administered Benzonatate six times, assessed Resident #12 on four occasions two to three hours after administering the medication, and failed to assess his/her cough relief on two occasions. During an interview on 05/25/17 at 8:25 a.m., an administrative staff member (#1) expected staff to assess and document the resident's pain level on a scale from 0 to 10 and document the follow up time and effectiveness of the PRN medication administered within one hour.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.	F 309		7/6/17

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F 309	Continued From page 9 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 4 sampled residents (Resident #8 and #10) with a diagnosis of constipation. Failure to implement interventions to manage constipation in a timely manner and administer the less invasive intervention may have resulted in these residents receiving unnecessary suppositories.	F 309	F309 Provide Care/Services for Highest Well Being 1. Resident #8 and #10 will have interventions implemented to manage constipation in a timely manner and administer the least invasive interventions initially. 2. All residents who experience constipation will have interventions implemented to manage constipation in a	

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F 309	Continued From page 10 Findings include: Review of the facility policy titled "CONSTIPATION, TREATMENT/PREVENTION OF" occurred on 05/25/17. This policy, dated April 2015, stated, "POLICY: All residents will have BM's [bowel movements] monitored to assure adequate elimination and prevention of fecal impactions. PROCEDURE: . . . If resident has had no bowel movement in 2-3 days, the standing orders will be initiated for constipation. . . ." Review of the facility's "Standing Orders" occurred on 05/25/17. These orders, revised September 2016, stated, ". . . BOWEL MANAGEMENT: Constipation: Follow facility protocol. 1) MOM [Milk of Magnesia] 30 cc [cubic centimeters] po [by mouth] qd [every day] prn [as needed] 2) Bisacodyl suppository 10 mg [milligrams] qd prn . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included constipation and pain. Medications included Miralax (to promote a BM) daily, MS Contin (morphine) (for moderate to severe pain and may cause constipation) 30 mg twice a day for pain, MOM PRN, and Bisacodyl suppository rectally PRN. Review of Resident #8's bowel records and medication administration records (MARs) from 03/01/17 through 05/24/17 showed the facility administered a suppository on six occasions without first attempting MOM, a less invasive intervention.	F 309	timely manner and administer the least invasive interventions initially. 3. Reviewed policy and procedures for Treatment/Prevention of Constipation. All licensed individuals who administer medications will be educated on the policy and procedure for Treatment/Prevention of Constipation and directed to administer the least invasive intervention initially by the Director of Nursing on 6/20/17. Nurse Managers will review assessments of all residents who experience constipation by 7/01/17 to assure interventions in place to effectively manage their constipation and will follow up with provider for any changes that are needed. 4. Audits will be completed initially by 7/03/17 by the Nurse Managers and/or Director of Nursing to ensure all residents who experience constipation have interventions in place and implemented in a timely manner with least invasive interventions implemented initially. Audits will then be completed weekly for one month, then monthly x3 months and then quarterly. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The Nurse Managers and/or Director of Nursing will follow up on further education/training on an as needed basis. 5. July 6, 2017	

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F 309	Continued From page 11 - Review of Resident #10's medical record occurred on May 24-25, 2017. Diagnoses included constipation and pain. Medications included Senna-S (to promote a BM) twice a day, Tylenol 500 mg twice a day, MOM PRN, and Bisacodyl suppository 10 mg rectally PRN. Review of Resident #10's bowel records and MARs from 03/01/17 through 05/24/17 showed the facility administered a suppository on three occasions without first attempting MOM, a less invasive intervention. In addition, the records showed Resident #10 had no BM May 03-06 (4 days) with no interventions, May 10-12 (3 days) with no interventions, and May 16-19 (4 days) with no interventions. During an interview on 05/25/17 at approximately 11:30 a.m., an administrative nurse (#1) stated she expected nursing staff to follow the facility's bowel protocol.	F 309		
F 314 SS=E	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314		7/6/17

