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F 000	INITIAL COMMENTS	F 000		
F 274 SS=D	Annual Licensure and Certification Survey 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to complete a significant change comprehensive assessment within 14 days following a decline in activities of daily (ADL's) and cognition for one of two residents (R4) reviewed for the need for ADL help in the sample of ten. Findings include: The facility's RAI (Resident Assessment Instrument) Assessment Summary dated 7-2-10, documents a Significant Change in Status Comprehensive Assessment should be completed no later that the 14th calendar day	F 274		4/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/20/2016

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after the determination that a significant change in the resident's status occurred.

R4's Quarterly Minimum Data Set (MDS) dated 1-1-16, documents that R4 requires a limited assistance of one person for walking and locomotion. This same MDS documents that R4 needs extensive assistance of one staff for dressing and toilet use, and has a Brief Interview for Mental Status (BIMS) score of 10.

R4's History and Physical Report dated 3-4-16, documents R4 slipped and fell out of a lift recliner, resulting in R4 sustaining a fracture to the left ankle.

R4's Physician Order dated 3-08-16, documents R4 returned to the facility with the following orders: Non weight bearing to the left lower extremity for approximately 12 weeks. Physical and Occupation Therapy to evaluate and treat.

R4's MDS (Medicare five day) dated 3-15-16, documents R4's ADL's declined and BIMS declined in the following areas: Walking did not occur. Locomotion requires total dependence on one staff. Toileting and Dressing requires extensive assistance of two staff. BIMS score of eight.

On 4-4-16 at 10:40 a.m., E6 (Certified Nursing Assistant) transferred R4 to bed using a mechanical lift due to R4 being unable to bear weight to the left leg. E6 verified that R4 cannot bear weight due to a fracture to the left leg. E6 also verified that R4 could transfer with assist of one staff prior to obtaining the fracture.

On 4-4-16 at 2:15 p.m., E5 (Care Plan

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F 274	Continued From page 2 Coordinator) stated, "A significant change Minimum Data Set (MDS) should have been done within 14 days of (R4's) re-admission with the fracture on 3-8-16 when (R4) had a decline in (R4's) Brief Interview for Mental Status (BIMS) and Activities of Daily Living (ADL's). A significant change assessment was not done."	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop a smoking safety/cessation and hypnotic/antianxiety care plan for one of 10 residents (R4) reviewed for care planning in the	F 279		4/20/16

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sample of 10.

Findings include:

A facility's Care Plan Policy and Procedure "undated" documents, "The care plan team is responsible for the review and updating of care plans; when there has been a significant change in condition...the team will review orders, medications, treatments, and other documents...areas of concern that are triggered during assessment are evaluated using specific assessment tools and interventions...the residents comprehensive care plan is designed to; incorporate identified problem areas...incorporate risk factors associated with problem areas...reflect treatment goals, timetables, and objectives immeasurable outcomes...aid in preventing or reducing declines in functional status and/or levels...Triggered Care Areas will be evaluated by the team to determine the underlying causes, potential consequences and relationships to other triggered care areas; the care area assessment (CAAs) consist of the following; identify areas of concern triggered on MDS (Minimum Data Set)."

1. R4's Progress Notes dated 11-3-15 and 10-27-15, indicate R4 has been found with cigarettes and matches in her room, and R4 insists on smoking. These same notes indicate it is a safety concern to R4 and the other residents that R4 continues to bring in cigarettes and matches.

