DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
MAY 18 2015
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355113	A. BUILDING _____ B. WING _____	04/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(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 04/20/15 and completed on 04/22/15, 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 two (2) additional residents to verify specific concerns during the survey.	F 000		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure personal funds deposited with the facility were conveyed within 30 days of death for 2 of 2 supplemental residents (Resident #11 and #12). This has the potential to affect all residents with funds in a resident account. Findings include: Review of conveyance of funds following death occurred on the morning of 04/22/15 with a managerial staff member (#1). Review of resident trust account information identified the following: * Resident #11 expired on 11/22/14. The facility issued a check for the remaining $5.50 on 01/22/15, 61 days later.	F 160	**F 160** 1. The residents that were affected by the deficiency have been refunded their money, resident #11 on 1/22/15 and resident #12 on 11/18/15. 14 - per t.c. & DON 5/19/15 3:45 pm 89 2. All residents have the possibility of the same issue happening to them. The business office manager will check the Action Summary Report on a daily basis, this is where deaths and discharges are reported, and the deaths/discharges are entered in by the nursing staff. Once informed that a death has occurred, National Campus will be contacted to request an RTA refund. 3. The business office manager will request a refund as soon as the resident discharges or expires. We will, also, have the administrator conduct an internal audit of discharged residents from here on out. The Administrator will audit that a request for RTA refund is being made of national campus and a copy of the request e-mail is placed in the resident's RTA file. The Administrator will also Audit the RTA refund sheet to ensure the date of the RTA refund check is within 30 days of death or discharge. 4. The Administrator will complete an internal audit that will take place over the course of six months. The guidelines for the audit are as follows: 1) Once a week for one month. 2) Once a month for six months. The audit reports will be reviewed by the QAPI committee. 5/13/15 per t.c. & DON 5. Completion date ~~11/15/15~~. 5/19/15 3:30 pm 89	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mina Schaack, LNHA — TITLE — (X6) DATE: 5/13/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160	Continued From page 1 * Resident #12 expired on 10/08/14. The facility issued a check for the remaining $164.35 on 11/18/14, 41 days later. During an interview on the morning of 04/22/15, a managerial staff member (#1) confirmed the facility failed to convey the residents' funds and provide a final accounting of the funds to the individual or probate jurisdiction administering the residents' estates, as required.	F 160		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	**F-272** 1. Resident #3 has expired. The needs of Residents #5, #7,and #9 were met when education was provided to Care Plan Team/ MDS Coordinator regarding failure to identify information to support resident falls. Resident #5, #7, and #9 Fall CAA'S reviewed. Fall CAA'S addressed in education to include all falls the resident experience on admission, annually, and with a significant change. 2. All residents have the potential to be affected. 3. Care Plan Team/MDS Coordinator were educated on Fall CAA'S using RAI User's Manual under CAA Process. The Fall CAA'S will include addressing all falls the resident has experienced and circumstances related to fall. This meeting occurred on 05/13/2015. All nursing staff were educated on documentation of falls in risk management, progress notes, and UDA's in PCC. This meeting occurred on 05/18/2015.	

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F 272	Continued From page 2 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility staff failed to identify the information used to support the decision making for the triggered Care Area Assessments (CAAs) for 4 of 9 sampled residents (Resident #3, #5, #7, and #9) with comprehensive Minimum Data Sets (MDSs) completed. Failure to identify the information used to complete the CAAs does not allow staff the opportunity to assess the nature of the problem, determine the specific causes, and develop specific interventions for the triggered area. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2014, page 4-3, stated, "CAA Process and Care Planning . . . The CAA process . . . refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. . . ."	F 272	4. The Director of Nursing will use the MDS/Care Plan notification tool to audit all Fall CAA's for completion to include dates of falls and circumstances of each fall. These audits will be done weekly x 1 Month, and Monthly x6 Months. Audit reports will be reviewed at monthly QAPI meeting. 5: Corrective action completed on 05/18/2015.	

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F 272	Continued From page 3 - Review of Resident #5's medical record occurred on all days of survey. The significant change MDS, dated 11/18/14, identified the resident experienced two falls, one with injury and one without injury, since the last assessment period. The CAA related to falls stated, "At risk for falls d/t [due to] poor balance, fall hx [history] and use of antidepressants . . . Does lean forward, to the side when left unattended in seated position and needs staff to regain balance w/ [with] transitional changes. . . . Care Plan Considerations . . . Monitor for changes in gait/strength, cognition, comfort. Assist w/ambulation, transfers to prevent falls. Has poor safety awareness/judgment d/t Dementia . . ." The CAA failed to address the two falls Resident #3 experienced and the circumstances related to the falls. - Review of Resident #3's medical record occurred on all days of survey. An annual MDS, dated 10/15/14, identified the resident experienced a fall resulting in a non-major injury, since the lass assessment period. The CAA related to falls stated, ". . . At risk for falls d/t hx of falls, balance problems w/transitional changes, ambulation, medication use. . . . Needs staff to regain balance w/transitional changes, does not have the strength/ability to rebalance self at times. . . . Care Plan Considerations . . . Monitor for changes in functional abilities, changes in strength, safety awareness/judgment, if fall occurs evaluate cause, implement interventions to prevent further falls." The CAA failed to address the fall Resident #3 experienced and the circumstances related to the	F 272		