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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 314	Continued From page 12 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference review, and staff interview, the facility failed to provide the necessary care and services for 4 of 12 sampled residents (Resident #1, #6, #8, and #9) identified as at risk for pressure ulcers. Failure to turn and reposition (Resident #1, #8, and #9), apply heel protectors or float heels (Resident #6 and #9), apply palm protectors (Resident #8), and check and change every two hours (Resident #1 and #9) may result in worsening of current pressure ulcers and/or the development of new pressure ulcers. Findings include: Review of the facility policy titled "Repositioning" occurred on 05/25/17. This policy, dated 2013, stated, "Purpose: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, . . . to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. . . . General Guidelines: 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. . . . Interventions: 1. A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. . . . 2. Frequency of repositioning a bed- or chair-bound	F 314	F314 Prevent Pressure Sores 1. Residents #1, #8, and #9 will be turned and repositioned every two hours to prevent skin breakdown. Residents #6, and #9 heel protectors will be applied per plan of care to prevent skin breakdown. Resident #8 will have palm protectors applied per plan of care to prevent skin breakdown. Residents #1 and #9 will have check and changing toileting program completed every two hours to prevent skin breakdown. 2. All residents who are at risk for skin breakdown will have interventions implemented per individualized plan of care to maintain intact skin integrity; such as repositioning every two hours, floating heels or heel protectors, palm protectors in place, and/or completion of toileting programs as directed. 3. Director of Nursing reviewed policy Prevention of Pressure Ulcers. All licensed nurses and certified nursing assistants will receive education on 6/20/17 regarding prevention of skin breakdown with following interventions and specific individualized care plans in regards to turning and repositioning, toileting programs, positioning techniques, and protectors for heels and palms; by the Director of Nursing. All residents at risk for skin breakdown will	

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F 314	Continued From page 13 resident should be determined by: b. The condition of the skin; c. the overall condition of the resident; . . . 3. Residents who are in bed should be on at least an every two hour (q2hour) repositioning schedule. . . . 5. Residents who are in a chair should be on an every one hour (q1 hour) repositioning schedule. . . ." Review of the facility policy titled "Check and Change for Bladder Incontinence" occurred on 05/27/17. This policy, dated April 2014, stated, "C & C [check and change] is designed to promote good skin integrity . . . Check the resident every 2 hours or as specified in their individual schedule on the care plan. . . . Document each toileting episode on the resident record . . ." Review of the facility policy titled "Pressure Ulcer Risk Assessment" occurred on 05/27/17. This policy, revised September 2013, stated, ". . . Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues. . . . Intrinsic (contributes to the production of a result) risk factors for pressure ulcers include: Immobility. . . Altered mental status. . . Incontinence . . . Diagnoses and Conditions that increase risk for pressure ulcers: . . . Urinary incontinence . . . Alzheimer's disease and other dementia . . ." Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing, Concepts, Process, and Practice", 10th ed., Pearson Education, Inc., New Jersey, page 1035, stated, "Positioning Clients: . . . Any position, correct or incorrect, can	F 314	continue to have individualized plan of care to prevent skin breakdown interventions listed on the CNA group sheet (CNA work assignment) to ensure communication of interventions needed. 4. Audits will be completed initially by 7/03/17 by the licensed nurses and/or Nurse Managers to ensure all residents at risk for skin breakdown receive their individualized interventions to maintain intact skin integrity; such as repositioning every two hours, floating heels or heel protectors, palm protectors in place, and/or completion of toileting program. Audits will then be completed weekly for one month, then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed nurses and/or Director of Nursing will follow up on further education/training on an as needed basis. 5. July 6, 2017	

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be detrimental if maintained for a prolonged period. Frequent change of position helps to prevent muscle discomfort, undue pressure resulting in pressure ulcers, damage to superficial nerves and blood vessels, and contractures. . . ."

- Review of Resident #8's medical record occurred on all days of survey. Diagnoses included dementia and pain of her left fingers. The quarterly Minimum Data Set (MDS), dated 05/01/17, identified total assistance required for bed mobility, at risk for pressure ulcers, and on a turning/repositioning program.

