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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	118 22ND ST NE BEULAH, ND 58523

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey started on 05/13/12 and completed on 05/17/12, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included 26 additional residents to verify specific concerns during the survey.	F 000		
F 166 SS=F	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of Resident Council Meeting Minutes, review of the facility's abuse and neglect investigations, and group, resident, family, and staff interview, the facility failed to ensure prompt efforts to resolve grievances for 6 of 14 sampled residents (Resident #1, #5, #9, #10, #11, and #14) and 13 supplemental residents (Resident #A, #B, #D, #E, #F, #G, #H, #22, #23, #24, #27, #31, and #32) who voiced concerns regarding waiting long periods of time for staff to answer call lights, late meal times, and delayed delivery of room trays. Failure of the facility to resolve the residents' grievances resulted in residents wait up to 60 minutes for staff assistance and delayed service of meals in the dining room and in resident rooms. This failure has the potential to result in weight loss related to palatability of food,	F 166	**F166** **F166 Plan of Correction – Meal Service/Room Trays** Knife River Care Center (KRCC) recognizes the statement, "A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior to other residents." 1. Staff and residents will be educated on Scheduled Meal Service Policy. Staff will be educated to assist resident with menu completion, delivery of meal tray and proper set up. Concerns voiced by Resident #1, #9 and #10, etc. or any resident during the Food Committee	07/09/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 07-25-12

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

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falls, and injury to the residents.

Findings include:

- During the initial tour, on 05/13/12 at 7:20 p.m., observation showed the following:
* Resident H (identified by the facility as interviewable) sitting in his wheelchair looking out his window. When asked if he felt he received assistance from staff when needed, Resident H stated, "They sometimes work short." He further stated he has had to "wait up to 30-60 minutes" for staff to answer his call light.
* Resident #5 (identified by the facility as interviewable) waiting for staff assistance after activating his call light. A nursing staff member (#20) was passing medication at the end of Resident #5's hallway. Approximately 25 minutes later, the resident's call light remained activated and the nursing staff member (#20) was no longer on the unit. When asked if staff had attempted to assist him, he stated, "No one answered my call light."
* Resident G identified staff failed to answer call lights for long periods of time during shift change/staff report.

- Observation on 05/15/12 at 7:33 a.m. showed Resident #31 and #32 had activated their call lights. At 8:16 a.m., two unidentified staff members enter ed Resident #31 and #32's rooms to assist them.

- Observation on 05/15/12 at 8:10 a.m. showed Resident H had activated his call light. At 8:45 a.m., the call light above Resident H's room remained lit, and the door to his room remained open. Resident H spoke with an unidentified staff

F 166

Meeting will be written on a Resident Council Feedback form (see Exhibit F166-8) and forwarded to the appropriate department head.

2. Every resident is at risk to be affected by this deficient practice therefore, all residents will be educated on the Scheduled Meal Service Policy.

3. Scheduled Meal Service Policy (See exhibit F166-6) and Service Food Policy (See Exhibit F166-7) will be updated to include expanded meal service times, room tray service and staff set up of trays. Resident Council Feedback forms will be reviewed, discussed, and a plan of action will be developed at the Supervisor`s Meeting. The Dietary Manager will be adding additional

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member, stating "My light's been on for a half hour." The unidentified staff member stated, "It must not be working right." When asked if staff had attempted to assist him, Resident H stated, "The girl came in, in like five minutes. She said she was going to go get some help and come back. The other CNA came in like a half hour later to check on me."

During confidential resident and family interviews during the week of survey:
* Resident E stated it took staff over an hour to answer his call light in the afternoon, approximately one month ago. He thought his call light was broken until staff came to empty his urinal which had overflowed and spilled on him and onto the bed/blankets. Resident E identified the "afternoon is the worst shift for answering call lights." Resident E stated when he brings up concerns staff fail to address them.
* Resident F and her family member both identified the facility needed more staff and stated staff take a long time to answer call lights during the evening and night shifts. Resident F stated she searched for staff herself at times during the night and it took a long time before she finally found assistance.
* Resident A's family member stated Resident A had activated her call light at 2:30 p.m. At 3:00 p.m., after searching for and failing to locate a staff member, Resident A's family member assisted Resident A with toileting.
* Resident D's family member stated there have been several occasions she or another family member have initiated the call light in Resident D's room and have waited 15 minutes or more for a staff member to come to the room. This family member stated on 01/05/12, she initiated

F 166

staff to the Dietary Department (See exhibit F166-9). Part of their job duties will be to assist with meal service.