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F 272	Continued From page 4 fall. - Review of Resident #7's medical record occurred 04/22/15. An annual MDS, dated 08/07/14, identified the resident experienced a fall without injury, since the lass assessment period. The CAA related to falls stated, ". . . At risk for falls d/t recent fall, unsteady balance. . . . Unsteady balance w/transitional changes. . . . Care Plan Considerations . . . Monitor for changes in mobility, continue w/current interventions as care planned." The CAA failed to address the fall Resident #7 experienced and the circumstances related to the fall. - Review of Resident #9's medical record occurred on 04/22/2015. The significant change MDS, dated 03/01/15, identified the resident experienced two falls, both without injury, since the last assessment period. The CAA related to falls stated, "At risk for falls d/t hx of falls, balance impairment, recent fall . . . Nature of the problem . . . Needs assist to maintain a seated balance and needs staff assist w[with]/transitional changes. . . . Care Plan Considerations . . . Monitor for changes in mobility, changes in functional abilities, impulsive behaviors. . . ." The CAA failed to address the two falls Resident #9 experienced and the circumstances related to the falls.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 5 provide the necessary care and services to attain or maintain the highest practicable physical, 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, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavior symptoms for 1 of 2 sampled residents (Resident #1) who received an anti-psychotic medication (Seroquel) for behaviors prior to attempting non-pharmacological interventions. Failure to identify target behaviors, assess the reason/causative factor(s) for the behaviors, and establish accurate on-going monitoring of the behaviors could potentially prevent Resident #1 from attaining her highest practicable physical, mental, and psychosocial well-being. Findings included: Review of the facility policy titled "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 04/22/15. The policy, dated August 2014, stated, ". . . Behavioral Interventions: Individualized non-pharmacological approaches that are provided as part of a supportive physical and psychosocial environment and are directed towards preventing, relieving and/or accommodating a resident's distressed behavior . . ." Review of the facility policy titled "Psychopharmacological Medications and	F 309		

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F 309	Continued From page 6 Sedative/Hypnotics" occurred on 04/22/15. The policy, dated March 2015, stated, ". . . It is important to initiate other care plan interventions prior to the use of prn [as needed] psychopharmacological medications . . ." - Review of Resident #1's medical record occurred during all days of survey. Diagnoses included Alzheimer's dementia with behavioral disturbance, depression, psychosis, paranoia, anxiety, sleep disturbance, and wandering. A significant change Minimum Data Set (MDS), dated 03/13/15, identified severe cognitive impairment, trouble concentrating, minimal depression, delusions, physical/verbal behaviors directed towards others, behaviors not directed towards others, rejection of care, and wandering. The current care plan stated, "Problem: Impaired cognitive function . . . episodes of confusions [sic] . . . wandering . . . exit seeking behavior . . . forgetting she ate meals, refusing to change clothing and being easily agitated . . . resistive to cares . . . Approach: . . . Attempt non-pharmacological interventions reassurance, redirection, reality orientation . . . validation . . . 1:1 visits . . . Visit with resident about past and her children/grandchildren. Try to involve in an activity . . . Reminisce with resident using photos of family and friends . . . warm blankets . . . provide diversionary activities such as folding towels and weather permits outside walks. . . . Reapproach resident at a later time or have another staff try to assist . . . Keep room dark . . . and limit noise distractions at noc [night] . . ." The physician's orders identified the following: * Seroquel (an antipsychotic) 25 mg every 24 hours prn, started 12/02/13	F 309	**F-309** **1. Resident # 1 will have non-pharmacological interventions done prior to use of prn Seroquel by documentation shown in progress notes. All nurses were educated regarding failure to use non-pharmacological interventions when using prn anti-psychotics and documentation need to support these interventions.** **2. All residents on psychotropic medications have the potential to be affected.** **3. All nursing staff were educated at staff meeting held 05/18/2015. Education included use of non-pharmacological interventions when using prn anti psychotics for residents. Education provided on Order entry of Psychotropic Medications to include Non-Pharmacological interventions.** **Good Samaritan Policy/Procedure on Psychopharmacological Medications and Sedatives/Hypnotics Reviewed at staff meeting.** **4. Director of Nursing or designee will complete focus audit on all prn Antipsychotic Medications to include documentation of non-pharmacological interventions for residents affected. These audits will be done weekly x 1 month and then monthly x6 months. All findings of Audits will be reviewed at monthly QAPI meetings.** **5. Corrective action completed on 05/18/2015.**	

