STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355096	A. BUILDING _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANETA PARKVIEW HEALTH CTR	113 5TH ST S ANETA, ND 58212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on July 13, 2015 and completed on July 16, 2015, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included seven (7) additional residents to verify specific concerns during the survey. An extended survey subsequent to the standard survey was completed on 07/29/15.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of the facility's policy/procedure, the facility failed to assess, care plan and develop interventions for the use of a restraint for 1 of 1 sampled resident (Resident #2) observed with a seatbelt on his wheelchair. Failure to complete the necessary assessment, care plan for the use and include directions for staff, prior to the placement of a seatbelt placed the resident at risk for injury. Findings include: Review of the facility policy/procedure titled "Physical Restraints" occurred on 07/16/15. This	F 221	F221 1)It is the policy of this facility to complete an assessment and attempt all other possible alternatives before restraining a resident. Deficient practice will be corrected for Resident #2, by completing both nursing assessment, OT evaluation, and communication to staff on self releasing safety belt. Resident #2's care plan will also be updated/ 2)All residents have the potential to be affected, specifically any resident with implementation of a restraint. 3)The facility policy "Physical Restraints" was updated to include requiring completion of	9/2/15

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

Electronically Signed | 08/17/2015

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F 221	Continued From page 1 policy, undated, stated, ". . . A physical restraint is defined as a manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to ones body . . ." Facility policy failed to address the necessity of completing an initial assessment for a restraint. During an observation on 07/13/15 at 4:30 p.m., certified nurse aides (CNAs) (#15 and #16) released Resident #2's seatbelt and assisted him to stand from his wheelchair (w/c), then had him sit again and refastened the seatbelt. Observations on 07/13/15 and 07/14/15 showed the resident in his wheelchair, with the seatbelt fastened, propelling himself throughout the special care unit (SCU). Review of Resident #2's medical record occurred on all days of survey and identified a diagnosis of dementia and a history of falls. Review of a significant change Minimum Data Set (MDS), dated 06/25/15 identified the resident was always incontinent of bladder and bowel, required extensive assistance of two or more for bed mobility and transfers, and used a trunk restraint on a daily basis. A physician's order, dated 05/22/15, stated "may have self releasing belt to w/c." Review of Resident #2's current care plan dated 07/07/15, stated, "Problem: I have the potential of skin breakdown . . . self releasing safety belt to w/c [wheelchair] for positioning . . . Approach: . . . Repos [reposition] q [every] 2-3 [hours] & [and] prn [as needed] . . . I'm at risk for falling . . . I	F 221	an initial assessment including OT/PT evaluation prior to implementation of a physical restraint of non-emergent nature. Education of new policy will occur at nurses meeting 8/20/15. 4)Documentation of nursing assessment, OT/PT eval, and communication to staff will be completed by the MDS Coordinator and reviewed by the QA Coordinator. QA will be completed prior to completion date and again in 6 months.	

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F 221	Continued From page 2	F 221		

have a self releasing safety belt to w/c for positioning purposes . . . " The care plan lacked an approach/plan for the use of the seatbelt that would guide staff in the implementation of this device.

During an interview on 07/16/15 at 10:00 a.m., a CNA (#9) stated, "the way I was taught about (Resident #2's name) belt is that it is not on all the time" and the CNA indicated that they fasten it as needed. The staff member stated, "the resident can open it (the seat belt)."

During an interview on 07/16/15 at 12:25 p.m., an administrative nurse (#2) stated, "it is not our practice" to just put a seatbelt on a resident. "We need to assess." The staff member provided a copy of an assessment, dated 07/29/14, for Resident #2. This assessment completed by the therapy department almost a year ago, referred to the resident's recent falls and failed to address the self releasing seat belt. When asked how the seatbelt is to be used, the staff member (#2), stated the seatbelt should be on when the resident is in his wheelchair and further added that the CNAs should not be fastening the seatbelt only when they think he needs it.

During the survey, the facility staff reported conflicting statements as to whether Resident #2 could or could not release the seatbelt. An administrative nurse (#2) reported he could not, and a CNA (#9) reported he could open it. Documentation in a Care Area Assessment, dated 06/30/15, stated ". . . Res [resident] has a self releasing safety belt to wc for positioning purposes. Res is able to release belt at times . . ."

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F 221	Continued From page 3 Failure to complete an initial assessment, identify less restrictive alternatives attempted and proven unsuccessful and determine the medical necessity/need for the restraint increased the potential for the resident to experience immobility, skin breakdown related to incontinence and increased risk for injury.	F 221		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure residents were free from physical abuse by 1 of 1 sampled residents (Resident #3) who resided on the special care unit. Failure to ensure residents were free from abuse resulted in resident to resident altercations. Findings include: Review of the facility policy titled "Abuse Policy and Procedure" occurred on 07/16/15. This policy, dated 8/2011, stated, ". . .every resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, neglect and involuntary seclusion.	F 224	F224 1)All residents have the right to be free from verbal, sexual, physical, and mental abuse. Corrective action for Resident #3 was completed by discharge to the hospital on 7/20/15. 2)All resident have the potential to be affected. 3)Education on behavior charting will be given at nurses meeting 8/20/15. New monitoring system was developed and implemented on 7/30/15 in order to thoroughly assess, track, and trend behaviors to prevent abuse. 4)QA of behavior monitoring system will be completed weekly X4, monthly X6 by nursing staff and reviewed by QA coordinator.	9/2/15

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F 224	Continued From page 4 Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, . . . Definitions: A. Abuse: Means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish . . . PROCEDURE: . . . 2. Training . . . c. Facility staff will be involved in the care planning process, receive counseling and learn behavior management techniques through in-services . . . to increase awareness of potentially harmful aggressive behaviors and/or catastrophic reactions from residents. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses include Dementia with Lewy bodies and episodic mood disorder. Review of an admission Minimum Data Set (MDS), dated 01/14/15, indicated intact cognition and a quarterly MDS, dated 04/08/15, indicated moderately impaired cognition. Review of a "Behavior and Mood Event -Aggressive Combative Behavior," dated 02/04/15, at 6:24 p.m., stated, ". . . Description: [Resident #3] was agitated with [Resident #13] as she was following him around and bothering him. Resident then grabbed [Resident #13] hair and she lost her balance and fell hitting her head . . . Physical Observation: Behavior: Per CNA [certified nurse aide] report, [Resident #13] was following this resident around and 'nagging' him. This residen [sic] then grabbed [Resident #13] by the hair causing her to fall backwards and hit her head on a chair. Residents were separated at this time . . . 24 hour behavior [sic] started d/t [due to] resident on resident behavior . . ." The report indicated that the physician and families	F 224		

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F 224	Continued From page 5 were notified. Review of the progress notes linked to the above event stated the following: * 02/05/15, 12:22 p.m., (recorded as late entry on 02/06/15 at 10:24 a.m.), stated, "Behavior: [Resident #3] asked [name of CNA] if she had heard what he did last night. Resident stated that he shouldn't have done what he did but 'she' wouldn't leave him alone and kept slapping her hands in front of her [sic] face. Resident remorseful." * 02/09/15, 1:08 p.m., stated, "Author spoke with res [Resident #3] in r/t [relation to] behavior on 2/04/15. Res stated he shouldn't have done what he did but she wouldn't leave him alone. Res is remorseful and hopes [Resident #13] has forgiven him" Review of a Progress note, dated 06/08/15 at 2:00 p.m., stated, "Care plan Meeting: . . . Behaviors are most often toward roommate during the night . . . Discussed impulse control and Depakote and Seroquel increases. Resident understands and is re-directable and apologetic after out bursts. . . ." A progress note for Resident #3, dated 07/12/15 at 5:00 p.m., stated, "Combative behavior: Res. [resident] cornered and punched res [Resident #14] in the SCU [special care unit] dining room by the fridge and then punched res in the face. CNA's seperated [sic] res." Review of an incident report dated 07/12/15, stated, ". . . Resident to Resident . . . Location: Special Care Dining Room . . . [Resident #3] Cornered res [Resident #14] into a corner et [and] punched him in the face."	F 224		