R4's current comprehensive care plan does not include interventions related to R4's safety concerns with smoking, or R4's concerns with wanting to continue to smoke. R4's current care

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F 279	Continued From page 4 plan also does not include interventions to help R4 with smoking cessation. On 4-4-16 at 2:00 p.m., R4 stated, "The staff get to smoke in the shack behind the building, so I do not know why I cannot smoke. I do not care if my family doesn't want me to smoke or not. I have smoked my whole life and it is not their decision to make. I do not want to take a nicotine patch." On 4-4-16 at 2:00 p.m., E5 (Care Plan Coordinator/CPC) stated, "(R4) does not have a care plan addressing (R4) wanting to smoke, or bringing in cigarettes/lighters. (R4) does not have a safety care plan due to safety concerns with smoking, either. 2. R4's current Physician Order Summary documents the following: Clonazepam (Sedative medication) 1 mg (milligram) by mouth at bedtime and 0.25 mg at bedtime related to Anxiety Disorder. R4's CAA (Care Area Assessment) Worksheet dated 7-3-15, documents R4 should have an antianxiety/hypnotic care plan addressing the overall objective to the use of the medication. On 4-4-16 at 2:00 p.m., E5 (CPC) stated, "(R4) does not have an sedative medication care plan with targeted behaviors for the use of this medication for anxiety."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		4/20/16

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F 309	Continued From page 5 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop a comprehensive hospice plan of care for one of one resident (R1) reviewed for hospice services in the sample of 10. Findings include: R1's Physician Order Sheet dated 4\5\16 documents, R1 has diagnoses of Encephalopathy and Failure to Thrive. A Physician's Note dated 3\17\16 documents, (R1) has been diagnosed with Encephalopathy, a life-limiting disease, and is now receiving Hospice Care. The facility's Care Plan Report dated 4\1\16 for R1 does not include a plan of care with interventions documented for Hospice Care. On 4\5\16 at 11:01 a.m., E5 (CPC\Care Plan Coordinator) stated, "(I) did a significant change MDS (Minimum Data Set) for (R1) on 3\21\16 due to (R1's) declining condition and going to Hospice but do not have a Hospice Care Plan in place and should have."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and	F 311		4/25/16

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F 311	Continued From page 6 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide a restorative bed mobility program for one of seven residents (R3) reviewed for range of motion in the sample of ten. Findings include: R3's Minimum Data Set dated 3/3/16 documents R3 has severely impaired cognition and R3 has impaired range of motion in the lower extremities. R3's care plan documents a bed mobility program dated 1/28/16. The bed mobility program documents the program will be performed every shift and documents the description as, "Resident will attempt to extend (R3's) legs as far as possible prior to repositioning in bed. Staff will gently stretch/massage muscles in legs during this activity. Resident will then attempt to grasp side rail to assist with side turn. Staff will use verbal and physical prompts as indicated." On 4/5/16 at 9:05 AM, E6 Certified Nurse's Assistant (CNA) and E7 (CNA) transferred R3 into bed and provided R3 with incontinence care. During R3's incontinence care R3 was turned by E6 and E7 from side to side. E6 and E7 did not use verbal or physical prompts to encourage R3 to grasp the side rail to assist with a side turn. After completing incontinence care, E7 put pants on R3 and then E6 and E7 repositioned R3 and placed a pillow between R3's legs. E6 and E7 did not use verbal or physical prompts to encourage	F 311		

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F 311	Continued From page 7 R3 to extend her legs as far as possible prior to repositioning in bed. E6 and E7 did not gently stretch/massage R3's muscles during repositioning. On 4/5/16 at 1:55 PM, E6 stated E6 and E7 should have completed the stretching exercises prior to putting R3's pillow between R3's legs. E6 stated it was just easier to turn R3 then to have R3 do it. On 4/5/16 at 1:45 PM, E7 stated, "I did not know that (R3) had a bed mobility program." On 4/5/16 at 1:30 PM, E2 (Director of Nursing) stated E2 would expect R3's bed mobility program to be completed anytime R3 receives incontinence care, anytime R3 is laid down or gotten up, and whenever R3 is turned in bed.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to safely transfer one of two residents (R3) reviewed for increased need for ADL (Activities Of Daily Living) help in the sample of ten.	F 323		4/25/16

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F 323	Continued From page 8	F 323		

Findings include:

The facility's undated Two Man Lift policy documents, "This technique is used for transferring a resident from one surface to another without placing undo stress on resident's joints...Apply gait belt. Pick up resident by having both lifters bend down on either side of the resident. Reach under the resident's shoulders and under their knees. Place your arms under resident's thighs..."