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F 309	Continued From page 7 * Seroquel 300 mg at bedtime, started 12/22/14 * Seroquel 50 mg [daily], started 02/18/15 The progress notes identified the following: * 07/16/14, "Resident states she is going to coffee with [visitor] uptown x [times] 4 . . . Seroquel 25 mg given for caution . . . effective." * 07/28/14, "[Seroquel 25 mg] given for mild agitation . . . ineffective Resident less agitated with more confusion than on a normal day for her. Doesn't know what to do or where to go. Keeps wandering up & [and] down the halls." * 07/31/14, "Res [resident] came into hallway yelling, weeping, and talking in gibberish. Res ledf [sic] back to room and given PRN seraquil [sic] and a warm blanket." * 08/18/14, "Res has come out into the hall x 2 yelling. The first she claimed diarrea [sic] was dripping out of her, at the time no BM [bowel movement] was on her clothes, floor, or toilet. Second time res was yelling she had heart burn and acting like she couldn't walk gave her maalox and res was happy w [with]/ that and is now resting. . . . [Seroquel 25 mg] Effective." * 10/24/14, "[Seroquel 25 mg] anxiety r/t [related to] pain . . . Resident comes out screaming that her legs hurt and that she cant walk although she walked into hallway just fine. CNA [certified nursing assistant] walked her back to her room and CN [charge nurse] gave her a seraquil [sic] and a warm blanket and she slept . . . Effective" * 11/10/14, "[Seroquel 25 mg] Ineffective. Continues to be agitated, yelling out." * 11/14/14, "[Seroquel 25 mg] paranoid/anxious . . . Awoke at 0400 very anxious claiming to need a[n] ambulance and to call her aunt. Has been pacing and claiming her aunt is standing next to her. PRN RX [medication] given." * 02/14/15, "[Seroquel 25 mg] given for anxiety *	F 309		

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F 309	Continued From page 8 crying . . . Effective." * 03/05/15, "[Seroquel 25 mg] Given due to resident pulling her pull up off & shredding it. CNA's tried putting a brief on her & she absolutely refused to let them. PRN seroquel given . . . Effective." * 03/10/15, "[Seroquel 25 mg] Resident was calling for ambulance over and over. . . . 'for [Resident #1] because everything is going down.' She kept asking for ambulance multiple times. . . . Effective." * 03/30/15, "[Seroquel 25 mg] given d/t [increased] anxiety per [staff] . . . Effective. Resident has now been able to recall her shoes are being washed, less anxious and was able to get cleaned up after being incontinent." * 04/01/15, "[Seroquel 25 mg] Resident showing abnormal behavior of crying in the lounge & telling cnas that her undwewear [sic] is right [sic] no glasses on & they were on her face . . . Effective." * 04/02/15, "[Seroquel 25 mg] Irritated with her shoes being washed & she is not able to wear them & keeps zipping her sweater up & down . . . Effective. Resident talking nicely & smiling making comments regarding the wind." * 04/06/15, "[Seroquel 25 mg] Resident being nasty with rude comments & walking off without her walker . . . Effective." * 04/10/15, "[Seroquel 25 mg] given d/t increased anxiety d/t a bath per [staff] . . . Effective. continued to call out during bath, but was not physical and has had a mostly quiet day today." The resident's care plan did not identify prn Seroquel as an intervention for behaviors due to a bath. * 04/11/15, "[Seroquel 25 mg] given d/t increased anxiety/crying per cn . . . Resident has a quiet morning and then suddenly got up out of the chair	F 309		

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F 309	Continued From page 9 in the cove area, slammed her walker on the floor and started muttering angrily about clothes and upset she can't find what she wants and starting to cry etc. Med aid asked to give resident prn med for agitation . . . somewhat more calm . . ." * 04/13/15, "[Seroquel 25 mg] Resident has been taking off jacket & putting it back on. I don't like this it's not mine take it off me. I don't want it. Standing by the wall shaking & not knowing what to do attempted to cry & stopped . . . Effective." * 04/14/15, "Full body skin assessment completed this morning. Found no new skin issues. Resident a little agitated with the body assessment but no striking out or yelling. just facial expression that she is not really happy about it. . . . PRN given was not really effective . . ." * 04/15/15, "[Seroquel 25 mg] very tery [sic] eyed & agitated . . . Effective." * 04/18/15, "[Seroquel 25 mg] agitated today swinging walker around on the floor times 3 goes down the hall & states I will find something to eat on my own anyway . . . med [medication] effective within 15 minutes." * 04/19/15, "Suddenly angery [sic] outburst in east lounge, cause unknown, unable to understand what she was saying, mumbling. PRn Seroquel given . . . swinging walker around in cove lounge walking down hall very fast & careless . . . Effective." During an interview on 04/22/15 at 11:30 a.m., an administrative nurse (#4) confirmed staff failed to document the non-pharmacological interventions they attempted prior to administering Resident #1's prn Seroquel. Failure to attempt non-pharmacological interventions and monitor the effectiveness of	F 309		