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F 224	Continued From page 6 Review of a "Behavior and Mood Event -Aggressive Combative Behavior" dated 04/11/15, at 2:30 p.m., stated, ". . . Description: [Resident #3] punched another resident in the face causing bodily harm . . . Physical Observation: Behavior: Resident [Resident #3] was having a discussion with [Resident #2] about vehicles in the hallway near the SCU dining room, when the discussion quickly escalated and [Resident #3] punched [Resident #2] in the face causing him to scream out for help and [Resident #2] got a bloody lip. Residents were quickly separated and [Resident #3] was started on 24 hour behavior monitoring . . . This resident [Resident #3] had his care plan behavior section updated as well . . . " Review of Resident #3's current care plan stated, ". . . Problem: My mood may fluctuate and I may have behaviors because of having dementia. When people get to close into my space I may become physically aggressive. I have pulled the hair of [Resident #13]. I have put my hands on/punched [Resident #2]. I wander into other's rooms . . ." Approach: Contact my family when needed. Contact my MD and Psychiatrist PRN [as needed]. Give me an anti-depressant as it is ordered . . . Give me anti-psychotic medications as it is ordered . . . Let me sleep anywhere and at anytime assuring mine and my neighbors safety. Monitor interactions with [Resident #13] and [Resident #2]. Allow me to eat at a different table during meals. Give me activities at the opposite end of the SCU [special care unit] . . . Redirect me by conversation or making jokes . . . Problem: I have a Dx [diagnosis] of Dementia, mood disorder . . . Approach: . . Have 1-1 visits with me	F 224		

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F 224	Continued From page 7 about all the places I've been . . . assistance with setup and supplies for independent activities of rummaging, wandering, visiting and observing others . . ." Failure of the facility to monitor, track, and trend Resident #3's behaviors and thoroughly assess the causative/precipitating factors leading up to, or resulting in the resident's aggressive and abusive behavior, develop and implement effective interventions (proactive approach versus reactive), contributed to the potential for Resident #3 to seriously injure another resident and/or for another resident to cause serious harm to Resident #3.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures	F 225		9/2/15

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F 225	Continued From page 8 (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 2 of 2 sampled residents (Resident #3 and #8) identified with injuries of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin and report to the State Agency (SA) placed these residents and all other residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled "Abuse Policy and Procedure" occurred on 07/16/15. This policy, dated August 2011, stated, "Initial Report	F 225	F225 1)It is the policy of this facility to report all alleged violations of abuse to administration and the state survey agency. Corrective action for Resident #3 was completed by reporting the allegation to the DOH on 7/20/15. Corrective action for Resident #8 was completed by reporting the allegation to the DOH on 7/23/15. 2)All residents have the potential to be affected. 3)Education on the abuse policy with regard to injuries of unknown origin will be given to all staff at meeting on 8/26/15. 4)QA of skin impairments will be completed by random selection of 6 events to screen for need of reporting weekly X3, monthly X3, and	

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F 225	Continued From page 9 of Allegation (immediate) It is the policy . . . every resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, neglect and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, . . . Definitions: A. Abuse: Means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish . . . Procedure: . . . 4. Identification: a. Any staff witnessing or possessing reliable knowledge of any act, or suspected act of abuse, including injuries of unknown source, such as fractures, bruising, skin tears, etc., or misappropriation of resident property, must immediately notify their department supervisor . . . 6. Investigation: . . . e. All suspected violations and all substantiated incidents of abuse will be promptly reported to state agencies and other entities or individuals as may be required by law. The report must be submitted to the Administrator/designee as soon as possible and they will notify the State Department of Health of the incident . . ." - Review of Resident #8's medical record occurred on 07/16/15 and diagnoses included dementia with behavioral disturbances and explosive personality disorder. Review of an admission Minimum Data Set (MDS), dated 05/01/15, identified moderately impaired cognition, and physical and verbal behaviors occurring 1 to 3 days during the seven day assessment period. Review of Resident #8's progress notes stated the following:	F 225	quarterly X4. QA will be completed by nursing staff and reviewed by the QA coordinator.	

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* 05/17/15, 9:29 a.m., "Abrasion: 0.5 cm [centimeter] linear abrasion noted to L) [left] eyebrow. Res stated, 'I don't know how it happened.' Res denied bumped [sic] with something or fall [sic]. Slightly swelling and puffiness noted to L) upper eye. Res's glasses firm [sic] noted to be bent to L) side . . ."

During an interview on the morning of 07/16/15, an administrative nurse (#2) stated "we do not have an incident report for 05/17/15," regarding Resident #8's abrasion to his eyebrow. The staff member confirmed it was not reported to the State Agency (SA) as a injury of unknown origin.

- Review of Resident #3's record occurred on all days of survey. Diagnoses include Dementia with Lewy bodies and episodic mood disorder.

Review of Resident #3's progress notes stated the following:
* 06/03/15, 2:10 p.m., "Bruise: Resident presented with a bruise this am [morning] on his L) upper eyelid/lower eyebrow. Resident unable to state where it came from. Resident is very unsteady on his feet at times, and no event/fall were witnessed."

During an interview on 07/15/15 at 11:25 a.m., an administrative nurse (#2) confirmed the facility did not report the bruise of unknown origin found on 06/03/15 to the SA and stated "they should have."

During an interview on the morning of 07/16/15, an administrative nurse (#2) confirmed no potential abuse, resident to resident altercations, or injuries of unknown origin had been

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F 225	Continued From page 11 investigated in the past year.	F 225		
F 250 SS=H	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide medically-related social services for 3 of 3 sampled residents (Resident #2, #3, and #8) and 2 supplemental residents (Resident #13 and #14) who exhibited and/or experienced physical, and abusive behaviors. The facility failed to: 1. Implement the facility's own policy to identify residents and/or situations with potential for the occurrence of injury, prevent resident to resident injury, and protect residents from recurring resident to resident injury. 2. Adequately assess resident behaviors, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happenings prior to and at the time of the behavior, and implement appropriate interventions to prevent behaviors from escalating. 3. Monitor the effectiveness of interventions and revise interventions as appropriate. 4. Implement an interdisciplinary approach to address behaviors which have the potential to result in resident to resident altercation. Failure to adequately assess and monitor	F 250	F250 1)It is the facility policy to provide medically related social services. Corrective action for #2, 3, 8, 13, 14 was completed by discharge of resident #3 as well as review and revision of interventions and monitoring of resident's behaviors. 2)All residents have the potential to be affected. 3)Review and revision of "Behavior Management Committee" policy will be completed. Education on policy changes will be given at all staff meeting 8/26/15. Early identification of residents with the potential for behaviors, interventions for the prevention of behaviors, adequate assessment of intervention effectiveness, and care plan communication with interdisciplinary approach will be completed for all residents. All residents will have an individualized care plan that communicates the interventions. Behaviors will be evaluated in a timely manner at manager's meetings and interventions revised as needed. MDS	9/2/15

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F 250	Continued From page 12 residents' behaviors and implement effective interventions or evaluate current interventions to prevent further behaviors resulted in other residents being victims of physical, verbal, and mental abuse. Finding include: Review of the policy/procedure titled "Behavior Management Committee" occurred on 07/16/15. This policy/procedure dated 02/10/11, stated, ". . . PURPOSE: To identify residents who have aggressive or abusive behavior and whose personal histories render them at risk for conflict, abusing or harming self or others, to develop and implement appropriate intervention strategies to prevent occurrences, to review intervention strategies on regular basis to assure continued effectiveness, and to monitor for any changes that could trigger abusive behavior. . . .PROCEDURE: . . . 2. When residents have aggressive or abusive behaviors or behaviors that have the potential to cause injuries to self or others, they are identified in this manner: a. Aggressive/Behavior Events are completed to relay the behavior to the multidisciplinary team. . . c. Incident Reports are used when a behavior requires investigation, when there is injury, or resident to resident harm/injury. . . .4. Care plans are updated to reflect changes. Changes in care plan approaches are communicated to staff at report at change of shift." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses include Dementia with Lewy bodies and episodic mood disorder. Review of an admission Minimum Data Set (MDS), dated 01/14/15, indicated intact	F 250	Coordinator and CNA traveled to Ellendale for review of their facility's interdisciplinary approaches to behaviors on 8/7/15. Social Service Designee and Activity Director, along with CNA will visit Sheyenne Care Center on 8/21/15 for review of their interdisciplinary approaches to behaviors. Social Service consultant and prior SSD will provide training to new SSD prior to completion date. SSD and AD will provide staff with a list of non-pharmacological interventions and post on inside of door to activity cabinet. A new behavior monitoring system for tracking and trending of behaviors was developed and in place 7/30/15. 4)QA of all behavior events will be completed weekly X4, monthly X3 and quarterly X3 by nursing staff. QA will be reviewed by the QA Coordinator.	