R3's Minimum Data Set dated 3/3/16 documents R3 requires extensive assistance with two person physical assistance for transferring between surfaces and R3 has limitation in range of motion in the lower extremities. R3's care plan includes an intervention dated 10/7/14 which documents, "The resident requires extensive assist by 2 staff to move between surfaces as necessary."

On 4/5/16 at 9:05 AM, E6 Certified Nurse's Assistant (CNA) and E7 (CNA) assisted R3 with a transfer from R3's reclining wheel chair into R3's bed. During the transfer, E7 placed a gait belt around R3's chest. E6 and E7 were standing on each side of R3. E6 and E7 then placed their arms underneath R3's armpits and grabbed the gait belt lifting R3 into the air. R3 did not stand or bear weight during the transfer. R3's knees and R3's thighs were not supported during the transfer. R3's legs and feet were slightly drawn up and dangling in the air during the transfer.

On 4/5/16 at 9:45 AM, E7 stated R3 is a two person transfer. E7 confirmed that during R3's transfer on 4/5/16 at 9:05 AM, R3 was lifted under the arms with a gait belt and that R3's legs or feet

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F 323	Continued From page 9 were not supported during the transfer. On 4/5/16 at 10:02 AM, E2 (Director of Nursing) stated R3 is a two person transfer. E2 stated R3 can not bear weight and R3 pulls R3's legs up frequently. E2 stated E2 would have expected E6 and E7 to transfer R3 by doing a fireman/cradle lift so that R3's legs did not dangle.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to administer oxygen as prescribed by the physician for one of one resident (R4) reviewed for specialty care in the sample of 10. Findings include: The facility's Oxygen Administration policy dated 10/2010, documents staff are to verify that there is a physician's order for this procedure (oxygen	F 328		4/20/16

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delivery) and staff are to observe the resident periodically to be sure oxygen is being tolerated and the proper flow of oxygen is being administered.

R4's current Physician's Orders dated 4-4-16, document the following: O2 (Oxygen) at two liters per nasal cannula continuously.

On 4-4-16 at 9:30 a.m., 10:15 a.m., and from 10:40 a.m. to 2:15 p.m., R4's oxygen was not on R4 as ordered by the physician. During these times R4's oxygen concentrator was on, and set on two liters, with R4's nasal cannula (oxygen administration device) hanging off the top of the concentrator and not applied to R4.

On 4-4-16 at 10:40 a.m. and 11:50 a.m., E6 (Certified Nursing Assistant) provided R4 with personal cares. During and after the cares, E6 did not ensure R4 had oxygen on, and left R4's room without ensuring R4 had oxygen on.

On 4-4-16 at 3:00 p.m., R4 stated, "The staff forget to give me oxygen a lot of times."

On 4-5-16 at 10:20 a.m., E4 (Licensed Practical Nurse) stated, "(R4) should have oxygen on at two liter by nasal cannula continuously. If the oxygen is off, then the Certified Nursing Assistants should tell me. No one told me yesterday that (R4) did not have oxygen on."

On 4-6-16 at 2:00 p.m., E2 (Director of Nursing) verified that R4's physician (Z1) ordered R4 to have continuous oxygen because Z1 felt like it would improve R4's confusion.