Resident #8's current care plan stated, "SKIN: Hx [history] recent Ulcerations to left finger pads . . . Approach: Right palm protector [rolled washcloth] on in am and off at hs [bedtime] . . . left hand finger orthotic; on times 3 hrs [hours] in AM and 3 hrs in afternoon . . . ADL [activities of daily living] Function . . . Bed Mobility and Repositioning: 1 assist, q 2 hours; Requires staff assist and standing PAL [sit to stand mechanical lift] for transfers in and out of bed. Body pillow for repositioning d/t [due to] muscle/body alignment . . ." On 01/03/17, Resident #8's provider discontinued the left hand orthotic and replaced with a rolled washcloth.

Observation and interviews identified the following:
* 05/23/17 at 7:30 a.m. - Resident #8 seated in a wheelchair in the dining room. A certified nursing assistant (CNA) (#3) stated the facility staff transferred Resident #8 into the wheelchair at approximately 6:30 a.m. At 10:30 a.m., the CNA (#3) brought Resident #8 and the sit to stand lift

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into the resident's room. The CNA removed a rolled washcloth from the resident's right hand, placed her fingers around the handlebar of the lift, and transferred her onto the toilet. A rolled washcloth remained in her left hand. When finished, the CNA transferred the resident back to the wheelchair. The CNA (#3) failed to place the rolled washcloth back in the resident's right hand. Observation and interview identified Resident #8 sat in her wheelchair for approximately four hours.
* 05/23/17 at 3:45 p.m. - Two CNAs (#4 and #5) checked and changed Resident #8's brief and transferred her from bed to a wheelchair. Observation showed a rolled washcloth in the resident's left hand but not in her right hand.
* 05/24/17 at 7:30, 9:30, 10:25, and 11:05 a.m. - Resident #8 seated in a wheelchair. During an interview at 10:25 a.m., a CNA (#6) stated they (CNA (#6) and another CNA) transferred Resident #8 into the wheelchair at approximately 6:15 a.m. The CNA stated facility staff usually lay the resident down after lunch for a nap and check/change her brief at that time. Resident #8 sat in her wheelchair for over five hours.
* 05/25/17 at 7:45, 8:10, and 9:45 a.m. - Facility staff failed to place a rolled washcloth in either of Resident #8's hands.

During an interview on 05/25/17 at 10:30 a.m., an administrative nurse (#1) stated she expected facility staff to reposition Resident #8 at least every two hours and to place the washcloths in her hands.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. The

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annual MDS, dated 03/27/17, identified severely impaired cognition, extensive assistance of one for bed mobility, total assistance of two for transfers and toileting, frequently incontinent of urine and stool, at risk for pressure ulcers, and on a turning/repositioning program.

Resident #1's current care plan stated, ". . . ADL Function: . . . Toileting: incontinent B & B [bowel and bladder] . . . check & change q2h dep [dependent] on pericare with every inc [incontinent] episode, . . . Repositioning: Assist with repositioning every 2 hours and as needed. . . . Urinary Incontinence . . . check and change program q2h r/t [related to] level of cognitive loss . . . Resident at risk for impaired skin integrity r/t . . . assistance with cares . . . incontinence . . . Pressure reducing mattress on bed/chair . . ."

Resident #1's daily toileting charting and repositioning record, dated May 2017, failed to identify the facility staff repositioned and provided toileting assistance every two hours as care planned for Resident #1.

Observations on 05/23/17 identified the following:
* 7:30 a.m. to 9:50 a.m. - Resident #1 laid in bed on his back, the head of the bed flat.
* 9:50 a.m. - Resident #1 laid in bed on his back. The CNA (#6) completed morning and incontinence cares. Two CNAs (#6 & #22) transferred the resident from the bed to the wheel chair using a mechanical lift.
* 12:15 p.m. - Resident #1 sat in the dining room in the wheel chair.
* 1:55 p.m. - A staff CNA (#6) informed this surveyor two CNAs transferred Resident #1 from the wheel chair to the bed and completed

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incontinence cares. Facility staff failed to reposition and check and change the resident for approximately four hours.
* 1:55 p.m., 2:30 p.m., 3:30 p.m., and 4:00 p.m. - Observation showed Resident #1 positioned on his left side, propped with a pillow under his back and under the right foot.
* 5:15 p.m. A CNA (#4) informed this surveyor two CNAs completed incontinence cares and transferred Resident #1 into the wheel chair at 5:00 p.m. Facility staff failed to reposition Resident #1 for three hours.