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F 250	Continued From page 13 cognition. A quarterly MDS, dated 04/08/15, indicated moderately impaired cognition. Review of a "Behavior and Mood Event -Aggressive Combative Behavior" dated 02/04/15, 6:24 p.m., stated, ". . . Physical Observation: Behavior: Per CNA [certified nurse aide] report, [Resident #13] was following this resident around and 'nagging' him. This residen [sic] then grabbed [Resident #13] by the hair causing her to fall backwards and hit her head on a chair. Residents were separated at this time . . . 24 hour behavior [sic] started d/t [due to] resident on resident behavior . . ." The report indicated that the physician and families were notified. Review of the progress notes linked to the above event stated the following: * 02/05/15, 12:22 p.m., (recorded as late entry on 02/06/15 at 10:24 a.m.), stated, "Behavior: [Resident #3] asked [name of CNA] if she had heard what he did last night. Resident stated that he shouldn't have done what he did but 'she' wouldn't leave him alone and kept slapping her hands in front of her [sic] face. Resident remorseful." * 02/09/15, 01:08 p.m., stated, "Author spoke with res [Resident #3] in r/t [relation to] behavior on 2/04/15. Res stated he shouldn't have done what he did but she wouldn't leave him alone. Res is remorseful and hopes [Resident #13] has forgiven him" Review of a progress note for Resident #3 stated the following: 04/11/15, 5:23 p.m., "Behaviors: Writer contacted [physician name] at the [hospital name] . . .	F 250		

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informed him of residents history with episodic mood disorder and his past history of pulling another residents [sic] hair approx [approximately] 6 weeks ago. Writer informed him of residents [sic] most recent behavior of injuring another resident physically by punching him . . . inform him that they are currently separated and resident is calm and had no current aggression or behaviors. [physician name] asked that resident just be monitored for now and observe for increased aggression or behaviors, and resident will need to be admitted if aggression increases or behaviors begin . . . asked that [another physician name] be contacted on Monday in regards to possible medication changes or medication increases."

Review of a Progress note, dated 06/08/15, at 2:00 p.m., stated, "Care plan Meeting: . . . Behaviors are most often toward roommate during the night . . . Discussed impulse control and Depakote and Seroquel increases. Resident understands and is re-directable and apologetic after out bursts. . . ."

According to Behavior Management Meeting notes, dated 06/24/15, ". . . Resident #3 was started on 24 hr behavior monitoring. Responsible parties and [physician name] were contacted. Incident report completed, behavior event created, care plan updated. Addendum: [Resident #3] has had a significant decline since this particular event. There was a med change on 5/17/15 and a change in roommate on 6/3/15." The incident referenced at the behavior meeting occurred on 04/11/15, two months prior to the date of this meeting. The facility failed to address Resident #3's behaviors in a timely manner and

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F 250	Continued From page 15 implement effective interventions to prevent further incidents of physical aggression. A progress note for Resident #3, dated 07/12/15 at 5:00 p.m., stated, "Combative behavior: Res. [resident] cornered and punched res [Resident #14] in the SCU [special care unit] dining room by the fridge and then punched res in the face. CNA's seperated [sic] res." Review of an incident report dated 07/12/15, stated, ". . . Resident to Resident . . . Location: Special Care Dining Room . . . [Resident #3] Cornered res [Resident #14] into a corner et [and] punched him in the face." Review of Resident #3's current care plan stated, ". . . Problem: My mood may fluctuate and I may have behaviors because of having dementia. When people get to close into my space I may become physically aggressive. I have pulled the hair of [Resident #13]. I have put my hands on/punched [Resident #2]. I wander into other's rooms . . ." Approach: Contact my family when needed. Contact my MD and Psychiatrist PRN [as needed]. Give me an anti-depressant as it is ordered . . . Give me anti-psychotic medications as it is ordered . . . Let me sleep anywhere and at anytime assuring mine and my neighbors safety. Monitor interactions with [Resident #13] and [Resident #2]. Allow me to eat at a different table during meals. Give me activities at the opposite end of the SCU [special care unit] . . . Redirect me by conversation or making jokes . . . Problem: I have a Dx [diagnosis] of Dementia, mood disorder . . . Approach: . . Have 1-1 visits with me about all the places I've been . . . assistance with setup and supplies for independent activities of rummaging, wandering, visiting and observing	F 250		

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F 250	Continued From page 16 others . . ." Review of a "Behavior and Mood Event -Aggressive Combative Behavior" dated 04/11/15, at 2:30 p.m., stated, ". . . Description: [Resident #3] punched another resident in the face causing bodily harm . . . Physical Observation: Behavior: Resident [Resident #3] was having a discussion with [Resident #2] about vehicles in the hallway near the SCU dining room, when the discussion quickly escalated and [Resident #3] punched [Resident #2] in the face causing him to scream out for help and [Resident #2] got a bloody lip. Residents were quickly separated and [Resident #3] was started on 24 hour behavior monitoring . . . This resident [Resident #3] had his care plan behavior section updated as well . . . " Review of an incident report, dated 04/11/15, in regards to the injury to Resident #2, stated, ". . . Type of injury: abrasion . . . Intervention Provided/Ordered First Aid stopped the bleeding . . ." This form was signed as reviewed by the administrator and social services on 07/06/15 and by the director of nursing on 05/01/15. Social services failed to review these resident behaviors until approximately three months after the incident. Failure of the facility to monitor, track, and trend Resident #3's behaviors and thoroughly assess the causative/precipitating factors leading up to, or resulting in aggressive and abusive behavior, develop and implement effective interventions (proactive approach versus reactive), as well as revise them as necessary; resulted in altercations and harm to residents.	F 250		

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- Review of Resident #8's medical record occurred on 07/16/15 and diagnoses included dementia with behavioral disturbances and explosive personality disorder. Review of an admission MDS, dated 05/01/15, identified moderately impaired cognition and physical and verbal behaviors occurring 1 to 3 days during the seven day assessment period.

Review of Resident #8's progress notes stated the following:
* 05/04/15, 4:02 p.m., "Resident was heard yelling at his roommate [Resident #3] today, because roommate was rummaging through residents belongings. Resident stated, 'I pay rent here too, you can't just go through my things.' Residents than [sic] stated, 'I am gonna hit you.' Staff intervened and resident was easily redirected."
* 05/11/15, 11:05 p.m., "Resident noted to be walking in hallway naked this evening and reported, 'that guy is taking my stuffs [sic]' Res [resident] redirected to his room and assisted to bed. His roommate [Resident #3] was rummaging [sic] resident's dresser . . ."
* 05/17/15, 9:29 a.m., "Abrasion: 0.5 cm [centimeter] linear abrasion noted to L) [left] eyebrow. Res stated, 'I don't know how it happened.' Res denied bumped [sic] with something or fall. Slightly swelling and puffiness noted to L) upper eye. Res's glasses firm [sic] noted to be bent to L) side . . ."
* 06/03/15, 2:53 p.m., "Room change: Moved to room [room number]" Resident #8 was a roommate of Resident #3.
* 07/14/15, 3:38 p.m., "Behavior: [Resident #3] wandered into res room. Both res noted to have

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red marks on face. Res. stated 'he came into my room and we boxed.' [Resident #3] removed from this res room."

On 07/14/15 between 5:04 p.m. and 5:20 p.m. observation in the dining room of the SCU showed a CNA (#16) sat at a table with Resident #3 when another CNA (#12) brought Resident #8 into the dining room and attempted to seat him at the same table next to Resident #3. The CNA (#16) stated, "don't sit him here next to [Resident #3] they just got into a fight." The CNA (#12) indicated she was unaware of the altercation.

During an interview on 07/14/15 at 6:10 p.m., a staff nurse (#11) stated, "Resident #3 and #8 were roommates before and have a history of not getting along."

Review of Resident #8's current care plan lacked information regarding a history of behaviors between Resident #3 and #8 and failed to identify their past as roommates.

During an interview on the morning of 07/16/15, an administrative staff member (#23) stated, "they have a contract with a licensed social worker and she has been to the facility on April 10, 12, 14 and May 20, and 21 of 2015." This staff member (#23) reported a date of hire for the current Social Service Designee as 04/28/15.