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F 329	Continued From page 11	F 329		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to document a clinical indication for the use of and increase of an antipsychotic medication and failed to document and monitor targeted behaviors. These failures have the potential to affect two of four residents (R5, R10) reviewed for psychotropic medications in the sample of ten.	F 329		4/20/16

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Findings include:

The facility's Antipsychotic Medication Use Policy revised February 2014, documents, "Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective...the attending Physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others...Antipsychotic medications shall generally be used only for the following conditions... a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders; f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms; h. Tourette's Disorder; i. Huntington Disease; j. Hiccups, k. Nausea and vomiting associated with cancer or chemotherapy...If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function. The staff will document the following information about specific problem behaviors: a. Number and frequency of episodes, B. preceding or precipitating factors, c. Interventions attempted, d. Outcomes associated with interventions."

1. On 4-5-16 at 2:15 p.m., R1 was sitting up in a recliner. During this time R1 was calm and quiet. On 4-6-16 at 10:12 a.m., E13 (Certified Nursing Assistant) walked R1 from the recliner to the bathroom, and then walked R1 back from the toilet to the recliner. During this transfer R1 was calm, quiet, and exhibited no behaviors. On

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4-6-16 from 12:06 p.m. to 12:45 p.m., R1 was sitting up in a dining room chair, and exhibited no behaviors or yelling during this time.

R10's POS (Physician Order Sheet) dated 4-7-16 documents, "Olanzapine (Zyprexa/Antipsychotic medication) 5 mg (milligram) one time a day related to Unspecified Dementia with Behavior Disturbance."

R10's Antipsychotic Medication Quarterly Evaluation dated 1/2/16 documents diagnosis for the use of Zyprexa as Dementia with Behavior Disturbances, Depression, and Personality Disorder. This report also documents R10's behaviors as verbal "help, help" and Impulsive behaviors "risk and history of falls."

R10's Psychotropic Care Plan revised on 3-3-16 documents, "The resident uses psychotropic medications Zyprexa related to behavior management...Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy....monitor/record occurrence of for target behavior symptoms (yelling out frequently) and document per facility protocol."

R10's Order Audit Report dated 4-6-16 documents, R10's Olanzapine was decreased on 7-9-15 from 2.5 mg twice a day to 2.5 mg at bedtime for prophylaxis. R10's Gradual Dose Reduction Tracking Report dated 2-16-16 documents R10's Olanzepine was increased back to 2.5 mg twice a day. There is no documentation in the clinical record of the clinical indication for the increase (behavior tracking or nursing notes etc.) R10's Nurse Progress Notes, Care Plans, and Antipsychotic Medication

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Quarterly Evaluations from 7-9-15 (date of reduction) to 2-16-16 (date of increase) do not include an increase in R10's behaviors or rationale as to why the Zyprexa was increased.

R10's MDS's (Minimum Data Set) dated 10-9-15 and 1-25-16 both document R10 had no behaviors during the psychotropic increase period.

R10's Behavior Monitoring Record dated 3-8-16 to 4-6-16 documents targeting behaviors as: Demanding and up without calling for assist. R10's medical record includes no Behavior Monitoring Records prior to 3-8-16.

On 4-6-16 at 2:20 p.m., E2 (DON/Director of Nursing) verified R10's use of psychotropic medication as behaviors of "yelling out, demanding, and up without calling for assist"...and resident does not have behaviors of harming others or self and no documentation of such." E2 verified using an antipsychotic for behaviors of yelling, demanding, and getting up without calling for assistance is not an appropriate use of an antipsychotic medication, according to facility policy.

2. R5's Physician Order Sheet documents an order dated 1/23/16 for Seroquel 25 milligrams (mg) by mouth at hour of sleep for major depressive disorder. R5's psychotropic medication assessment dated 1/5/16 documents R5 is receiving Seroquel for Depression for the targeted behaviors of restlessness, pulling at catheter/oxygen tubing, disrobing, and removal of personal alarm.