4. An educational meeting for residents on the Scheduled Meal Service Policy will be held on July 5, 2012. Nursing staff will be educated on the updated policy at the Nurse/C.N.A meetings scheduled for Thursday, July 5th, 2012. A memo will be put out for the dietary staff on the updated policy (See exhibit F166-10).

5. A Quality Assurance Assessment Tool (See exhibit F166-11) has been devised to monitor meal service times, quality of food and timeliness of the delivery of meal trays. The Quality Assurance tools will be completed by Dietary Manager, Dietary Staff, Nursing Staff (LPN, RN, CMA, C.N.A, RCC, C.N.A Trainers, and Nurse

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Resident D's call light twice for staff assistance. Staff told them the call light system must not be working. Resident D's family member identified several days in March and April 2012, facility staff failed to answer the call light and the family member assisted the resident to the bathroom.
* Resident B's family member stated approximately three weeks ago she and another family member visited with their mother in the lounge area near the resident's room. They heard an alarm sound, went to investigate, and found a male resident who had triggered his chair alarm, in their mother's room. Resident B's family member stated it took 10 to 15 minutes for facility staff to respond to the male resident's chair alarm.

During confidential staff interviews during the week of survey:
* A staff member (A) stated, "In the evenings, we are very short staffed. It can be overwhelming. One person for 15-16 residents. We can't be everywhere. People's call lights are on for a long time."
* A staff member (B) stated, "There's not enough staff. That's an understatement. Lights are on for a long time. We have had more falls, because they're waiting. They [the residents] don't wanna be incontinent so they try to do it themselves. Room trays are delivered late too. If called in at 5:30 p.m., trays don't go out until 6:00 p.m."
* A staff member (C) stated, "I think they are short a lot of times." When asked if residents have had to wait for assistance, she stated, "I'm sure they have. They may be sitting there a half an hour."

Review of the facility policy titled "Scheduled Meal Hours" occurred on 05/15/12. This policy, dated

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Managers), Activity, Laundry, Housekeeping, Maintenance and Administrative Staff. Random observations are included in the QA process. The initial QA will be done on or before July 9, 2012, weekly for 4 weeks, twice monthly for three months, and then once monthly for six months.

F 166 Plan of Correction – Call lights

1. Since is it difficult to go back and provide corrective action on that particular day when the survey team observed resident #5, #31 and #32's call lights not being answered in a timely manner, we opted to do the following. A Quality Assurance tool was completed by July 9, 2012 to evaluate if resident #5, #31 #32's

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02/03/12, stated, "1. The following meals times have been established by our facility:
Breakfast Resident Dining 7:30 AM; 7:15 Whispering Winds
Lunch . . . Resident Dining 11:30 AM; 11:15 AM Whispering Winds
Supper . . . Resident Dining 5:30 PM; 5:15 PM Whispering Winds . . .
Meal . . . times are approximate and may vary plus/minus 15 minutes. Nursing staff is responsible for bringing residents into the dining areas promptly."

- Observation of the supper meal on 05/14/12 at 5:58 p.m. showed Resident #1 sitting at the dining room table and hollering out, "Hey! I want some food so I can go to bed!" Resident #1 received his meal at 6:10 p.m. (40 minutes after the scheduled serving time).

- Observation on 05/14/12 at 5:35 p.m. showed an unidentified CNA assisting Resident #11 with her menu. At 6:15 p.m., the same unidentified CNA passed the resident's room tray and provided set-up.

- Observation of the noon meal on 05/15/12 identified the following:
*Resident #1 came to the dining room at 11:38 a.m. and staff served his meal at 12:05 p.m. (27 minutes after he sat down). While waiting for his food, Resident #1 stated, "do we wait until afternoon?"
*While waiting for her meal at 11:45 a.m., Resident #23 stated, "I get so tired of waiting." (unknown when meal actually arrived)
*Resident #10 sat at her table in the dining room at 11:30 a.m. and received her meal at 12:00 p.m.

F 166

call lights were being answered in a timely manner.

2. Any resident concerns voiced at Resident Council, from residents to Social Service, from families, other KRCC departments, etc. will be addressed as promptly as possible the staff member receiving the resident's concern. Concerns voiced by residents will be discussed by department managers at daily Stand-up Report. Frequent Quality Assurance monitoring will also help KRCC identify those residents with concerns.