During an interview on 05/23/17 at 3:45 p.m. an unidentified family member stated Resident #1 frequently laid in bed positioned on his left side over three hours at a time.

During an interview on 05/25/17 at 8:25 a.m. an administrative staff member (#1) confirmed Resident #1 should be repositioned, checked for incontinence, and changed every two hours.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, left heel deep tissue injury, dementia, and edema (lower extremities). The admission MDS, dated 05/15/17, identified severely impaired cognition, extensive assistance of two required for bed mobility and toileting, total assistance of two required for transfers, at risk for pressure ulcers, a left heel deep tissue injury, and always incontinent of urine and stool.

Resident #9's current care plan stated, ". . . ADL Function . . . a full body lift for all transfers with 2 staff assist . . . Ambulation: Unable . . .Bed

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Mobility: 1 assist . . . Repositioning: 1 assist . . . Toileting: Scheduled check and change every 2 hours. Inc of both bowel and bladder . . . Skin: Resident at risk for impaired skin integrity r/t left heel suspected deep tissue injury . . . needing staff assist for all cares and transfers, incontinence . . . Blue heel protectors on bilateral feet when in bed . . . Provide incontinence care after each incontinent episode . . . Skin treatments as ordered and PRN . . ."

The facility was unable to provide Daily Toileting charting and Repositioning documentation for Resident #9.

Resident #9's Admission Weekly Skin Assessments identified:
* 05/09/17 ". . . 2 cm [centimeter] x 4.6 cm suspected deep tissue injury (left heel) - dark brown in color."
* 05/16/17 " . . . Lt [left] heel area has brown area, dry, no redness or drainage."
* 05/23/17 ". . . 2 cm x 4.6 cm deep tissue wound (dark brown/black in color) no drainage . . ."

Resident #9's Skin Risk Assessment, dated 05/09/17, identified ". . . Chronic Incontinence . . . Peri Area . . . Redness . . . Edema . . . Mobility . . . Very Limited - Makes occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently. . . . Interventions . . . Elastic Stockings . . . Elevate Edematous/Affected Extremities . . . Heel Protectors . . . Turning/repositioning program . . . Pressure ulcer care . . ."

Observations showed the following:
* 05/22/17 at 5:15 p.m. - Resident #9 laid in bed

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both heels rested directely on the mattress. The staff failed to place the blue heel protectors on both feet.
* 05/23/17 at 7:30 a.m. - Resident #9 laid in bed propped on the left side with two pillows behind his back and both heels rested directly on the mattress. The staff failed to place the blue heel protectors on both feet. At 8:00 a.m., a CNA (#19) and a nurse (#23) provided personal cares. During cares, the CNA and nurse turned Resident #9 on the left side. Observation showed a large dark brown area on the bottom of the resident's left heel. The CNA (#19) and the nurse (#23) transferred Resident #9 from the bed into the wheelchair.
* 05/23/17 at 8:35 a.m., 9:50 a.m., 10:10 a.m., 12:15 p.m., and 12:30 p.m. - Resident #9 sat in the wheelchair.
* 05/23/17 at 1:50 p.m. - A CNA (#19) confirmed Resident #9 had not been repositioned or toileted between 8:00 a.m. and 12:50 p.m., nearly five hours.
* 05/23/17 at 1:50 p.m., 2:30 p.m., 3:30 p.m., 4:00 p.m., and 5:00 p.m. - Resident #9 laid in bed on the left side with a body pillow propped behind his back and both feet rested directly on the mattress. The staff failed to place the blue heel protectors on both feet.
* 05/23/17 at 5:15 p.m. - Resident #9 laid in bed. Both heels rested directely on the mattress. Two CNAs (#4 and #24) entered the room and completed incontinence cares. Observation showed swelling in both feet and ankles. One CNA (#24) placed Resident #9's shoes on over thick gripper socks making the shoes tight. The two CNAs (#4 & #24) transferred Resident #9 from the bed to the wheel chair.
* 05/24/17 at 3:25 p.m. - Resident #9 laid in bed

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propped on the left side. Both heels rested directly on the mattress. The staff failed to place the blue heel protectors on both feet.