R5's care plan dated 9/18/15 documents R5 has

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F 329	Continued From page 15 a behavior problem related to restlessness and impulsiveness. R5's care plan includes an intervention dated 9/18/15 which directs staff to, "Monitor behavior episodes and attempt to determine underlying cause...Document behaviors and potential causes." R5's behavior tracking sheets dated 1/1/16 through 4/7/16 do not include the behaviors of restlessness, pulling at catheter/oxygen tubing, disrobing, removal of personal alarm, or impulsiveness. On 4/5/16 at 1:30 PM, E2 stated R5's behaviors are tracked by the Certified Nursing Assistants on R5's behavior tracking monitoring screens on the facility's computer system. E2 confirmed R5's targeted behaviors were not listed as a choice on the behavior tracking monitoring screens. E2 confirmed R5's targeted behaviors for R5's Seroquel were not tracked. E2 stated, "I need to figure out how to make the right behaviors pop up on the computer." E2 stated R5 could not be properly assessed/reassessed for the use R5's Seroquel if the targeted behaviors are not documented or tracked.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/20/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to document dishwasher temperatures, failed to store prepared food in a sanitary manner, and failed to maintain proper refrigerator temperatures to safely store food. This has the potential to affect all 38 residents who reside in the facility.

Findings include:

1. The facility's Dishwashing Machine use policy, undated, documents that dishwasher temperatures will be checked with each dishwashing machine cycle, and the results will be recorded in a facility approved log.

The facility's Dishroom log, dated 4/2016, documents that on 4/1/16 and 4/3/16 no temperatures were logged for the dishwasher, on 4/2/16 and 4/4/16 the dishwasher temperatures were checked twice, and on 4/5/16 and 4/6/16 the dishwasher temperatures were checked one time.

On 4/6/16 at 1:00 p.m., E10 (Dietary Manager) stated, "The dishwasher temperature should be checked three times a day with each meal."

2. The facility's Foods Preparation and Service policy, undated, documents, "Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness."

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The Facility's Menu, dated 4/4/16, documents that the menu for 4/4/16 was Turkey Shortcake, Stewed tomatoes, banana berry cup, and pumpkin bars.

On 4/4/16 at 11:27 a.m., E9 (Dietary Manager) placed a pan of pureed turkey shortcake inside of the pan of mechanical soft turkey shortcake. The outside of the pureed turkey shortcake pan was directly in contact with the contents of the mechanical soft turkey shortcake. Then, E9 placed a pan of pureed stewed tomatoes inside of the pan of regular stewed tomatoes. The outside of the pureed stewed tomatoes was directly in contact with stewed tomatoes. E9 stated, "I put the pureed foods inside of the other food because I didn't have a spot for them on the steam table, and I wanted to make sure they were warm."

On 4/6/16 at 11:10 a.m., E1 (Administrator) stated, "Food pans should not be placed inside of the actual food."

3. The facility's Refrigerators and Freezers policy, undated, documents, "Acceptable temperatures should be 35-40 degrees Fahrenheit for refrigerators. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. Food Service Supervisors or designated employees will check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening."

The facility's Foods Preparation and Service policy, undated, documents, "The 'danger zone' is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that

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cause forborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese."

On 4/4/16 at 2:20 p.m., a refrigerator located in the dining room contained a thermometer that displayed a temperature of 46 degrees Fahrenheit. E11 (Maintenance Supervisor) confirmed the refrigerator temperature. The refrigerator contained a tray labeled "Night time snacks." The tray contained four half pint cartons of 2% milk, two half pint cartons of whole milk, four bowls of vanilla pudding, three glasses of cranberry juice, one glass of chocolate milk, 1 glass of apple juice, two glasses of orange juices, four prepared sandwiches, and five bottles of diabetic supplement. E11 removed a carton of whole milk, and E11 checked the temperature of the whole milk. The temperature of the whole milk was 46 degrees Fahrenheit. Then E11 removed a bowl of vanilla pudding, and E11 checked the temperature of the vanilla pudding. The temperature of the vanilla pudding was 44.6 degrees Fahrenheit.

On 4/4/16 at 3:15 p.m. E9 (Dietary Manager) stated, "The night time snack tray is for third shift after the kitchen leaves. They are snacks for all of the residents."