3. Problems identified during the observations will be addressed with appropriate staff (i.e. floor staff, IT staff, etc.) KRCC will utilize reports generated from the call light system (See exhibit F166-12) and cross

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(30 minutes after the scheduled serving time).
*At 12:00 p.m. Resident #22 stated, "I might as well go home," when referring to the long wait for meal service. Staff brought the resident's food at approximately 12:05 p.m.
*Resident #24 agreed with the other residents sitting at her table and stated, "long wait." The resident received her meal at approximately 12:05 p.m.

- Observation of the noon meal on 05/17/12 at 11:50 a.m. identified the following:
*Resident #9 sat in her wheelchair at the dining room table. The resident stated, "It takes forever. I am getting so tired." The resident identified the facility scheduled lunch for 11:30 a.m., so she comes to the dining room at 11:30 a.m. Resident #9 stated she will leave and go back to her room if staff don't bring her food soon. (Unknown when resident actually received her meal).
*Resident #1 received his meal between 11:50-11:55 a.m. (20-25 minutes after the scheduled time).

Resident interviews regarding meal service revealed the following:
* During the initial tour on the evening of 05/13/12, Resident G stated it takes staff "forever" to serve meals and identified she waits the longest for her food during supper.
* On 05/14/12 at 4:00 p.m. during the group interview, residents identified meal times as Breakfast from 7:30 a.m. to 10:00 a.m.; Lunch at 11:30 a.m.; and Supper at 5:30 p.m. When asked about promptness of meal service residents shook their head no. One resident stated, "Pretty close to on time [staff] are still working on it."
* On 05/16/12 at 1:25 p.m., Resident #14

F 166

reference with staff observations to assure the call light system is functioning properly and that the call lights are being answered in a timely manner. KRCC has provided communication equipment (i.e. pagers, PDA's and walkie-talkies) for staff to utilize when call lights are activated and as a means of communication with their co-workers.

4. Correction of the deficiency is a work in progress. KRCC is currently accepting bids toward the purchase of a more durable system designed for LTC use.

5. The Quality Assurance tools will be completed by Dietary Manager, Dietary Staff, Nursing Staff (LPN, RN, CMA, C.N.A, RCC, C.N.A Trainers, and Nurse Managers), Activity, Laundry, Housekeeping, Maintenance and Administrative Staff.

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identified during the past six months it takes staff longer to deliver his room tray. He identified breakfast usually arrived between 9:30 a.m. and 9:45 a.m., lunch approximately at 12:30 p.m., and supper around 6:00 p.m.

- During a confidential interview during the week of survey, a staff member (A) stated the facility badly needed more staff. She identified normally activity aides, managers, social service staff members, etc. never help out in the dining room or on the floor so it usually takes even longer than what survey observations showed to serve residents' meals and room trays and to assist them with cares.

- Review of the facility's Resident Council minutes identified grievances concerning meal times/service as follows:
* November 2011: " . . . a concern was presented that residents are waiting too long for meal service. They are informed early up to an hour before to start going to the DR [dining room] for meals. They go down there and just sit and sit. Sometimes waiting up to an hour. . . ."
* February 2012: ". . . Residents are concerned about waiting sometimes up to an hour before they receive their meals. The other side is served and you wait for your meal. Residents are not served as they arrive, they are served after everyone is seating at the table."

The facility did not hold a Resident Council meeting in October 2011 or April 2012. Resident council notes identified concerns from the residents about meal service since November 2011. At a group meeting six months later, six of seven residents in attendance identified

F 166

Random observations are included in the QA process. The initial QA will be done on or before July 9, 2012, weekly for 4 weeks, twice monthly for 3 months, and then once monthly for 6 months.

Per telephone conversation on 8/6/12 @ 2:00pm c̄ Rhonda DON:

For all deficiencies (except F253, F257, F315, F325, F364, F371) QA will be conducted by a random sampling of staff members from different disciplines. Findings will be tabulated and recorded ~~and reported~~ by the QA manager and reported to the QA Committee.

K. Beechie

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continued concerns with meal service.

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES — F 226

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 review of facility policy, abuse/neglect investigations, and staff interview, the facility failed to immediately report 2 of 8 allegations of abuse/neglect (dated 09/17/11 and 10/18/11) to the state survey and certification agency and failed to ensure staff reported all allegations for 1 of 1 allegation (dated 09/09/11) reviewed which was not reported immediately to the adminstrator. This failure placed residents at risk for possible abuse/neglect.