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OMB NO. 0938-0391

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F 309	Continued From page 10 those interventions prior to administering an anti-psychotic medication did not allow staff to evaluate what interventions were most effective for Resident #1's behavior.	F 309	F312 1. The needs of Resident #1, #2, and #5 were met when education was provided on Dining Assistance needed for dependent residents to all staff. Education to include prompting and cueing, cutting and preparing items served, and offering second choices for those who are not eating what is served. The needs of Resident #2 were met when education was provided to nursing staff on bathing schedules and following the care plan of bathing needs. Resident #2 care plan was reviewed at this time.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain good nutrition for 3 of 3 sampled residents (Resident #1, #2, and #5) who required assistance with meals and/or tray set-up. Failure to provide assistance during meals placed residents at an increase risk for weight loss and may result in continued weight loss and delayed healing of a pressure ulcer for Resident #5. Findings include: Review of the facility policy titled "NUTRITIONALLY DEPENDENT RESIDENT" occurred on 04/22/15. This policy, revised in 2013, stated, "PURPOSE: To assist resident incapable of independently consuming their food . . . PROCEDURE: . . . If resident dislikes food/fluid offered or has poor intake, offer/try alternative and refer to director of dietary services for evaluation of dining needs and preferences. . . ."	F 312	2. All residents needing assistance in Dining/Eating and bathing have the potential to be affected. 3. Nursing Staff /Cna's were educated on Dining assistance for dependent residents. Good Samaritan Policy on Nutritional Dependent Resident reviewed at this meeting. Education provided on monitoring Care plan and bathing schedule to comply with maintaining personal hygiene. Good Samaritan Policy on Bathing and Care Planning reviewed. Meetings were held on 05/18/2015 and 05/19/2015. 4. Director of Nursing will do dining audits on resident requiring assistance in dining room to ensure that resident needs are met. The audits will include ensuring residents are prompted to eat, reviewing residents at nutritional risk, and Resident intake is adequately charted. These audits will be done on 5 residents weekly x 1 month. And 10 audits done monthly x 6 months. These findings will be reported to monthly .QAPI team meetings. Director of nursing will do focus audit on residents bathing schedule and following the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARTHUR	150 COUNTY RD 34 ARTHUR, ND 58006

(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 312	Continued From page 11 Review of the facility policy titled "DINING ASSISTANT" occurred on 04/22/15. This policy, dated 2012, stated, ". . . PROCEDURE: 3. Dining assistance can be provided for any resident by licensed nurses, certified nurse aides, certified medication aides, speech language pathologists, and occupational therapists without additional education and training. . . . Non-nursing staff (e.g. activity, social work, dietary) who have not completed dining assistant training and volunteers can assist with the following dining-related duties. . . . c) Opening milk cartons d) Cutting meat e) Buttering bread f) Offering alternatives to the meal g) Pouring liquids . . ." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, depression, and a pressure ulcer to the left buttock. Resident #5's quarterly Minimum Data Set (MDS), dated 02/17/15, identified weight loss and set-up help for meals. The current care plan stated, "The resident [Resident #5] has unplanned/unexpected weight loss Poor food intake . . . Monitor and record food intake at each meal . . ." A progress note, dated 04/21/15 (late entry from 04/17/15), stated, "Meeting with daughter [name] to discuss weight loss and not eating much. Discussed moved [sic] res. [Resident #5] to assisted table which daughter felt was a good idea. She hopes with staff prompting he'll eat more." Observation on 04/21/15 from 8:15 a.m. to 8:50 a.m. showed Resident #5 seated at a table in the	F 312	care plan of each resident needs. This audit will be done on 10 residents weekly x 1 month and then 10 residents monthly x 6 months. Findings will be reported to QAPI team monthly. 5. Corrective action completed on 05/19/2015	

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F 312	Continued From page 12 dining room designated for residents who require supervision and/or assistance with their meal. A certified nursing assistant (CNA) (#2) also sat at the table assisting another resident with her meal. Resident #5's meal included a hard boiled egg, two slices of bacon, a slice of toast, a dietary supplement drink, and a cup of coffee. Resident #8 consumed one slice of bacon, the toast, the supplement drink, and coffee. The egg and a slice of bacon remained on his plate at the end of the meal. The CNA (#2) failed to cut the egg. Observation on 04/21/15 at 11:50 a.m. showed Resident #5 seated at a table in the dining room. An unidentified CNA also sat at the table. Resident #5's meal included mashed potatoes and gravy, a chicken breast, a slice of bread, a dietary supplement drink, a glass of water, and a cup of coffee. The CNA failed to cut the chicken or butter the bread. The CNA said to the resident, "That chicken looks very good." Resident #8 stated, "Don't like white meat." The CNA replied, "Yeah, that's what I thought." The CNA failed to notify the dietary staff and/or offer Resident #8 an alternative meal. Observation showed he consumed all his beverages. During an interview on 04/21/15 at 2:20 p.m., an administrative staff member (#3) stated the facility placed Resident #5 at an assistive table on 04/17/15 for more prompting and cueing. The CNA assigned to the assistive table is responsible for cutting the resident's meat and buttering the bread. This staff member stated the CNA should have gotten Resident #5 something else to eat when she discovered he didn't like the meat. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses	F 312		

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F 312	Continued From page 13	F 312		

included dementia, psychosis, and gastric distress. The significant change MDS, dated 03/13/15, identified severely impaired cognitive skills and limited assist of one person required while eating.

The current care plan stated, ". . . Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] functional and cognitive impairments . . . Interventions: . . . EATING: . . . Resident is independent, needs encouragement at times. . . ." The care plan contradicted the MDS which identified Resident #1 required limited assistance of one person with meals.

Review of the nutrition progress notes identified the following:
* 01/26/15, "Wt [weight] . . . down 4# [pounds] . . . in 90 days . . . Meal intake varies . . . but usually eats well for breakfast and supper, but less for dinner. She is independent with eating, following tray set-up help. . . . She is at risk for wt loss . . ."
* 02/19/15, "Resident has been eating poorly, most meals less than 50%. . . . She takes fluids poorly as well. . . ."