On 4/6/16 at 1:00 p.m., E10 (Dietary Manager) stated, "The dining room refrigerator does not have a temperature log. Refrigerators should temp at 40 degrees Fahrenheit or below. The contents should be at 40 degrees Fahrenheit or below."

The Resident Census and Condition of Residents, dated 4/4/16 and signed by E1,

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F 371	Continued From page 19 documents that 38 residents reside in the facility.	F 371		
F 441 SS=E	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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		4/25/16

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This REQUIREMENT is not met as evidenced by:
Facility failures resulted in two deficient practices.

A. Based on observation, interview, and record review the facility failed to disinfect the blood sugar monitoring machine according to the facility's policy. This failure affected one resident (R7) in the sample of 10, and three residents (R14-R16) in the supplemental sample.

B. Based on observation, record review, and interview the facility failed to properly handle soiled linens for two of six residents (R3,R4) reviewed for incontinence care in the sample of ten.

Findings include:

A. The facility's Glucose Meter (Glucometer/Blood Sugar Monitoring Machine) Cleaning Policy dated 10/2015, documents, "All glucose meters should be cleaned after each patient use. Wipe down with a sani-wipe or bleach wipe and let dry before use or storage."

1. On 4-4-16 at 11:25 a.m., E4 (Licensed Practical Nurse/LPN) took R16's blood sugar using the Glucometer. E4 then placed the Glucometer on top of the medication cart. E4 then wiped the Glucometer down with an alcohol prep, took R15's blood sugar using this same Glucometer, and then placed the Glucometer back on top of the medication cart.

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On 4-4-16 at 11:45 a.m., E4 stated, "I used an alcohol pad to wipe the Glucometer down. We have other wipes but I have always used alcohol wipes everytime I use the Glucometer."

2. On 4/4/16 at 11:42 A.M., E12 LPN checked R14's blood glucose level with a Glucometer. After checking R14's blood glucose level, E12 placed the Glucometer in the top drawer of the medication cart on top of a stack of alcohol pads. E12 did not sanitize the Glucometer prior to placing it into the medication cart.

On 4/4/16 at 11:45 AM, E12 stated, "I should have cleaned it (Glucometer) after using it."

On 4-5-16 at 8:45 a.m., E2 (Director Of Nursing) stated, "The facility policy indicates the nurses should us a sani-cloth or a bleach wipe to sanitize the Glucometer. Using an alcohol wipe is not appropriate to use."

On 4-7-16 at 9:00 a.m., E2 verified that E4 (LPN) and E12 (LPN) obtain R7 and R14-R16's blood glucose levels on day shift each day.

B. The facility's Linen Handling policy (undated) documents, "Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. Place contaminated laundry in a bag or container at the location where it is used."

1. On 4/5/16 at 9:05 AM, E6 (Certified Nursing Assistant/CNA) and E7 (CNA) provided R3 with incontinence care. During the incontinence care R3 was lying in bed on top of an incontinence

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pad. R3's incontinence brief was removed and personal cares were provided due to R3 being incontinent of bowel. After incontinence care was provided R3 became incontinent of bowel which soiled the incontinence pad with loose brown stool. E7 then removed the incontinence pad from the bed and laid it on the floor. E6 and E7 then finished with the R3's incontinence care.

On 4/5/16 at 9:45 AM, E7 stated, "I should have put the incontinence pad into a bag instead of throwing it onto the floor."

2. On 4-4-16 at 10:40 a.m., E6 (CNA) removed R4's soiled/stained linens from R4's bed and placed them on R4's floor.

On 4-5-16 at 10:15 a.m., E6 stated, "I should have put (R4's) linens in the bin in the hallway, and not on the floor."

On 4-5-16 at 8:45 a.m., E2 (Director of Nursing) stated, "Soiled linens should be placed in a barrel. Linens should not be thrown on the floor."