During an interview on 05/25/17 at 8:25 a.m., an administrative staff member (#1) confirmed staff should have repositioned and check and changed Resident #9 every two hours and Resident #9 should have had the blue heel protectors placed on both feet when in the bed.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, diabetes mellitus, psychosis and hand contracture. The quarterly MDS dated 03/19/17, identified total assistance of two required for bed mobility, transfers did not occur, at risk for pressure ulcers, and on a turning/repositioning program.

Resident #6's current care plan stated, ". . . ADL Function: Resident is total dependence of 2 physical assist with ADL's related to severely impaired cognitive status, tube feeding, poor vision, weakness and contractures, chair/bed bound status secondary to Dx [diagnosis]. . . . Approach: Bed Mobility and Repositioning: 1-2 assist q [every] 2 hr [hours] and PRN [as needed] with check and change of brief; Elevate and Float heals [sic] as resident allows. . . ."

Observations and interviews showed the following:
* 05/23/17 at 9:47 a.m. - A CNA (#21) and a nurse (#18) completed incontinence cares, positioned her to her right side, and placed a pillow between the resident's knees with her feet laying directly on the mattress and heels not

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F 314	Continued From page 21 floated. * 05/23/17 at 1:30 p.m. - Resident #6 rested in bed on her left side with a pillow between her knees, feet laying directly on the mattress, and heels not floated. * 05/23/17 at 3:30 p.m. - A CNA (#21) repositioned Resident #6 onto her right side, placed a pillow behind her back, and a pillow between her legs. The resident's right foot laid directly on the mattress and heels not floated. * 05/24/17 at 8:00 a.m. - Resident #6 laid on her right side with the right foot elevated on a pillow and her left foot directly against the mattress with her heel not floated. * 05/24/17 at 10:10 a.m. - Resident #6 laid on her left side with the left foot directly against the mattress and her heels not floated. During an interview on 05/2517 at 9:50 a.m., a staff nurse (#20) and an administrative nurse (#1) stated that Resident #6 should have her heels floated on pillows at all times.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		7/6/17

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F 323	Continued From page 22 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 1 of 5 sampled residents (Resident #5) who uses a wheelchair and is able to self propel. Failure to ensure staff remove leg rests and/or foot pedals after transporting the resident increases the risk for falls and injury. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, major depression and psychosis. The significant change Minimum Data Set (MDS), dated 05/03/17, identified two falls since the prior MDS. The current care plan stated, ". . . Problem: ADL Function: Resident requires extensive assist with ADLS [activities of daily living] related to severely impaired cognitive status . . . Approach: Wheelchair/Foot Pedals: no pedals on wheelchair-resident propels with feet and pedals increase her risk for falls with self transfer attempts and skin breakdown r/t [related	F 323	F323 Free of Accidents 1. Resident #5 expired 5/29/17. 2. All residents who at risk for falls and injuries from wheelchair foot pedals will have leg rests and/or foot pedals removed after transporting per individualized plan of care. 3. Director of Nursing reviewed policy Transporting Resident in Wheelchair. All licensed nurses and certified nursing assistants will receive education on 6/20/17 regarding prevention of falls and injuries with removal of wheelchair leg rests and/or foot pedals per individualized plan of care after transporting residents; by Director of Nursing. All residents at risk for fall and injuries due to wheelchair leg rests and/or foot pedals will continue to have individualized plan of care interventions listed on the CNA group sheet to ensure communication of interventions that are needed to prevent falls and injuries. 4. Audits will be completed initially by	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