Meal observation on 04/21/15 at 11:40 a.m. showed Resident #1 sitting at an assisted table with three other residents and an unidentified CNA. Resident #1 ate a small bowl of bread pudding prior to staff passing dinner trays. Her meal, when delivered, consisted of a chicken breast, mashed potatoes, and carrots. She made no effort to feed herself. Ten minutes passed before the CNA walked around the table to cut the resident's meat into bite sized pieces. Resident #1 again made no effort to feed herself. Another five minutes passed before the CNA

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F 312	Continued From page 14 cued Resident #1 to "eat." The resident made no attempt to eat any other item on her tray. During an interview on 04/21/15 at 2:26 p.m., when asked what staff should do if they notice Resident #1 not eating, a managerial dietary staff member (#3) stated she expects them to cut her meat, assist her during the meal, and/or offer her a slice of toast [Staff reported Resident #1 will usually eat toast when offered]. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, reflux, and cough. The annual MDS, dated 01/29/15, identified intact cognitive skills and supervision/set up help required during meals. The nutrition progress note, dated 03/24/15, stated, ". . . Regular diet, regular liquids. . . . Set-up and supervision with meals. Meal intake varies, but is usually good for breakfast, but poor to fair for dinner/supper. . . ." Meal observation on 04/21/15 at 9:05 a.m. showed Resident #2 in her room trying to maneuver her over-the-bed table and room-tray so that all of the items on her tray were within reach. After making several attempts, she requested assistance from this surveyor. She also asked this surveyor to open her milk carton and complained about not having a glass to poor the milk into. The CNA who passed Resident #2's breakfast tray failed to provide adequate set-up. During an interview on 04/21/15 at 2:26 p.m., a managerial dietary staff member (#3) stated she expects staff to assist with dining-related duties	F 312		

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F 312	Continued From page 15 such as opening milk cartons and pouring liquids. 2. Based on record review, review of facility policy, and staff interview, the facility failed to maintain good hygiene/bathe 1 of 8 sampled residents (Resident #2) as care planned. Failure to provide bathing assistance limits the resident's ability to maintain her personal hygiene, skin integrity, and dignity. Findings include: Review of the facility policy titled "Bathing" occurred on 04/22/15. This policy, dated June 2014, stated, ". . . Purpose To promote cleanliness and general hygiene . . . comfort and relaxation . . . To assist resident with personal care. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and dermatophytosis (fungal infection of the skin). The annual Minimum Data Set (MDS), dated 01/29/15, identified intact cognitive skills and limited assistance required for bathing. The current care plan stated, ". . . Focus . . . The resident has an ADL [activity of daily living] self care performance deficit . . . Interventions . . . BATHING: Resident requires 1 staff participation with bathing task 2x [times]/wk [week] and as needed . . ." Review of the progress notes identified the following: * 06/01/14, "CNA [certified nursing assistant] reports that resident wants a bath today due to she did not get one last night. Resident told the	F 312		