Findings include:

Review of the facility policy titled "Abuse Prohibition Policy" occurred on 05/17/12. This policy, dated 08/29/11, stated, ". . . PROCEDURE . . . 1. The employee who witnesses or has knowledge of an act or suspected act of abuse, neglect, or misappropriation of property shall notify the administrator immediately verbally and/or in writing. . . . 3. All alleged acts or suspected acts of abuse, neglect, or misappropriation of resident property reported shall be immediately and thoroughly investigated and reported to other officials through established procedures and in accordance with State law

F 226 Plan of Correction — 07/09/12

Knife River Care Center (KRCC) recognizes the statement, "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

In the spirit of cooperation the facility has taken the positive action to promote immediate reporting of all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property.

1. The initial report of the allegation was submitted to the State Health Department, however, not in a timely manner.

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(including to the State survey and certification agency). . . ."

During confidential staff interviews during the week of survey:
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (D) stated, "I don't feel comfortable reporting abuse. I need my job. I have [family] to support."
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (A) stated, "You hear stories of people being suspended. I guess I'd still feel comfortable reporting, maybe."

Review of investigations of alleged abuse/neglect occurred on 05/17/12 with an administrative social services staff member (#38).

- "The Initial Allegation of Abuse Reporting Form" from the first investigation identified an incident had occurred on 09/09/11. Nursing staff reported the incident to administrative staff on 09/15/11. The form identified the facility then notified the state survey and certification agency on 09/15/11.

- The "Initial Allegation of Abuse Reporting Form" from the second investigation identified an incident had occurred on 09/17/11. Facility staff reported the incident to administrative facility staff the same day. The form identified the facility failed to notify the state survey and certification agency until 09/21/11.

- The "Initial Allegation of Abuse Reporting Form" from the third investigation identified an incident had occurred on 10/18/11. A resident reported the incident to a social services staff member the next day, 10/19/11. The form identified the facility

F 226

2. All Residents of KRCC have the potential to be affected by this practice. The Abuse Prohibition and Abuse Reporting Policies are in place to protect all residents (See exhibit F226-1).

3. The Director of Nursing (DON) and/or Unit Manager along with the Social Service Director and/or Social Service Designee will work together on all alleged allegations. Along with the DON and Unit Managers, the Social Service Director will review the Quality Assurance Event forms daily. In November 2011 the Quality Assurance Event form was changed so "injuries of unknown sources" would be better identified and reported to the Unit Manager or Social Services immediately. KRCC staff is currently educated annually, and as needed, on the Abuse Prohibition and Abuse Reporting

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(including to the State survey and certification agency). . . ."

During confidential staff interviews during the week of survey:
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (D) stated, "I don't feel comfortable reporting abuse. I need my job. I have [family] to support."
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (A) stated, "You hear stories of people being suspended. I guess I'd still feel comfortable reporting, maybe."

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Policies and sign an acknowledgement form that is placed in their employee file.

4. A Quality Assurance assessment tool has been devised to randomly monitor direct care staff's knowledge of abuse, neglect, and misappropriation of resident property. Staff from all three shifts will be interviewed. Social Service staff, RNs, LPNs, Nurse Managers, CNAs, CMAs and Managerial staff will be conducting the QA tool (See exhibit F226-2).

5. The initial QA tool will be completed on or before July 9th, 2012, twice monthly for three months, then once monthly for six months then quarterly thereafter. Results of the QA will be reviewed at the quarterly QA meeting, tentatively scheduled for August 2012 and as needed thereafter. Staff education on the reporting timelines was reviewed at

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F 226	Continued From page 8	F 226	the General Staff meeting on Wednesday, June 27, 2012 (See exhibit F226-3).	

(including to the State survey and certification agency). . . ."

During confidential staff interviews during the week of survey:
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (D) stated, "I don't feel comfortable reporting abuse. I need my job. I have [family] to support."
* When asked if he/she felt comfortable reporting abuse/neglect, a staff member (A) stated, "You hear stories of people being suspended. I guess I'd still feel comfortable reporting, maybe."

Review of investigations of alleged abuse/neglect occurred on 05/17/12 with an administrative social services staff member (#38).

- "The Initial Allegation of Abuse Reporting Form" from the first investigation identified an incident had occurred on 09/09/11. Nursing staff reported the incident to administrative staff on 09/15/11. The form identified the facility then notified the state survey and certification agency on 09/15/11.

- The "Initial Allegation of Abuse Reporting Form" from the second investigation identified an incident had occurred on 09/17/11. Facility staff reported the incident to administrative facility staff the same day. The form identified the facility failed to notify the state survey and certification agency until 09/21/11.