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F 323	Continued From page 23 to] legs being caught on pedals. . . . Problem: Falls: Potential for injury related to falls due to attempts self transfers with dementia and confusion. . . . Approach: fall due to self transfer attempt-w/c antilock brakes are in working order . . ." Observations identified the following: * 05/23/17 at 12:10 p.m. - Resident #5 seated in her wheelchair at dining room table with bilateral leg rests on and the foot pedals in the down position. The resident's feet rested on the floor behind the foot pedals. * 05/23/17 at 3:10 p.m. - Resident #5 seated in her wheelchair in her room with bilateral leg rests on and the foot pedals in the down position. The resident's feet rested on the floor behind the foot pedals. * 05/23/17 at 4:05 p.m. - Resident #5 seated in her wheelchair by the nurses station. with bilateral leg rests on and the foot pedals in the down position. The resident's feet rested on the floor behind the foot pedals. * 05/24/17 at 8:00 a.m. - Resident #5 seated in her wheelchair at the dining room table with bilateral legs rests on and the foot pedals in the down position. The resident's feet rested on the floor behind the foot pedals. * 05/24/17 at 10:10 a.m. - Resident #5 seated in her wheelchair in her room with bilateral leg rests on and the foot pedals in the down position. The resident's feet rested on the floor behind the foot pedals. During an interview on 05/25/17 at 9:50 a.m., a nurse (#20) stated Resident #5 should use her wheelchair pedals if staff are transporting or pushing her but staff should remove them when	F 323	7/03/17 by the licensed nurses and/or Nurse Managers to ensure all residents who are at risk for falls and injuries from wheelchair leg rests and/or foot pedals have these devices removed per individualized plan of care. Audits will then be completed weekly for one month, then monthly x3 months and then quarterly. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed nurses and/or Director of Nursing will follow up on further education/training on an as needed basis. 5. July 6, 2017	

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F 323	Continued From page 24 the resident is just sitting due to her fall risk.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, review of dishwashing logs, and staff interview, the facility failed to ensure appropriate sanitization of dishware in 1 of 2 dishwashers (South kitchen). Failure of facility staff to ensure the proper temperature of water to sanitize dishes, utensils, and cookware may	F 371	F-371 – Sanitary Conditions 1. Culinary staff will use ThermoWorks DishTemp Plate Simulating Dishwasher Tester to ensure appropriate sanitization temperature of dishware is achieved to the south side dishwasher in order to	7/6/17

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F 371	Continued From page 25 result in inadequate sanitization and place residents at risk for food-borne illness. Findings include: Review of the facility policy/procedure titled "Dishwasher Temperature Monitoring Logs" occurred on 05/25/17. This policy/procedure, dated 06/15/04, stated, "Policy: To ensure that the wash and risen temperatures are properly monitored and controlled, a log must be completed by those who are directly involved in the dishwashing process. Entries must be made daily according to health department regulations and quality assurance standards. Procedure: . . . 2. Wash and rinse temperature are observed and logged by the operator using the manufacturers thermometer on the machine during the dishwashing. Thermometer test strips (160 degrees F) are used at the beginning of each dishwashing cycle to assure appropriate temperature is achieved. Test strip will turn black when 160 degree F temperature is reached. (Use one at breakfast, brunch and supper). 3. If test strip does not turn black, notify maintenance immediately." Observation during the start of the dietary tour on 05/24/17 at 9:15 a.m. showed an unidentified dietary staff member washing dishes in the South kitchen. A thermometer sent through with a load of dishes, by the surveyor, registered a temperature of 153.1 degrees F. Facility staff then ran a test strip through and the strip did not turn black, to indicate a temperature of 160 degrees F or higher. The staff member washing dishes showed the test strip used at the start of breakfast dishes did turn black. A second test	F 371	prevent unsanitary dietary conditions and foodborne illness outbreak. Updated current policy/procedures for Dishwasher Temperature Monitoring Logs and Dishwashing Procedures. Consulted chemical supplier on resolving temperature issues. Recommended and replaced element in the wash tank, pressure gauges, rinse and wash solenoids, thermostat and decalcified rinse arms. 2. Culinary staff will use ThermoWorks DishTemp Plate Simulating Dishwasher Tester to ensure proper sanitization temperature of dishware is achieved to all dishwashers in order to prevent unsanitary dietary conditions and foodborne illness outbreak. 3. Updated current policy/procedures for Dishwasher Temperature Monitoring Logs and Dishwashing Procedures. All culinary staff was in-serviced regarding Dishwasher Temperature Monitoring Logs and Dishwashing Procedures on 6/14/2017. 4. Audits will be completed initially starting 7/1/17 by the culinary supervisor and/or designee to ensure proper wash temperature (150 degrees F), plate temperature (160 degrees F) and rinse temperature (180 degrees F) of the south side dishwasher are achieved and maintained to sanitize dishes, utensils and cookware so that residents who eat	