During an interview on the morning of 07/16/15, an administrative nurse (#2) stated, "when there is a behavior, staff create an aggressive behavior event and implement 24 hour monitoring." The administrative nurse (#2) reported she has been "monitoring falls, behaviors, and screening

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F 250	Continued From page 19 perspective residents" as the facility has experienced three changes in staff in the social services department in the last year.	F 250		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed and clarified physicians' orders for 2 of 8 residents (Resident #15 and #17) observed during medication pass. Failure of staff to follow and/or clarify physicians' orders may result in medication errors. Findings include: Review of the facility policy titled "Medication Administration" occurred on 07/16/15. This policy, revised September 2011, stated, ". . . Procedure for administering medications . . . 3. General Considerations . . . H. Medication directions on the pharmacy label should correlate with the medication directions on the eMAR [electronic] (Medication Administration Record). . . ." - Review of Resident #17's medical record occurred on 07/13/15. Current physician orders identified Miralax 8.5 grams twice a day. Observation on 07/13/15 at 4:28 p.m. during medication pass showed a certified medication	F 281	F281 1) It is the facility policy that provided services must meet professional standards. Deficient practice for Resident #15 and #17 by clarification of orders with physician on 7/16/15. 2) All residents have the potential to be affected. 3) Education on following label directions and physician orders will be provided to nursing staff at meeting on 8/20/15. 4) QA will be completed by DON on med pass to ensure standards are met prior to completion date and Quarterly X3. QA will be reviewed by the QA coordinator.	9/2/15

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aide (CMA) (#10) prepared Resident #17's medications. The pharmacy label on Resident #17's Miralax stated, "Take 8.5 gm [grams] in 8 oz [ounces] of liquid by mouth twice daily." The eMAR showed Miralax 8.5 grams twice a day. The CMA mixed the Miralax in 3 ounces of Plus 2 (a nutritional supplement).

Facility staff failed to receive clarification on the amount of fluid to mix with the Miralax until the surveyor brought it to their attention.

During an interview on 07/15/15 at 4:36 p.m. a nurse (#7) clarified the order with the physician who said to continue mixing the Miralax with 3 ounces of Plus 2.

- Review of Resident #15's medical record occurred on 07/14/15. Diagnoses included gastrostomy status. Current physician orders identified Jevity one can five times a day with 240 cc (cubic centimeter) water flush after feedings.

Observation on 07/14/15 at 4:03 p.m. during medication pass showed a nurse (#11) mixed 180 cc water with one can of Jevity and administered Resident #15's feeding. Following the feeding, the nurse administered a 90 cc water flush. The nurse (#11) stated she diluted the Jevity with water because it is too thick.

Observation on 07/15/15 at 10:51 a.m. during medication pass showed a nurse (#7) mixed 240 cc water with one can of Jevity and administered Resident #15's feeding. Following the feeding, the nurse administered a 60 cc water flush. The nurse (#7) stated she diluted the Jevity with the prescribed water flush because the Jevity is too

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F 281	Continued From page 21 thick. Facility staff failed to notify the physician when the Jevity was too thick and clarify the water flush orders. On the morning of 07/16/15, a nurse (#7) informed the dietician and the physician that facility staff dilute Resident #15's Jevity with water and do not administer a 240 cc water flush following the feedings as ordered. During an interview on 07/16/15 at 12:45 p.m. an administrative nurse (#2) stated staff should clarify orders with the physician.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide perineal care in a manner consistent with facility policy to prevent urinary tract infections (UTIs) for 1 of 5 sampled residents (Resident #6) observed receiving inappropriate	F 315	F315 1) It is the facility policy for incontinent resident to receive services to prevent UTIs. Corrective action for Resident #6 will be completed by staff review of peri-care policy and skills validation of	9/2/15

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F 315	Continued From page 22 perineal care. Failure to provide perineal care according to facility policy placed Resident #6 at risk of reoccurring UTIs. Findings include: Review of the facility policy titled "PERINEAL CARE" occurred on 07/16/15. This policy, revised April 2010, stated, ". . . PROCEDURE . . . 6. Female Resident . . . clean downward from front to back with one stroke. . . . Turn resident on side and wash, rinse, and dry anal area last, using front to back stroke. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. An annual Minimum Data Set (MDS), dated 05/15/15, identified short and long term memory problems and total assistance of two or more people required for toileting. The current care plan stated, ". . . Problem: I am incontinent of bowel and bladder, I also have a h/o [history of] reocurring [sic] UTI. . . . Approach . . . Help me with my peri cares after each incontinent episode. . . ." Observation on 07/13/15 at 4:48 p.m. showed two certified nursing assistants (CNAs) (#13 and #14) provided perineal care for Resident #6. The resident was incontinent of bowel and bladder. The CNA (#14) cleansed the rectal area. The CNA (#14) failed to perform frontal perineal cares. Observation on 07/15/15 at 10:17 a.m. showed two CNAs (#8 and #12) provided perineal care for Resident #6. The resident was incontinent of	F 315	CNA staff. 2)All residents who are incontinent have the potential to be affected. 3) Education of correct peri-care policy was given to nursing staff to review and initial on 8/20/15. Skills validation of all CNAs on peri-cares will be completed by completion date. 4) QA of peri-cares will be completed by Infection Control Coordinator. This will include observation of 3 random peri-cares prior to completion date, monthly X3, and quarterly X3. QA will be reviewed by the QA Coordinator.	

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F 315	Continued From page 23 bowel and bladder. The CNAs cleansed the rectal area. The CNAs (#8 and #12) failed to perform frontal perineal cares. During an interview on 07/15/15 at 10:25 a.m., a nurse (#7) stated she expected staff to perform front to back perineal cares.	F 315		
F 323 SS=K	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: During the standard recertification survey on 07/14/15, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from an observation at 11:05 a.m. on the special care unit when an unattended cleaning cart in the hallway was identified with open buckets of potentially hazardous cleaning solutions. After observation and interview with the facility staff using the cleaning cart, the survey team met at 11:20 a.m. and determined that corrective action needed to occur. At 11:30 a.m., the survey team met with the administrator and the cleaning cart was removed from service. The team then continued to gather further information and interview staff regarding the observed process.	F 323	F323 Level IJ in regards to open accessibility of toxic chemicals 1) At 11:31am, the special care unit housekeeping cart was removed from the special care unit. This cart was used to clean residents' rooms. The second housekeeping cart from the unit outside of the special care unit was also identified as having accessible chemicals and also removed from use. This had potential to affect all residents. 2) Housekeeping and maintenance were educated on chemical safety cleaning products accessible to residents so that each resident remains free from chemical hazards to assure safe storage and use immediately. All other	9/2/15

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F 323	Continued From page 24 At 12:38 p.m. the team contacted the management staff at the State Agency (SA) to report the findings and to discuss a potential IJ situation. At 1:20 p.m. the survey team notified the facility administrator of the IJ and that they must develop a plan for abatement. At 3:45 p.m. the facility provided a written plan of correction for the IJ. A copy of the plan was also given to the RO (Regional Office) staff person present with the team and a faxed copy was sent to the SA office. The team, RO, and SA reviewed and accepted the written plan. At 4:50 p.m. the team determined the IJ situation abated, reduced the scope and severity level to "E," and informed the administrator of this action. 1. Based on observation, staff interview, and review of Material Safety Data Sheets (MSDS), the facility failed to maintain a safe environment regarding chemicals used by staff while cleaning the facility. The practice of leaving these chemicals unattended placed cognitively impaired and wandering residents at risk for accidents and injury. Findings include: Observation on 07/14/15 at 11:00 a.m. showed an unattended cleaning cart in the hallway of the facility's special care unit. The cart contained the following cleaning chemicals: * an open bucket on the top of the cart contained a mixture of water and HDQ (a disinfectant that can cause eye damage, skin burns, and is harmful if swallowed) * an open bucket on the second shelf of the cart	F 323	staff will be educated as they come onto their shifts and sign education sheet documenting their acknowledgement of education on toxic chemical storage and safety. A temporary system was implemented until the new carts arrive. The new system includes storing the toxic cleaning chemicals with staff at all times. 3) Two high security cleaning carts along with new microfiber mopping system have been ordered and will be put into place 7/15/2015. Staff will be educated on new cleaning cart, mop system, and handling and storage of cleaning chemicals. 4) The maintenance manager will monitor 4 times a week for 4 weeks, then weekly for 4 weeks, monthly X3, and quarterly X3 to ensure the safety process is followed so that each resident remains free from chemical hazards by proper chemical storage and use. Monitoring documentation will be reviewed by QA Coordinator. Falls 1)The facility policy is to provide an environment free of accidents. Correction for Resident #2, 3, 7 was completed by care planning specific fall interventions and communicating interventions to staff. 2) All residents high risk for falls have the potential to be affected. 3) All fall events will be reviewed timely at manager's meeting and interventions revised/reviewed. Causative factors for falls will be assessed and care planned. Interdisciplinary interventions will be implemented for residents in the SCU.	