- The "Initial Allegation of Abuse Reporting Form" from the third investigation identified an incident had occurred on 10/18/11. A resident reported the incident to a social services staff member the next day, 10/19/11. The form identified the facility

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F 226	Continued From page 9 failed to notify the state survey and certification agency until 10/21/11. During an interview the morning of 05/17/12, an administrative social services staff member (#38) confirmed staff failed to follow the facility's current policy and procedure; by failing to notify the administrator and the state survey and certification agency immediately of any alleged incidents of abuse/neglect.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to provide care in a manner that promoted each resident's dignity and self respect for 4 of 14 sampled residents (Resident #2, #6, #7, and #12). Failure to cover a catheter bag when the resident is in a lounge/dining area (Resident #6), provide for privacy when assisting a resident with cares, assuring clothes are on correctly, and when assisting the resident with meals (Resident #7), change soiled clothing (Resident #12), and knock prior to entering a resident's room (Resident #2), did not enhance the residents' dignity and self-respect. Findings include:	F 241	**F – 241 Plan of Correction** In the spirit of cooperation consistent with Knife River Care Center's historical and current commitment to quality of care for the residents, the facility states: **Plan of Correction F-241** 1. The corrective action for resident's #2, #6, #7 and #12 was accomplished by reviewing Knife River Care Center's policies on Dignity, Respect and Resident rights at the General Staff meeting on June 27, 2012. (Exhibit F241-2). Included in this education will be Nurses, C.N.A staff, Activity staff, Dietary personnel, Housekeeping	07/09/12

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F 241 Continued From page 10

Review of the facility policy titled "Feeding the Resident" occurred on 05/17/12. This undated policy stated, ". . . 11. When feeding a resident, may position a chair next to the resident's bed or wheelchair in the dining room; if wheelchair is larger or taller than standard, position yourself to be at eye level when feeding a resident. . . ."

- Observation of Resident #6, on 05/14/12 at 12:50 p.m., showed the resident sitting in a lounge chair, eyes shut, and her catheter leg bag containing urine below her pant leg. As Resident #6 sat, she began to manipulate the catheter bag. An unidentified staff member intervened, pulled the resident's sock up over the lower half of the catheter bag and pulled her pants down over the top of the catheter bag.

Observation on 05/15/12 at 10:45 a.m., showed a certified nurse aide (CNA) (#4) assisted the Resident #6 with morning cares. The CNA (#4) placed the catheter leg bag onto the resident's lower leg. When the CNA (#4) assisted the resident to stand, one of the straps from the cathter bag hung below Resident #6's pant leg, the strap rested on the ground as she stood and walked. Observations throughout the rest of the day showed the strap of the catheter bag hung below Resident #6's pant leg.

Observation of Resident #6, on 05/16/12 at 8:53 a.m., showed the resident sitting at the breakfast table with her catheter bag exposed below the bottom of her pants leg. The catheter bag contained urine, and was strapped against the resident's bare skin. Later the same day, at 2:32 p.m., Resident #6 sat in a lounge chair with her catheter bag, containing urine, exposed below

F 241

personnel, Therapy personnel, Maintenance staff and Administration. Policies reviewed:

a. Guidelines for Maintaining Resident Privacy;

b. Resident Rights Information handout;

c. Knife River Care Center Procedure – Feeding the resident.

2. The potential is always there for diverting from the level of dignity and respect that Knife River Care Center expects from every employee, however, Knife River Care Center's plan is to educate staff at the General Staff meeting regarding maintaining resident dignity and respect. Also, the Nursing and C.N.A staff will be educated on Maintaining Dignity and Respect on July 5, 2012. Exhibit F241-3

3. Correction will be focused on employee observation and follow up. (Exhibit F241-4.)

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Continued From page 11
her pant leg.

- Observation of Resident #7, on 05/15/12 at 4:47 p.m., showed a CNA (#5) provided cares to the resident while she lay in bed in front of a window with the shade up. The CNA checked Resident #7's brief for continence, identified Resident #7 as "dry," and turned her side to side on the bed to pull up her pants. When the CNA (#5) finished pulling up Resident #7's pants, the side pockets were on her abdomen and behind her back, not at her sides. The CNA (#5) placed the full body sling, transferred Resident #7 to her wheelchair, covered Resident #7's lap with a blanket, and did not attempt to straighten the resident's pants.