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F 371	Continued From page 26 with the thermometer measured 157.8 and a third 162.2. An administrative dietary staff member (#7) told the dietary staff member doing dishes to call maintenance to check the dishwasher. By the end of the dietary tour, the facility moved all dishwashing for the facility to the North kitchen which tested at 160 degrees F or greater. Review of the test strip logs for the months of April and May 2017 showed the test strips failed to turn black (indicating improper sanitization temperatures) 31 times in April and 23 times in May. The logs also showed staff failed to monitor temperature as per policy twice in April and three times in May. During an interview on 05/24/17 at 4:00 p.m., an administrative maintenance staff member (#8) identified the dishwashing machine in the South kitchen was not working properly due to calcium build up. When asked, this staff member (#8) indicated dishwashing staff failed to inform maintenance when the test strips failed to turn black, to indicate the appropriate temperature was achieved. During an interview on 05/24/17 at 4:40 p.m., an administrative dietary staff member (#7) reported the South kitchen dishwasher was not reaching the appropriate temperature and multiple staff members were working on it. When asked, this staff member (#7) identified dishwashing staff failed to inform her when the test strips failed to turn black to indicate the appropriate temperature was achieved. Failure to report to maintenance and/or the dietary manager that the South kitchen	F 371	food prepared in the facility are not at risk for foodborne illness. Audits will then be completed weekly for one month and then monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). Culinary supervisor and/or designee will follow up on further education/training on an as needed basis. 5. Date of Correction: 7/6/2017	

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F 371	Continued From page 27 dishwasher was not reaching the required temperature resulted in continued inconsistent water temperatures to sanitize items washed in the South dishwasher. Improper sanitization of dishes, utensils, and cookware may place residents at risk for food-borne illness.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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;	F 441		7/6/17

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F 441	Continued From page 28 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow	F 441	F 441 Infection Prevention 1. Resident #1 and #9 will have infection	

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F 441	Continued From page 29 standard infection control practices for 3 of 10 sampled residents (Resident #1, #5 and #9) observed during personal cares. Failure to follow infection control practices related to perineal cares and hand hygiene has the potential to cause/spread infection within the facility. Findings include: Review of the facility policy titled "Handwashing" occurred on 05/25/17. This policy, revised June 2015, stated, ". . . The facility must require staff to wash hands when indicated by accepted professional practice, according to proper procedure. . . . Before and after assisting a resident with personal care (e.g. care, bathing). After contact with a resident's mucous membranes and body fluids or excretions. Before and after toileting a resident . . . After removing gloves. . . ." Review of facility policy titled "Perineal Care" occurred on 05/25/17. This policy, revised 07/01/16, stated, ". . . Perineal care promotes cleanliness and prevents infection. . . . Pericare will be completed from cleanest to the dirtiest areas, with the urethral area considered the cleanest, the anal area the dirtiest. . . . Wash/dry hands and put on gloves. . . . Male: . . . Use clean sections of the washcloth with each stroke. . . . Remove and dispose of gloves. . . . Wash hands . . ." - Review of Resident #5's medical record occurred on all days of survey. Progress notes identified the resident on contact isolation for methicllin resistant staphylococcus aureus to a right foot wound.	F 441	control practices related to perineal cares and hand hygiene followed during personal cares to prevent the spread/control of infections. Resident #5 expired 5/29/17. 2. All residents will have infection control practices related to perineal cares and hand hygiene followed during personal cares to prevent the spread/control of infections. 3. Director of Nursing reviewed policies Handwashing/Hand Hygiene and Perineal Care. All licensed nurses and certified nursing assistants will receive education on 6/20/17 regarding infection control practices related to perineal cares and hand hygiene to prevent the spread/control of infections. 4. Audits will be completed initially by 7/03/17 by the licensed nurses on all certified nursing assistants that provide personal care on proper perineal care and hand hygiene. The licensed nurses will then complete audits on a minimum of five certified nursing assistants per week for one month. Audits will then be completed monthly for one year. Results of monitoring will be reported to the QA Committee at each scheduled meeting (at least quarterly). The licensed nurses and/or Director of Nursing will follow up on further education/training on an as needed basis. 5. July 6, 2017	