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F 323	Continued From page 25 contained a toilet bowl cleaning sponge and a mixture of water and NABC Plus IV (a cleaning product that may cause eye and skin irritation and harmful if swallowed) * the lower level contained an open mop bucket containing HDQ mixed with water for cleaning the floors * other cleaning products on the top of the cart and/or hanging in spray bottles on the side were as follows: Comet, Febreze, Drano, Pledge, shower and glass cleaner, Spitfire cleaner, and Brawny wipes with HDQ (all identified as harmful if swallowed and/or can cause eye irritation) During this observation, Resident #1, #13, #14, and #15 walked by the cart in the hallway, at one point during the observation, Resident #13 approached the cart with an empty drinking glass. During an interview on 07/14/15 at 11:10 a.m., a housekeeping staff member (#3) identified the above cleaning products and stated it is her "normal practice" to leave the cart unattended when she is cleaning residents' rooms. The staff person (#3) stated, she "parks the cart with the side with the spray bottles by the wall so they don't take them." When asked about the items on the cart, she stated, "no one has taken anything that I know, but they have touched it and I've found a donut and a sock in the mop bucket." The staff member (#3) reported she is not able to view the cart all the times as she is "in the room cleaning and has to leave the cart in the hallway." During an interview on 07/14/15 at 12:01 p.m., an administrative staff member (#1) reported that she had reviewed the video tape from the unit	F 323	Interventions will be care planned and clearly communicated to staff. Education will be provided to nursing staff at meeting 8/20/15. 4) QA of fall events will be completed by nursing staff weekly X4, monthly X3, quarterly X3 and reviewed by the QA Coordinator. Safety 1) It is the facility policy to maintain a safe environment. Deficient practice was corrected for rooms 201, 204, and 205 by replacing door knobs with non-locking knobs on 7/29/15. 2) All residents in rooms 102,105, 106, 108, 112, 109, 114, 115, 201, 204, 205 have the potential to be affected. 3) All knobs bathroom knobs in the facility will be checked for a locking mechanism. All rooms affected will have door knobs replaced prior to completion date with non-locking knobs. 4) The deficient practice will be corrected and no further review is required.	

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and saw Resident #1, #13, and #14 in the hallway and that staff had left the cart unattended for about five minutes.

FALLS

2. Based on observation, record review, and staff interview, the facility failed to provide an environment free of accidents, and to provide adequate supervision to prevent falls for 3 of 5 sampled residents (Resident #2, #3, and #7) who reside in the special care unit. Failure to adequately assess, monitor, and revise interventions in a timely manner resulted in frequent falls and avoidable injury.

Findings include:

Review of the facility policy titled "FALLS PREVENTION" occurred on 07/16/15. This policy, revised March 2013, stated, "PURPOSE: To identify each resident at risk for accidents and/or falls and provide a safe environment. To reduce the number of falls by identifying and implementing individualized fall prevention strategies. . . PROCEDURE . . . 2. Fall prevention strategies for residents at risk are to be documented on the care plan. . . . 3. E. Place call light, personal items, and assistive devices within easy reach. (This may not be appropriate for the dementia resident.) . . . K. Review bowel and bladder for level of continence and initiate toileting assistance as appropriate. . . 4. Falls committee will meet prn [as needed] to discuss specific falls . . . Fall Committee will activate or discontinue strategies as appropriate."

- Observations in the special care unit on the

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morning and between 5:00-6:00 p.m. on 07/14/15, showed Resident #2 self propel in his wheelchair (w/c) with his shoulders touching the back of the w/c and his buttocks on the front edge of the seat.

Review of Resident #2's medical record occurred on all days of survey. Diagnoses included falls, dementia, anxiety, and Alzheimer's. Review of a Significant Change in Status Minimum Data Set (MDS), dated 06/25/15, identified the resident with short and long term memory problems and moderately impaired cognition, requiring extensive assist of two persons for bed mobility, transfers, dressing, toilet use and personal hygiene; frequently incontinent of bowel and bladder; two or more falls with no injury and with injury; and a trunk restraint used daily.

Review of Resident #2's falls report and progress notes revealed the following:
* 08/19/14, 6:50 a.m., "Fall in res [resident] bathroom attempting to transfer self to toilet . . ."
* 08/20/14, 4:00 a.m., "Found lying on the floor. . . ."
* 08/23/14, 6:55 a.m., "Res. found lying on the floor in the hallway . . ."
* 08/24/14, 7:35 p.m., "Resident was found on floor in bathroom doorway. . . ."
* 08/28/14, 6:45 a.m., "Resident found on floor. . . ."
* 09/18/14, 10:30 p.m., "Resident found on the floor. . . ."
* 09/22/14, 3:15 p.m., "Resident found on floor next to wheelchair by the exit doors. Skin Tear to L) [left] elbow. C/o [complained of] pain to left side of lower abd [abdomen]. . . ."
The Fall committee hand wrote the following note

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on the fall report, ". . . continue TP [toileting plan] 4-6am or when awake and b/4 [before] 6pm." The current care plan failed to contain this intervention.

* 10/10/14, 6:30 a.m., "Res. found on floor in [another resident's bathroom] . . . Res. had taken brief off and was saturated with urine. . . ."
* 10/11/14, 7:26 a.m., "Had gotten out of w/c [wheelchair] & [and] walked . . . Was found lying on the floor . . ."
* 10/12/14, 5:30 a.m., "Resident was found sitting on carpeted floor in the TV room . . . "
* 10/15/14, 4:00 a.m., "Found resident lying on the floor in his room between the bathroom door & the foot of his roommate's bed. No apparent injury . . ."
* 10/15/14, 5:20 a.m., "Found resident lying on the floor in the hallway with w/c nearby. No injuries noted. . . Apparently resident does not call out when he falls, or call for help once he's on the floor as nothing is heard. Was in another room assisting another resident with am [morning] cares & found him on the floor in hall . . ."
* 10/20/14, 7:30 p.m., "Resident found on floor on [sic] sitting position in BR [bathroom] . . ."
* 10/20/14 11:17 p.m., "Staff heard bang noise from DR [dining room] in SCU [special care unit] and noted resident was laying on floor. Res's w/c was about 5 ft [feet] from him. . . ."

The Fall committee hand wrote the following note on the fall report, "get up and ready first on nights and do activity 10/20/14." The current care plan failed to contain this intervention.

* 11/10/14, 11:55 p.m., "Found resident lying on the floor at the foot of his bed, naked from the

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waist down & urine on the floor. . . ."
* 11/15/14, 11:00 p.m., "Resident found on floor mat next to his bed on back position. Moderate amount of blood noted on floor. Laceration noted to the back of head. Res stated, 'I tried to stand up and lost my balance, hit my head with [sic] the nightstand.' . . . Dressing applied to laceration per SO [standing orders] Neuro and VS [vital signs] . . ."
* 11/29/14, 7:30 p.m., "Resident found on the floor at 7:30 pm in his room, bleeding from a laceration to his L) forehead near his hairline, approx [approximately] 3.6 cm[centimeters] x [times] 0.7 cm . . . Also small laceration to ear & skin tear 3.0 cm x 1.5 cm at L) elbow . . . transported to ER [emergency room] per ambulance . . . Has 9 sutures in forehead . . . "
* 11/30/14, 2:35 p.m., "Resident found on floor near to BR [bathroom] door . . . "
* 12/02/14, 6:30 a.m., "Res found on floor in residents BR. Res brief was off and t-shirt was soiled with urine. Res stated 'I was trying to go to the bathroom' . . . Bed was in low position and fall mat was in place by bed . . . Res noted to have skin tear to R) [right] brow and R) forearm . . ."
The Fall committee hand wrote the following note on the fall report, "silent bed alarm placed helmet attempted" "bedside table moved to BR" The current care plan listed the intervention of a silent bed alarm but failed to contain the other interventions.