Observation of Resident #7, on 05/15/12 at 6:10 p.m., showed a CNA (#7) standing to assist Resident #7 with eating. When Resident #7 looked toward the CNA (#7), her eyes were at the level of the staff member's chest.

- Observation showed a CNA (#9) assisted Resident #12 with cares on 05/16/12 at 5:30 p.m. Resident #12 had a pink stain on the front of his black and white checkered shirt. The CNA (#9) failed to assist and/or offer to change Resident #12's soiled shirt and escorted him to the dining room. Resident #12 sat a table with other residents for the evening meal wearing the stained shirt.

- Observation on 05/14/12 at 1:00 p.m. showed Resident #2 lying on his bed as the CNA (#8) provided perineal cares. During the observation, an unidentified CNA opened the door to the resident's room without knocking or introducing herself.

F 241

It is noted this QA form is specific to one resident observed by the rater. Several random residents will be reviewed at any given time. Any employee concerns will be addressed through additional training, coaching, counseling and discipline, if needed. Staff members responsible for observation will be Nurses, C.N.A staff, Activity staff, dietary personnel, housekeeping personnel, therapy personnel, maintenance staff and Administration.

4. The Plan of Correction is to be implemented starting on June 27, 2012 starting with training and education of KRCC staff.

5. Quality Assurance observations will be completed by July 9, 2012, twice monthly for three months, once monthly for six monthly and quarterly, prn. Additional findings will be reviewed through the quarterly Quality Assurance meetings.

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F 253 SS=B 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES — F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of the cleaning schedule, and staff interview, the facility failed to provide a clean and homelike environment regarding cleanliness of fans and bathroom exhaust vents on 2 of 3 resident care units (Whispering Winds and Shady Lane). Failure to clean the fans and vents creates a source of airborne material which placed residents, staff, and visitors at risk of inhaling dust and debris.

Findings include:

During the initial facility tour, on 05/13/12 at 7:30 p.m., observation identified the following:
*Bathroom exhaust vents with accumulated dust and debris - Room 107, 352, 353, 355, 357, 360, 361, and 365.

During the environmental tour, on 5/16/12 at 3:45 p.m., observation with a housekeeping staff member (#16) confirmed the vents with accumulated dust and debris from the initial tour. In addition, observation identified a personal fan with accumulated dust and debris on the blades and protective housing in Room 353.

During an interview on the afternoon of 05/16/12, a housekeeping staff member (#16) stated staff check residents' personal fans weekly and clean

F 253 Plan of Correction — 07/09/12

1. Vents and fan were cleaned on 5-17-2012. And all other vents and fans were inspected to insure that they were free of any dust. No residents were affected.
2. Vents and fans will be monitored weekly and cleaned monthly to insure that they are free of dust. If vents are visibly dusty in-between scheduled cleaning they will be cleaned at that time. If the vents are dusty beyond the grate a Maintenance Request will be filled out and Maintenance will remove the grate and clean internally.
3. Education of Housekeeping staff on proper cleaning of vents and fans will occur on June 27, 2012.
4. A Quality Assurance Tool, "Vent and Fan Cleanliness" will be implemented. (See

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F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of the cleaning schedule, and staff interview, the facility failed to provide a clean and homelike environment regarding cleanliness of fans and bathroom exhaust vents on 2 of 3 resident care units (Whispering Winds and Shady Lane). Failure to clean the fans and vents creates a source of airborne material which placed residents, staff, and visitors at risk of inhaling dust and debris. Findings include: During the initial facility tour, on 05/13/12 at 7:30 p.m., observation identified the following: *Bathroom exhaust vents with accumulated dust and debris - Room 107, 352, 353, 355, 357, 360, 361, and 365. During the environmental tour, on 5/16/12 at 3:45 p.m., observation with a housekeeping staff member (#16) confirmed the vents with accumulated dust and debris from the initial tour. In addition, observation identified a personal fan with accumulated dust and debris on the blades and protective housing in Room 353. During an interview on the afternoon of 05/16/12, a housekeeping staff member (#16) stated staff check residents' personal fans weekly and clean	F 253	Exhibit# H1). This tool will be used to monitor effectiveness of proper cleaning of vents and fans and will be completed by the Housekeeping supervisor. This QA tool will be completed by July 2, 2012. In addition, it will be completed monthly x 3 months and quarterly and prn thereafter. The findings will be presented at the next Quality Assurance meeting. 5. The corrective action was completed 5-17-2012. The follow up actions will start before July 9, 2012, and will be monitored as indicated in item #4.	