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F 312	Continued From page 16 CNA that the staff had no time to give a bath last night. Noc [night] CN [charge nurse] still here and had no comment. This CN explained that resident is to get her bath on Saturday evening and if she doesn't get it she is to mention it to the noc nurse on Saturday and the CN is to assist in getting it arranged. CNA states she did reinforce the same with resident, but is not certain if resident mentioned it to staff last night or waiting until this AM. . . . This CN stopped and talked to resident regarding bath that was missed last night. . . . Resident states she didn't think she should have to remind the staff on Saturday nights that she was supposed to get a bath. CN reviewed she really shouldn't have to remind staff, but until it becomes routine, we will all have to work at reminding each other." * 09/01/14, "Resident had told staff over the weekend that she needed a bath on Monday or Tuesday morning because she did not get one on Saturday night due to staffing and when it was offered she was already in her PJs and refused to get out of them to take a bath." * 12/26/14, "Resident didn't get a bath this AM due to staffing." The "bathing" schedule identified staff failed to bathe Resident #2 twice weekly for 15 of 33 weeks between 08/24/14 - 04/18/15. During an interview on 04/22/14 at 11:30 a.m., an administrative nurse (#4) confirmed staff should bathe the residents as careplanned.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 17 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 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 the necessary treatment and services to promote the healing of a facility acquired pressure ulcer for 1 of 2 sampled residents (Resident #2) with a heel ulcer. Failure to provide timely and appropriate interventions and ensure staff consistently implemented those interventions contributed to the development of and has the potential to cause further deterioration of Resident #2's existing pressure ulcer and the development of additional pressure ulcers. Findings include: Review of the facility policy titled "Skin Assessment and Pressure Ulcer Prevention" occurred on 04/22/15. This policy, dated June 2014, stated ". . . If a pressure ulcer [injury to the skin or underlying tissue, usually over a bony prominence, as a result of pressure] is identified . . . the registered nurse [RN] should record the type of wound and the degree of tissue damage . . . The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. . . . The pressure ulcer should be assessed/evaluated at least weekly . . . Observations of the ulcer's characteristics may be	F 314	F-314 1. Resident #2 needs were met when nursing staff were educated on proper documentation of pressure sores to include assess/record the type/degree of tissue damage after intially identifying the wound. Will continue weekly skin checks which will include pressure sore documentation. Slipper will be applied as care planned. Resident not wearing poor fitting shoes. Resident #2 also scheduled to see podiatry per her physician order. 2. All residents with pressure sores have the potential to be affected. 3. Nursing Staff education provided to Nursing Staff on 05/18/2015. Pressure ulcer management, User Defined Assessmen on Wound Data Collection and Wound RN assessment reviewed with nursing staff. Educated nursing staff on weekly skin assessments with accurate documentation to include type of wound and degree of tissue damage, and following plan of care related to pressure sores of each resident. 4. Director of nursing will do focus audits on weekly skin checks and Wound Data Collection User Defined Assessment to include identifying type	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 18 documented by a licensed nurse and should include at least the following: Measurements - length, width, depth, Characteristics of the ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin, etc, Presence of pain, Current treatments, Progress towards healing and any modifications to the plan of care/treatments should be assessed and evaluated by the registered nurse. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a left heel ulcer. The annual Minimum Data Set (MDS), dated 01/29/15, identified intact cognitive skills, at risk of pressure ulcers, and ulcer treatments including pressure reducing device for chair/bed and ointments/medications. The current care plan further stated, ". . . Focus The resident has a pressure ulcer to L) [left] inner heel from poor fitting shoes. . . . Interventions . . . Assess/record/monitor wound healing q [every] shift, Report improvements and declines to the health care provider. . . . Provide slippers to feet during the day w [with]/non slip bottoms. Float heels at night and keep area free from pressure. . . ." The current physician's order, dated 04/07/15, stated, "Monitor pressure area Lt [left] inner heel until resolved." Review of the progress notes identified the following: * 04/01/15, "Full body skin assessment completed. No new skin issues found. An old callous on her left heel still noted but skin is intact. . . . Resident has no skin concerns at this time."	F 314	of wound and degree of tissue damage. 10 skin check audits will be weekly x1 month, and then 10 checks monthly x 6months. Wound Data Collection tool will be audited, 10 residents reviewed weekly x 1 month, then 10 residents reviewed monthly x6 months. All findings will be reported to QAPI Team monthly meeting. 5. Corrective action completed on 05/18/2015.	

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F 314	Continued From page 19 * 04/07/15, "Routine skin assess [assessment] done this am after her bath. Calloused skin removed from Lt inner hel [sic], tissue dark in color & [and] spongy to touch. Surrounding tissue calloused. . . ." After identifying the area, the registered nurse failed to record the type of wound and the degree of tissue damage per facility policy. * 04/08/15, "Resident said callous area is tender to touch. Scab is intact and to [sic] drainage noted. . . . Received fax from MD [medical doctor] acknowledging callous on resident's left heel and we will monitor till healed." * 04/11/15, "Pressure relieving boot to Lt foot when in bed at bedtime for pressure area Lt inner heel." The "Wound RN Assessment," dated 04/14/15, identified Resident #2 had an "unstageable pressure ulcer [full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar]." A progress note, dated 04/15/15, stated, "Weekly skin assessment completed. Old bruises are fading and new bruises are still being monitored d/t [do to] recent fall. No new skin tear noted and no other skin concerns at this time." Facility staff failed to address Resident #2's unstageable heel ulcer during the weekly skin assessment. The "Wound Data Collection" form, dated 04/16/15, identified Resident #2 had a pressure area to her left inner heel, without drainage, odor, or other complications. Resident #2 voiced no complaints of pain related to the wound. A progress note, dated 04/17/15, stated, "Improvement re [regarding]: pressure area Lt	F 314		

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F 314	Continued From page 20	F 314		

inner heel. Area is no longer spongy to touch in the center. Now resemables [sic] a bruise."

The "Wound Data Collection" form, dated 04/17/15, identified Resident #2 had a left inner heel wound, measuring 1.0 x 1.3 centimeters (cm) in diameter, with a wound bed that was 100% epithelialized, without drainage, odor, or other complications, and surrounding skin that was dry and intact. Resident #2 voiced no complaints of pain related to the wound.

The "Wound Data Collection" form, dated 04/20/15, identified Resident #2 had a left inner heel wound, measuring 1.0 x 1.3 cm in diameter, with a very thick, firm callous area with a dark center, without drainage or odor, that is tender when pressure is applied.