* 12/26/14, 5:19 p.m., "Res found on floor in SCU dining room on buttocks in front of w/c . . . Res was wearing hipsters, non slip foot wear, res has anti roll backs on w/c, low bed fall mat and silent bed alarm. . . ."
* 12/27/14, 9:45 p.m., "Resident found on floor in

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F 323	Continued From page 30 back position in SCU salarium [sic]. Res was in w/c and wandering prior to fall . . ." * 12/29/14, 6:55 p.m., "Res found on floor on sitting position in SCU solarium attempted to transfer himself to regular chair . . ." * 01/05/15, 11:48 a.m., "CNA [certified nurse aide] checking on resident and found resident lying on his back, with head by door. . . ." * 01/18/15, 4:30 p.m., "Res found on back in SCU by nurses station by w/c. . . ." * 01/25/15, 11:10 p.m., "The CNA reported res was sliding from his w/c and this CNA tried to assisted [sic] him to recliner res came forward, down in [sic] knees and hit the [sic] face . . . Abrasion noted to nose and 3 x 2 cm laceration to nose bridge . . ." The Fall committee hand wrote the following note on the fall report, "falls remain [arrow down]" * 02/04/15, 11:25 p.m., "Per CNA report, resident was in SCU dining room moving chairs around. CNA heard resident whistle and went to dining room. Resident was found lying on his back on the floor . . ." * 02/06/15, 1:15 p.m., "Res was sitting in w/c. Another res family witnessed fall and stated res slid out of w/c . . ." * 02/08/15, 7:20 a.m., "Resident found on floor mat next to bed laying on his right side . . ." * 03/01/15, 8:15 p.m., "Resident found on floor laying on R) side position. 1.5 x 1 cm T-shape laceration noted the back of head . . ." * 03/11/15, 1:52 p.m., " Res found on buttock next to w/c at TV area in SCU . . . Res received a 2 x 3 blood blister to R) upper thumb area . . . Res has anti-roll backs to w/c, geri sleeves, hipsters, low bed, wing mattress . . ." * 03/14/15, 6:51 a.m., "fall: 3/13 at 1030pm,	F 323		

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stood out of w/c and grabbed side rail to pull himself up, fell down onto but [sic] and layed down on back no injures . . ."
* 03/14/15, 2:15 p.m., "found on floor in solarium on back position. The CNA reported res was sliding from his w/c Res stated, 'I slide from this damn w/c' No injury noted. Dycem in placed [sic] to w/c to prevent sliding . . ."
* 03/30/15, 11:00 p.m., "found laying on back in front of w/c by his bedroom door, denies pain, said he just slid out of the chair, . . . dycem was in place . . ." The Fall committee hand wrote the following note on the fall report, "all interventions in place."

* 04/05/15, 11:55 a.m., "Resident slid out of his wheelchair landed on the floor . . ."
* 04/11/15, 7:00 p.m., "resident slid out of wheelchair onto buttocks on floor in front of the desk in the living room"
* 05/01/15, 5:52 a.m., "Pt [patient] found on floor next to w/c lying on right side in common area"
* 05/03/15, 4:09 p.m., " Resident slipped in between love seat and wheelchair when attempting to self transfer"
* 05/03/15, 8:30 p.m., "Slid out of wheelchair x 2 . . ."
* 05/04/15, 5:54 p.m., "Resident slid from recliner in SCU solarium to floor while attempting to self transfer"
* 05/10/15, 7:35 p.m., "Res was sitting in w/c in solarium. Author had just given res. his meds and was passing meds to another res, Female res stated 'Hey [name] on the floor . . ." The report lacked a note by the Fall committee.

* 05/11/15, 7:30 p.m., "Res got up from his w/c, attempted to walk by himself and fell on floor per

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witness. Res hit the [sic] head. Skin tear noted to R) ring and little finger and L) elbow . . . All injury and fall preventive measures implemented . . ."
* 05/16/15, 5:25 p.m., "Resident found on floor in solarium. Res stated that he slide [sic] from w/c . . ."
* 05/19/15, 4:00 p.m., "Res stood up from w/c and tried grabbing onto table and fell backwards . . ."
* 05/19/15, 7:00 p.m., "Resident was sitting with staff and attempted to scoot self back in chair and slipped out of his chair on to his butt"
* 05/21/15, 2:00 p.m., "Res had just been transferred to w/c from tub chair. Res leaned forward and fell before staff could get him repositioned into chair. Res noted to have seizure type activity. Res noted to be bleeding from his forehead and L) arm and hand . . ." This review contained a note dated 05/21/15, which stated, "seat belt ordered by [physician's name] for injuries due to falls"
* 05/25/15, 5:00 p.m., "Resident slid out of his wheelchair onto his butt . . . self release seat belt reapplied" A handwritten note on the right side of the fall report stated, "lap buddy ordered last week d/t [due to] falls [with] injury. Activities state [arrow up] behaviors [with] PM activity"
* 07/01/15, 5:56 p.m., "Res found on floor in SCU tv area on back. WC next to res. Safety belt to wc un-clipped . . ."

Resident #2's current care plan, dated 07/07/15, stated, "Problem: I have trouble with my mobility . . . I have unstable balance and a w/c is my primary mode of mobility . . . Approach: . . . Assist me with walking, transfers . . . I may roll myself out of bed at times and sleep on the floor . . . Provide me with assistive devices as needed .

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F 323	Continued From page 33 . . Problem: I'm at risk for falling . . . I have a dx [diagnoses] of dementia, hx [history] of falls, unsteady gait, balance problems which staff assist with stabilization and I am unaware of my own safety concerns at times . . . I have a self releasing safety belt to w/c for positioning purposes . . . Approach: Complete a Fall risk assessment as scheduled/indicated and implement appropriate safety measures, Dicem [sic] to w/c to prevent sliding, Encourage me to wear non-slip footwear. Keep my personal items within my reach. Keep my room clutter free . . . Orientate me to my room. Silent bed alarm . . ." Review of Resident #2's current care plan lacked the following interventions that were listed on the fall report sheets: hipsters, anti-roll brakes on his wheelchair, low bed with winged mattress, bedside table removed, helmet attempted, get resident up first on nights and do activity, toilet around 4:00 a.m. or when awake and before 6:00 p.m. Review of a Physical therapy assessment, dated 07/29/14, stated, ". . . Reason for referral: recent falls . . . Pt uses w/c for most mobility . . . Pt was educated to not get up on his own secondary to fall . . . encourage staff to assist [with] all mobility to reduce fall risk . . ." This assessment lacked information regarding w/c positioning. When an administrative nurse (#2) was asked about any further therapy assessments, the staff member provided an occupational therapy form dated 06/01/15, which stated, "OT consult for dining room audit . . ." This audit lacked any resident names. The care plan identified the seatbelt is used for positioning, however, the Fall Event report	F 323		

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identified the physician ordered it to prevent falls. Refer to F221.

During interview on the morning 07/16/15, an administrative nurse (#2), in reference to the frequent number of falls for Resident #2's stated, we put the belt on "because he had 3 head injuries."

The facility failed to adequately assess the causative factors contributing to the recurring falls experienced by Resident #2 who required extensive assistance with toileting and failed to implement/provide appropriate and effective interventions to prevent or decrease the number of falls/injury Resident #2 experienced.

- Observation on the SCU on 07/14/15 at 11:00 a.m. showed Resident #3 standing near the entrance door of the unit holding onto the hand rail. The resident swayed and appeared unsteady as he stood by the wall, an activity staff member assisted him to sit in a nearby recliner.

Review of Resident #3's medical record occurred on all days of survey. Diagnoses include dementia with Lewy bodies and episodic mood disorder. Review of an admission MDS, dated 01/14/15, indicated the resident had a history of falls before admission and a significant change in status MDS, dated 06/02/15, identified 2 or more falls with no injury and 2 or more falls with injury occurred since the last assessment, extensive assist of two persons for toileting and frequently incontinent of bladder and bowel.