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F 441	Continued From page 30 Observation on 05/23/17 at 7:30 a.m. showed CNA (#19) donned an isolation gown and gloves before entering Resident #5's room. The CNA provided morning cares, including pericares, in the bathroom, transferred the resident from the toilet to the wheelchair, applied sheep skin boots, and without hand hygiene and glove removal, offered the resident a drink of water with the same gloves on. The CNA (#19), then removed her gloves and applied a new pair of gloves without completing hand hygiene. The CNA (#19) then assisted Resident #5 with denture care, removed her isolation gown and gloves, then transported the resident to the dining room table. The CNA (#19) failed to remove her gloves and perform hand hygiene prior to completing additional tasks and prior to exiting the room. - Observation on 05/22/17 at 5:30 p.m. showed a CNA (#24) entered Resident #1's room to assist with personal cares and a transfer. The CNA (#24) assisted with the transfer to a wheel chair, combed the resident's hair, placed the glasses on his face, and exited the room with the resident in the wheel chair, and then transported the resident to the dining room. The CNA (#24) then entered another resident's room. The CNA failed to perform hand hygiene after completing tasks and prior to entering another resident's room. Observation on 05/23/17 at 9:20 a.m. showed a CNA (#6) entered Resident #1's room to provide personal cares. The CNA gathered supplies and applied gloves. The CNA (#6) removed the resident's soiled brief, completed perineal cares, applied a clean brief, adjusted the resident's clothing, held the resident's hand, buttoned the	F 441		

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F 441	Continued From page 31	F 441		

shirt to the neck area, moved the bedside table, returned supplies to the closet, then removed her gloves. The CNA failed to remove her gloves and perform hand hygiene after completing perineal cares and prior to completing additional tasks.

- Observation on 05/22/17 at 5:15 p.m., showed a CNA (#24) entered Resident #9's room, applied gloves and assisted the resident with incontinence care of urine and stool while the resident laid in bed. The CNA (#24) removed Resident #9's saturated incontinent brief. The CNA (#24) performed rectal care by wiping from front to back with a disposable wipe five times without folding the wipe. The CNA (#24) applied a clean brief, adjusted Resident #9's clothing, placed the lift harness under the resident, used the controls for the lift device to transfer the resident from the bed to the wheel chair. The CNA unhooked the harness from the mechanical lift, placed the resident's feet on the foot pedals, moved the mechanical lift, and then removed gloves. The CNA (#24) completed additional tasks prior to exiting the room. The CNA failed to use a clean section of the wipe with each stroke or obtain a fresh wipe, remove her gloves after providing perineal cares, and sanitize hands after removing the gloves prior to completing additional cares, and prior to exiting the room.

Observation on 05/23/17 at 8:00 a.m., showed a CNA (#19) entered Resident #9's room to complete personal cares. The CNA (#19) sanitized her hands, applied gloves, completed cares, removed her gloves, and exited the room. The CNA failed to perform hand hygiene prior to exiting the the room.

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F 441	Continued From page 32 During an interview on 05/25/17 at 8:25 a.m., an administrative staff member (#1) confirmed staff are expected to perform hand hygiene prior to entering a resident's room, after removing the gloves, and prior to exiting the room. The staff member stated the expectation is for staff to fold the disposable wipe, or washcloth with each wipeor obtain a fresh wipe during perineal cares.	F 441		