Observations showed the following:
* During the initial tour on 04/20/15 at 11:30 a.m., a managerial nurse (#14) reported Resident #2 had a "facility-acquired pressure ulcer on her left inner heel cause by ill-fitting shoes."
* On 04/21/15 at 8:55 a.m., 10:06 a.m., and 2:30 p.m., Resident #2 sat in her wheelchair, with shoes on her feet. Facility staff failed to apply slippers to Resident #2's feet as care planned.
* On 04/22/15 at 8:35 a.m., Resident #2 sat in her wheelchair, with shoes on her feet. She told the CNA, "My shoes are tight. My shoes are tied too tight."
* On 04/22/15 at 8:45 a.m., Resident #2 sat in her wheelchair, with shoes on her feet. She told the nurse, "My shoes are tied too tight." When asked if Resident #2 should be wearing shoes or slippers, the nurse (#13) stated, "I was going to ask her [Resident #2] that." Resident #2 responded, "They just put them on me." The

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F 314	Continued From page 21 nurse (#13) also described Resident #2's pressure ulcer as, "unstageable, not spongy, firm, and dark" and stated, "I don't feel there is any tunneling." The resident then stated, "It hurts if you push on it." During an interview on 04/22/15 at 10:30 a.m., a nurse (#13) confirmed staff failed to assess Resident #2's wound when it was first identified. She also reported Resident #2 "was supposed to have gripper socks on," and stated, "I'm gonna put her shoes in the back of her closet. I thought we put them out of sight the last time." The facility failed to: * assess/record the type/degree of tissue damage after initially identifying the wound, * identify Resident #2's unstageable heel ulcer during the weekly skin assessments, and * apply slippers to Resident #2's feet as care planned.	F 314		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/03/14.	F 323		

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F 323	Continued From page 22 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents or injury for 2 of 9 sampled residents (Resident #2 and #6) who required assistance for transfers/transport. Failure to use or properly use assistive devices during transfers placed the residents at risk of accident or injury. Findings include: Review of the facility policy titled "GAIT (TRANSFER) BELT" occurred on 04/22/15. This policy, revised in 2013, stated, "PURPOSE: *To safely transfer or ambulate resident [sic] *To aid resident in maintaining balance *To avoid injury to both resident and staff member NOTE: Gait belts used unless medically contraindicated. PROCEDURE: . . . 4. Make sure belt is securely buckled so it does not slide. Belt . . . should be just snug enough so you can get your fingers under it. This will prevent the belt from sliding up under the breasts, rib cage or axillae. . . . 5. When holding the belt, an underhand grasp should be used. The belt should not be used for lifting. It is for support and stability only. . . . 7. Do not use the pants/slacks as a gait (transfer) belt. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included muscle weakness and osteoporosis. The quarterly Minimum Data Set (MDS), dated 01/26/15, identified extensive assistance required for transfers and toilet use. Resident #6's current care plan stated, ". . . TOILET USE: Resident requires 2 staff participation to use toilet, pivot transfers on and off the toilet w/ [with] gait belt	F 323	F- 323 1. Resident #2 and #6 needs were met when the implementation of Resident Safe Handling Program was started on 05/12/2015. Resident #2 and #6 were assessed on Good Samaritan Mobilization Support Data Collection Tool. Resident #2 was assessed to be a total lift of 2 and repositioning device will be used for sliding up in bed. Due to decline in condition Resident is no longer able to be toileted. Resident #2 Care Plan was revised with these changes. Resident #6 was assessed to be a total lift of 2 and repositioning device for sliding up in bed. Toileting is now a total lift of 2 with hygiene sling. Resident Care Plan was revised with these changes. All Residents in the facility were assessed under new Resident Handling Program with Changes made to Care Plans as needed. 2. All residents with mobility concerns have the potential to be affected. All residents who are transferred in wheelchairs have the potential to be affected.	

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	355113	A. BUILDING _____ B. WING _____	04/22/2015

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F 323	Continued From page 23 and verbal cueing. . . . TRANSFER: Resident requires 2 staff participation with transfers, pivot transfer w/use of gait belt. If unable to stand/bear wt [weight] alert CN [charge nurse], use total lift and 2 assist w/medium sling." Observation on 04/20/15 at 3:55 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) sat Resident #6 on the edge of her bed and applied a gait belt around her waist and transferred her to a wheelchair. The CNA (#5) lifted under the resident's left arm as well as lifting with the gait belt. The CNAs (#5 and #6) transported Resident #6 into the tub room to use the toilet. When the resident finished on the toilet, the CNAs transferred her back to the wheelchair. The CNA (#5) failed to use the gaitbelt and lifted the resident under her left arm. Observation on 04/21/15 at 9:15 a.m. showed two CNAs (#7 and #8) applied a gait belt around Resident #6's waist. The CNA (#8) failed to use the gait belt and lifted under the resident's left arm. When the resident finished on the toilet, the CNAs transferred her to the wheelchair. The CNA (#7) failed to use the gait belt and lifted under the resident's right arm. Observation on 04/22/15 at 9:25 a.m. showed two CNAs (#5 and #7) applied a gait belt loosely around Resident #6's waist. As the CNAs lifted the resident upward, the gait belt slid up the resident's back, under her axillae (arm pits). The CNAs failed to tighten the gait belt. Observation on 04/22/15 at 10:20 a.m. showed two CNAs (#5 and #9) applied a gait belt around Resident #6's waist and transferred her from a wheelchair to the tub chair. Both CNAs had one	F 323	3. All staff were provided education on Resident Safe Handling Program the week of April 13th-16th 2015. Implementation of the Program was on 05/12/2015. This Program will be reviewed with Nursing and Cna's at staff meetings on May18th and 19th 2015. Education will be provided on correct use of Gait Belt. Good Sam Gait Belt Policy will be reviewed. Education will be provided on the proper use of foot pedals. 4. Director of Nursing or designee is required under Resident Handling Program to re-evaluate all staff trained for competency of correct mobilization data on residents within 90 days of training. This will be completed. Director of Nursing will due focus audits on proper gait belt use and foot pedal/transferring devices to ensure adequate safety measures, DON will complete 6 audits weekly x1 month and then x 5 months. 5. Corrective action completed 05/19/2015.	