Review of Resident #3's fall report and progress notes revealed the following:

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F 323	Continued From page 35 * 04/08/15, 4:30 p.m., "Resident was trying to rearrange furniture and pulled the recliner over on top of himself. Resident hit right top of head and got an abrasion . . ." * 04/14/15, 1:45 p.m., "Res was found on floor in hallway outside of his room . . ." * 04/28/15, 3:46 p.m., "Res was pushing around a dining room hair in solarium and fell . . ." * 05/17/15, 7:00 p.m., "Found on floor in SCU dining room. Has small bruise to rt [right] hip as well as inner rt elbow . . ." * 05/27/15, 4:43 p.m., "Res found on back in res room on floor . . ." * 05/28/15, 1:16 p.m., "General decline-Res has had increased incontinence, decreased cognition and gait has become more unsteady . . ." * 05/31/15, 7:55 p.m., "Res found on floor in hallway on L) side position. Res was wandering up and down in hallway prior to fall. Res c/o back and R) hand pain . . ." The Fall committee hand wrote the following note on the fall report, "pushing furniture frequently, decline - change of condition, [arrow up] psych meds due to aggressive outbursts, activity -sorting/stacking" * 06/08/15, 9:37 a.m., "Resident fell from wheelchair onto dining room floor. No injury noted fall unwitnessed." * 06/08/15, 6:14 p.m., "Resident fell in room without witnesses. CNA heard fall and found resident laying behind door on floor. CNA stated resident loss [sic] consciousness for about 30 seconds and hit the back of his head against the corner of the dresser . . ." * 06/09/15, 8:50 p.m., "Resident found on floor in between bathroom and bedroom . . ." * 06/13/15, 3:45 p.m., "Resident attempted to transfer self out of wheelchair and got tangled in	F 323		

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F 323	Continued From page 36 foot rests and fell to right side. Fall was witness [sic] by writer . . ." * 06/21/15, 1:02 a.m., "Writter [sic] heard some noises from room, writer went and checked every room and found resident on the floor by his bed." * 06/21/15, 8:00 p.m., "Resident was found laying on floor by his recliner . . ." The Fall committee hand wrote the following note on the fall report, "decline in status, unsteady gait -in w/c now. . ." Event details forms, dated 06/13/15 and 06/21/15, stated, "resident continuing with decline, anticipate further falls and continue with interventions" * 07/07/15, 10:53 p.m., "Res had been sitting in recliner with feet up in solarium. Author walked away to help another res and heard a chair tip. Res noted to be lying on the floor in front of recliner . . ." * 07/07/15, 11:59 a.m., "Res was sitting in recliner in room. Housekeeper found res on floor in room . . ." * 07/08/15, 6:55 p.m., "Res found on floor in DR on L) side position next to recliner . . . res wears hip hipsters, has lower bed, and bed alarm . . ." * 07/09/15, 9:00 a.m., "Res found on buttock on floor next to w/c in DR of SCU . . . Chair alarm applied to wc." * 07/14/15, 6:30 a.m., "Res found on floor on back position by SCU northeast exit door . . ." Resident #3's current care plan, dated 06/08/15, stated ". . . Problem: I'm at risk for falling because I have hx of falls, I wander and I receive daily scheduled antipsychotic and antidepressant meds . . . r/t [related to] Lewey Body Dementia and balance problems. 6/11/15 Recent decline in balance d/t progression of disease process	F 323		

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Anticipate further decline. I an unaware of own safety concerns . . . Approach: Complete a Fall risk assessment as scheduled/indicated and implement appropriate safety measures, Encourage me to wear non-slip footwear. Keep my personal items within my reach. Keep my room clutter free. Orientate me to my room. 6/11/15 may use w/c prn [as needed] if unsteady. . ." Review of Resident #3's current care plan lacked the following interventions that were listed in progress notes/fall reports: hipsters, bed alarm, and low bed.

The facility failed to adequately assess the causative factor contributing to Resident #3's recurring falls and implement interventions and provide additional assistance in regards to his changing condition and ongoing behaviors.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and Alzheimer's disease. Review of the fall event reports identified the following as current fall interventions in place; low bed, fall mat, non-slip footwear, and hipsters.

The current care plan stated, ". . . Problem: I'm at risk for falling because I have an unsteady gait, I have balance problems with ambulation and transitioning, I wander, I am unaware of my own safety concerns, I have a Hx [history] of falls and I receive a daily scheduled anti anxiety and antidepressant meds [medications]. Sometimes is [sic] purposely lower myself to the floor mat from my bed. . . . Approach: Complete a Fall risk assessment as scheduled/indicated and implement appropriate safety measures. Encourage me to wear non-slip footwear. Keep

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my personal items within my reach. Keep my room clutter free. Orientate me to my room. . . ." The facility failed to revise the care plan to include current fall interventions

During interview on the morning 07/16/15, an administrative nurse (#2) reported staff look at the times of the day falls occur, review with the Medical Director and review the videos to see what happened.

The facility failed to implement effective interventions individulized to the needs and the specific conditions of residents living in the SCU of the facility. Though the facility reviewed incidents after the occurrence, they failed to act proactively to minimize the frequency and injuries of these residents. The facility failed to update the plan of care for those individuals who are a higher risk for falls and injury related to problems with behavior and cognition.
SAFETY

3. Based on observation, review of staff education records, and staff interview, the facility failed to maintain a safe environment regarding 3 of 7 bathroom doors (201, 204, and 205) in the special care unit. The ability for residents to lock themselves in the bathroom unattended placed cognitively impaired, and wandering residents at risk for accidents and injury.

Findings include:

During the extended survey, on July 28-29, 2015, it was identified three rooms in the special care unit had bathroom door locks which allowed residents to lock the door from inside the

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F 323	Continued From page 39 bathroom. Review of the staff education record titled "Resident Bathroom Locks" occurred on July 28-29, 2015. This record, dated August 2014, stated, "Several bathroom doors have the ability to be locked from the inside. This includes rooms 102, 105, 106, 108, 112, 109, 114, 115, 201, 204 and 205. To open them use the side of a key (like a screwdriver) and turn." Observation on 07/29/15 at 9:17 a.m. showed the bathroom doors in room 201, 204, and 205 had locks which could be locked from inside. During an interview on the afternoon of 07/28/15, three certified nursing assistants (CNA) (#15 , #17, and #18) stated there were no bathroom doors in the facility that lock. When informed that three bathroom doors had locks, the CNA's were unaware of how to unlock these bathroom doors if a resident locked themselves in the bathroom. During an interview on 07/29/15 at 11:35 a.m., an administrative nurse (#2) stated she was unaware of any resident bathroom doors having the ability to lock from the inside of the bathroom.	F 323		
F 371 SS=E	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		9/2/15

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F 371	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer sanitizer guidelines, review of facility policy, and staff interview, the facility failed to ensure staff followed proper procedures for testing the concentration level for the sanitizer on 2 of 4 days of survey. Failure to follow proper testing procedures and concentration levels of the sanitizer has the potential to place residents, visitors, and staff at risk of food borne illness. Findings include: Review of the facility policy titled "Sanitation" occurred on 07/13/15. This policy, dated 08/28/06, stated, ". . . PROCEDURE . . . 2. Recorded sanitizer should be between 150-400 ppm [parts per million] to be effective. . . . 8. Wash tables with soap and water and sanitize also between meals." Review of an Ecolab "Oasis 146 Multi-Quat Sanitizer" informational chart located above the sanitizer container in the kitchen stated, ". . . Testing solution should be between 150-400 ppm . . ." It also identified QT-40 test strips should be used to test the quat concentration. - Observation during the initial dietary tour on 07/13/15 at 11:40 a.m. showed a supervisory dietary staff member (#5) tested Oasis 146 Multi-Quaternary (Quat) Sanitizer located in two red buckets with QUAC QR (brand name) test strips. The staff member placed a strip in the	F 371	F371 1) The facility will use proper procedure for testing the concentration level of sanitizer. Staff will use the recommended test strips for each product. 2) Failure to use proper test strips has the potential to place all residents, visitors, and staff at risk of food borne illness. 3) A dietary in-service was held on 8/10/15 on using recommended test strips and the potential for food borne illness. Policy and procedure has been updated and reviewed during the in-service. 4) QA will be completed on sanitizer ppm using proper test strip for 1 X weekly for 1 month and monthly X 6. The dietary manager will conduct the QA and it will be reviewed by the QA coordinator.	