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F 253	Continued From page 13 them monthly and as needed and identified staff clean the bathroom exhaust vents monthly. This staff member provided a current cleaning schedule which showed staff cleaned the bathroom exhaust vents on Shady Lane (Rooms 352-365) on March 25th and stated staff began dusting the vents on Whispering Winds (Room 107) in May. The housekeeping staff member (#16) confirmed that staff failed to clean the fan and bathroom vents in April.	F 253		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a comfortable temperature level for 3 of 3 sampled residents (Resident #3, #4, and #11) and 1 of 1 supplemental resident (Resident #33) who complained of being too warm on 1 of 3 units (Shady Lane). Failure to maintain comfortable temperature levels between 71-81 degree Farenheit can lead to resident discomfort. Findings include: - On 05/13/12, at 8:38 p.m., during the initial tour, Resident #33 identified his room as hot. Observation showed Resident #33 lying in bed wearing a hospital gown and covered with a sheet. The resident's face was flushed and the	F 257	**F 257 Plan of Correction** It is Knife River Care Center's practice to provide the necessary care and services to attain or maintain, the highest practical physical, mental and psychosocial well-being, in accordance with providing comfortable and safe temperature levels. The temperatures noted during the recent survey were in a particular area of the building (Shady Lane Neighborhood) that the facility has had problems with in the past. Once the problems were identified	07/09/12

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F 257	Continued From page 14 window was open. - Observation on 05/14/12 at approximately 4:15 p.m. showed an activity staff member (#37) transporting Resident #3 down the hallway to her room. Once inside the resident's room, the activity staff member (#37) commented on the warm temperature and attempted to assist Resident #3 in removing her sweater. Resident #3 stated, "It's so hot in here. It's cooler out there," and asked staff to return her to the lounge. At approximately 5:20 p.m., Resident #3's room temperature was at 88 degrees Farenheit. - Observation on 05/14/12 at 4:45 p.m. showed two CNAs (#6 and #28) assisting Resident #4's with incontinence cares. Following cares, Resident #4 asked staff to remove his light jacket. The CNA (#6) stated, "It's so hot in here," and assisted Resident #4 in removing his jacket. At approximately 5:25 p.m., Resident #4's room temperature was at 87 degrees Farenheit. - Observation on 05/14/12 at 5:35 p.m. showed an unidentified CNA assisting Resident #11 with her menu. Prior to exiting the room, the CNA covered the resident with a blanket and stated, "I'll be back in a bit." When asked if she was comfortable, Resident #11 stated, "I'm warm. It's kinda toasty in here." Resident #11's room temperature was at 85 degrees Farenheit. Observation midafternoon on 05/15/12 showed an unidentified CNA assisting Resident #11 with cares. The unidentified CNA stated, "Geez [Resident #11], it's hot in here."	F 257	previously, the bad reheat valves were replaced. EXHIBIT M1 Knife River care center's Maintenance staff provided education to staff members on June 27th as to the current policy in alerting the maintenance staff to reporting of uncomfortable temperatures throughout the facility. EXHIBIT M2 Instruction including the reporting by staff of "uncomfortable" temperatures (below 71 and above 81*F) to their immediate supervisor and the completion of a "Maintenance Request Form "alerting Maintenance staff to the problem. EXHIBIT M3 Maintenance staff has been instructed to review daily the computer settings template provided by Johnson Control in evaluating daily temperatures in the facility. EXHIBIT M4 A daily temperature log will be completed by Maintenance staff and submitted to the Quality Assurance manager weekly. This	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 257	Continued From page 14 window was open. - Observation on 05/14/12 at approximately 4:15 p.m. showed an activity staff member (#37) transporting Resident #3 down the hallway to her room. Once inside the resident's room, the activity staff member (#37) commented on the warm temperature and attempted to assist Resident #3 in removing her sweater. Resident #3 stated, "It's so hot in here. It's cooler out there," and asked staff to return her to the lounge. At approximately 5:20 p.m., Resident #3's room temperature was at 88 degrees Farenheit. - Observation on 05/14/12 at 4:45 p.m. showed two CNAs (#6 and #28) assisting Resident #4's with incontinence cares. Following cares, Resident #4 asked staff to remove his light jacket. The CNA (#6) stated, "It's so hot in here," and assisted Resident #4 in removing his jacket. At approximately 5:25 p.m., Resident #4's room temperature was at 87 degrees Farenheit. - Observation on 05/14/12 at 5:35 p.m. showed an unidentified CNA assisting Resident #11 with her menu. Prior to exiting the room, the CNA covered the resident with a blanket and stated, "I'll be back in a bit." When asked if she was comfortable, Resident #11 stated, "I'm warm. It's kinda toasty in here." Resident #11's room temperature was at 85 degrees Farenheit. Observation midafternoon on 05/15/12 showed an unidentified CNA assisting Resident #11 with cares. The unidentified CNA stated, "Geez [Resident #11], it's hot in here."	F 257	will become an agenda item for the quarterly Quality Assurance meetings. EXHIBIT M5 Daily QA will be done and information will be provided to the Quality Assurance Manager on a weekly basis. EXHIBIT M5	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 257	Continued From page 14 window was open. - Observation on 05/14/12 at approximately 4:15 p.m. showed an activity staff member (#37) transporting Resident #3 down the hallway to her room. Once inside the resident's room, the activity staff member (#37) commented on the warm temperature and attempted to assist Resident #3 in removing her sweater. Resident #3 stated, "It's so hot in here. It's cooler out there," and asked staff to return her to the lounge. At approximately 5:20 p.m., Resident #3's room temperature was at 88 degrees Farenheit. - Observation on 05/14/12 at 4:45 p.m. showed two CNAs (#6 and #28) assisting Resident #4's with incontinence cares. Following cares, Resident #4 asked staff to remove his light jacket. The CNA (#6) stated, "It's so hot in here," and assisted Resident #4 in removing his jacket. At approximately 5:25 p.m., Resident #4's room temperature was at 87 degrees Farenheit. - Observation on 05/14/12 at 5:35 p.m. showed an unidentified CNA assisting Resident #11 with her menu. Prior to exiting the room, the CNA covered the resident with a blanket and stated, "I'll be back in a bit." When asked if she was comfortable, Resident #11 stated, "I'm warm. It's kinda toasty in here." Resident #11's room temperature was at 85 degrees Farenheit. Observation midafternoon on 05/15/12 showed an unidentified CNA assisting Resident #11 with cares. The unidentified CNA stated, "Geez [Resident #11], it's hot in here."	F 257		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	**F280 Plan of Correction**	07/09/12