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hand on the gait belt, as one CNA (#5) lifted under the resident's arm and the other CNA (#9) pulled up on the resident's pants.

During an interview on 04/22/15 at 4:00 p.m., an administrative nurse (#4) stated facility staff are expected to appropriately use a gait belt and not lift under the resident's arms or pull on the resident's pants.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia, dizziness, fatigue, obesity, edema, arthritis, and osteoporosis. The annual MDS, dated 01/29/15, identified intact cognitive skills, extensive assistance of two or more persons required during transfers, and one person required during locomotion on/off the unit.

The current care plan stated, ". . . Focus . . . The resident has limited physical mobility . . . [and a] self care performance deficit . . . Interventions . . . AMBULATION: Encourage - Assist of 1 w/FWW [front-wheeled walker], gaitbelt and wc [wheelchair] behind. Distance to her tolerance. . . . MOBILITY: Resident uses wheelchair for mobility to and from meals and other areas of destinations. . . . assist as needed. . . . TRANSFER: Extensive assist of 1, FWW, gait belt. . . . Assist of 1 w/transfers bathroom w/use of grab bars. Only use standing lift, assist of 1 . . . if resident is unable to assist with standing. . . ." The care plan contradicted the MDS which identified Resident #1 required extensive assistance from two or more persons when transferred.

Observations showed the following:
* On 04/21/15 at 8:55 a.m., a CNA (#10)

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transported Resident #2 back to her room using her wheelchair. Resident #2's shoes slid along the surface of the floor and caught on the flooring, bringing her wheelchair to a stop. The CNA (#10) stated, "Oh, oh, oh, I'm sorry." She then cued the resident to lift her feet and resumed transport. The CNA (#10) failed to cue Resident #2 to lift her feet/place foot pedals on her wheelchair prior to transport.

* On 04/21/15 at 10:06 a.m., two CNAs (#11 and #12) as identified on the MDS, transferred Resident #2 from her wheelchair to the toilet using a sit-to-stand lift. The resident was not able to bear weight and was in a seated position hanging from the harness. As the harness straps pulled upward into Resident #2's axillae (armpits), her shoulders raised to ear level. The CNAs (#11 and #12) failed to ensure Resident #2 was able to bear weight throughout the stand lift transfer and failed to report her inability to bear weight to the nurse. When asked who determines how the resident is transferred, one of the CNAs (#12) stated, "It's in her care plan to stand-pivot or use the stand-lift to transfer her, but it's so hard for us to [physically] lift her."

During an interview on 04/22/15 at 8:22 a.m., when asked who determines how the Resident #2 is transferred, another CNA (#7) stated Resident #2 is transferred "to bed and the toilet using the stand lift."

Observation on 04/22/15 at 8:35 a.m., showed this same CNA (#7) ask Resident #2 if she would rather "use the bars or the [stand-]lift" to transfer onto the toilet. The resident stated, "bars." The CNA (#7) then placed a gaitbelt around Resident #2's waist, locked the wheelchair brakes, cued the resident to grab the bar on the left side of the

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toilet, and with one hand on the gaitbelt assisted her to stand-pivot onto the toilet. After Resident #2 voided, the CNA (#7) assisted her to stand, however she let go of Resident #2's gait belt while adjusting her clothing and failed to hold onto it while transferring her back into the wheelchair. Following toileting cares, the CNA (#7) transported Resident #2 to the dining room. Resident #2's shoes slid along the surface of the floor and caught on the flooring, bringing her wheelchair to a stop. The CNA (#7) stated, "You gotta lift your feet [Resident #2], okay," and resumed transport. The CNA (#7) failed to cue Resident #2 to lift her feet/place foot pedals on her wheelchair prior to transport.

During interview on 04/22/15 at 10:30 a.m., when asked who determines how Resident #2 is transferred, a nurse (#13) explained if staff tell Resident #2 they are "not to lift," she will make more of an effort to stand up. The nurse (#13) stated, "It's difficult to tell if this is a behavior or due to pain. We have primary CNAs who decide [whether to stand-pivot Resident #2 or use a stand-lift]."

During an interview on 04/22/14 at 11:30 a.m., an administrative nurse (#4) confirmed licensed nursing staff are to assess and determine Resident #2's transfer needs.

The facility failed to ensure:
* the current care plan reflected the resident's current transfer needs, as determined by the most recent MDS,
* staff cued Resident #2 to lift her feet/place foot pedals on her wheelchair prior to transport,
* Resident #2 was able to bear weight throughout the stand lift transfer,

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F 323	Continued From page 27 * staff reported Resident #2's inability to bear weight to the nurse, * staff held onto the gait belt when adjusting Resident #2's clothing and/or when transferring her into the wheelchair, and * licensed nursing staff assessed Resident #2 and determined her transfer needs.	F 323		