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F 371	Continued From page 41 sanitizer bucket, removed the strip and compared it to the color chart. Both buckets of sanitizer showed a concentration of 100 ppm. The staff member stated the concentration should be "anywhere between 50 and 400 ppm". - Observation on 07/14/15 at 5:00 p.m. showed a supervisory dietary staff member (#5) tested a bucket of sanitizer upon surveyor request. The staff member used QUAC QR test strips, which showed a quat concentration of 200 ppm. During an interview on 07/14/15 at 5:24 p.m., a supervisory dietary staff member (#5) stated she ordered quat test strips from Ecolab and was unaware the Oasis 146 Multi-Quat Sanitizer required specific test strips. The facility failed to use the correct test strips designed to test this specific sanitizer as identified on the sanitizer informational chart and failed to ensure the quat concentration was within an acceptable range.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		9/2/15

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F 441	Continued From page 42 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to follow standard infection control practices for 2 of 5 sampled residents (Resident #3 and #6) observed during personal cares. Failure to follow infection control practices during personal care and the timeliness of cleaning resident's bathrooms has the potential to cause or spread infection within the facility. Findings include:	F 441	F441 1) The facility policy is to prevent the development and transmission of disease and infection. Correction of deficient practice of Resident #3 and #6 will be completed by staff education and skills validations. 2) All residents have the potential to be affected. 3) Staff education on hand washing and hygiene will be given to nursing staff at meeting on 8/20/15. Skills validations of hand	

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F 441	Continued From page 43 - Observation on 07/13/15 at 4:48 p.m. showed two certified nursing assistants (CNAs) (#13 and #14) provided perineal care for Resident #6. Both CNAs donned gloves and a CNA (#14) cleansed the rectal area and visible BM remained on her gloves. With the soiled gloves on, the CNA (#14) opened a bedside table drawer, picked up a tube of skin barrier ointment and applied it to Resident #6's buttocks. The CNA (#14) failed to remove her gloves and perform hand hygiene after completing perineal care, prior to performing other tasks. - Observation on 07/14/15 at 9:05 a.m. showed Resident #3 walking in the hallway and incontinent of bowel. A CNA (#8) approached Resident #3, applied a gait belt around his waist, and walked with him to his room. The CNA directed the resident into the bathroom and cued him towards the toilet where she pulled down his pants and removed the brief. When the CNA removed the incontinent brief, BM (bowel movement) fell on the floor and splattered onto Resident #3's slippers and legs. When the CNA put the soiled brief in the garbage can, BM ran down the sides of the garbage can. The CNA (#8) removed the resident's slippers and pants and attempted to clean the floor with wipes/paper towels. During this observation of care, the resident, with bare feet, attempted to stand up from the toilet, pulled at his soiled clothing, was agitated and was not easily redirected. A CNA (#9) entered the room to assist and brought in clean clothes. The CNAs attempted to clean the resident, applied a clean brief, hipsters, pants, and gripper socks. The CNAs walked Resident #3 out of the bathroom and into his room. The CNAs failed to assist Resident #3 to wash his	F 441	hygiene will be completed for all nursing staff prior to completion date. Housekeeping staff was educated on 8/12/15 at meeting on timely response to housekeeping calls. 4) QA of resident and staff hand hygiene will be completed by the Infection Control Coordinator prior to completion date and quarterly X3. QA of timely housekeeping will be completed by nursing staff prior to completion date and repeated quarterly X3. The QA will be reviewed by the QA Coordinator.	

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hands before leaving the bathroom.

The CNA (#8) bagged the soiled clothes and garbage and stated she would tell housekeeping to clean the floor in the bathroom.

Observation at 10:15 a.m. showed Resident #3 walking in his room and into the bathroom. The resident had been rummaging in the room, as the dresser drawers were open and the bathroom floor was littered with papers. Observation showed the floor around the toilet and the garbage can remained soiled with BM.

Observation at 11:00 a.m. showed the bathroom floor had not been cleaned and an interview with a housekeeping staff member (#3) stated she was unaware the floor needed cleaning. At 11:20 a.m. housekeeping staff (#3) cleaned Resident #3's bathroom floor and garbage can.

Observation on 07/14/15 at 5:35 p.m. showed a CNA (#12) and staff nurse (#11) applied a gait belt around Resident #3's waist and assisted him into his bathroom. The CNA attempted to cue the resident to turn and sit on the toilet, but he resisted and stood at the toilet and urinated. The CNA then cued the resident to sit on the toilet as she changed his pants, wet with urine. During this observation, the resident was agitated, tried to stand, and grabbed at his wet pants. After the CNA provided perineal care, she walked the resident into his room. The CNA failed to assist Resident #3 to wash his hands before leaving the bathroom.

During an interview on 07/16/15 at 9:00 a.m., a nurse (#7) stated she expected staff to

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F 441	Continued From page 45 assist/encourage residents with hand hygiene after toileting and bathe residents who are visibly soiled.	F 441		
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide evidence of certified nurse assistant (CNA) competency evaluations every 12 months for 4 of 4 CNA (#19, #20, #21, & #22) files reviewed. Failure to complete competency evaluations may result in resident care provided by staff not deemed competent. Findings include: During the extended survey on July 28-29, 2015, review of the facility records for completion of competency evaluations for CNA skills showed no competency evaluations completed for CNAs	F 497	F497 1) the facility policy is to complete performance reviews every 12 months. Corrective action for CNAs 19,20,21,22 will be completed by competency evaluation of skills validations prior to completion date. 2)All residents have the potential to be affected. 3) Performance reviews will be re-assigned to Infection Control Coordinator for completion every 12month. Skills validation/competence evaluations will be completed on all CNAs prior to completion date. 4)QA will be performed by Staff Development	9/2/15

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F 497	Continued From page 46 #19, #20, #21, and #22 since May 2014. During an interview on the afternoon of 07/29/15, an administrative nurse (#1) stated the facility had not completed annual competency evaluations for CNA skills since May 2014.	F 497	Coordinator prior to the completion date and annually. QA will be reviewed by the QA Coordinator.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete, accurate, and accessible clinical records for 8 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8) and 1 discharged resident (Resident #10). Failure to ensure a complete medical record does not allow staff and/or providers to have access to all information necessary to provide care and treatment for the residents. Findings include:	F 514	F514 1) the facility policy is to maintain clinical records in accordance with accepted professional standards. Corrective action will be completed for Resident #1, 2, 4, 5, 6, 7, 8 by scanning in missing items to Matrix system. Resident #10 was corrected by invalidating 2 incorrect documentation entries on 7/16/15. Resident #3 was discharged prior to completion. 2)All residents have the potential to be affected. 3)a)All signed fall	9/2/15

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F 514	Continued From page 47 - Review of Resident #10's medical record occurred on 07/16/15. Resident #10 was discharged on 04/20/15. Review of the progress notes identified two notes, dated 04/28/15 and 06/05/15. During an interview on the morning of 07/16/15, two administrative nurses (#2 and #4) confirmed the progress notes were in the wrong chart. - Review of Resident #3's medical record occurred on all days of survey. The record showed an admission weight on 01/09/15 of 161 pounds, while the discharge exam from the hospital, dated 01/09/15 showed a weight of 143 pounds. During an interview on 07/16/15 at 10:30 a.m., an administrative nurse (#1) reported they did not compare Resident #3's weight on admission to the hospital record. The facility failed to ensure an accurate weight for Resident #3 which could affect the care planing process regarding potential weight loss. - During the review of the sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8) medical records, the survey team asked for additional information on falls and behavioral incidents. During an interview on 07/15/15 at 5:40 p.m., an administrative nurse (#2) stated the signed fall event forms were kept in the medical record office. During an interview on the morning of 07/16/15, an administrative nurse (#2) stated neurological	F 514	event forms,neuro checks, and signed behavior events will be scanned into the matrix system beginning 8/1/15. b)Staff will be educated on double checking they are charting on correct resident at nurses meeting 8/20/15. Transfer/last recorded weights will be recorded on initial care plan on admit for comparison. Staff will be educated on re-weigh policy at nurses meeting 8/20/15. A sign was hung by scale as reminder of re-weigh policy. A clipboard was placed by the scale for immediate comparison of weekly weights. 4)QA of documentation scanning will be complete prior to completion date and repeated in 6 months by nursing staff. QA of weights will be completed weekly X4, monthly X2, and quarterly X2 by the Dietary Manager. QA will be reviewed by the QA Coordinator. Incorrect charting was corrected on 7/16/15 and no further review is not required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355096	A. BUILDING _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 48 check flowsheets and 24 hour behavior monitoring sheets are attached to events/incidents and kept in the medical record office. Failure to ensure residents' records remained accessible to all direct care staff on all shifts may result in staff providing inconsistent care and treatment to the residents.	F 514		