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident and staff interview, the facility failed to review and revise the comprehensive care plans for 5 of 14 sampled residents (Resident #4, #8, #9, #10, and #14). Failure to review and revise the residents' care plans limits communication of resident care needs between staff and does not ensure continuity of care for each resident.

Findings include:

- Review of Resident #4's medical record occurred on May 14-17, 2012. Diagnoses

F 280

It is Knife River Care Center's practice that the resident has the right to participate in care planning and their treatment unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State.

1. Resident #4's care plan was updated to reflect his need to have his heels floated when in bed and his toileting schedule. (See exhibit F280-1) Resident #14 had his care plan updated to include the bed cradle. (See exhibit F280-2) The care plan for resident #9 was updated to include that she is capable of self administering medications. (See exhibit F280-3) The care plan for resident #10 was updated to include her bed alarm. (See exhibit F280-4) The activity portion of resident #8 was updated regarding her preference to go to the coffee shop. (See exhibit F280-5).

2. Other residents will be identified as having the potential to be affected by the same deficient practice through

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included diabetes, peripheral vascular disease, pain, history of/current lateral malleolus [ankle] pressure ulcer.

Resident #4's current care plan stated, "Nursing: . . . I'm at risk for skin breakdown because I have diabetes, decreased sensation in my feet and poor circulation. I currently have a stage II pressure area on the outer right ankle. . . . Please make sure to float my heels when I am in bed to reduce pressure. I have a pressure relieving mattress on my bed and a Roho cushion in my wheelchair. . . . I am frequently incontinent of bladder and occasionally incontinent of bowel. I wear a brief. I do still prefer to use the urinal but need help at times due to my impaired vision. I have an elevated toilet seat on the toilet in my bathroom. Do not leave me alone in the bathroom. . . ." The "Daily Care Guide" [care guide utilized by direct care staff] failed to address floating the resident's heels, his footwear, and/or his toileting needs.

Physician Orders, dated 04/03/12, stated, "12/07/12 - Float heels/ankles when in bed. . . . Mupirocin topically to (R) lateral malleolus tid."

Review of Resident #4's interdisciplinary progress notes [nurses notes] and fax alerts [notes to physicians] identified the following:
* 02/06/12 - "Noted 1.5 x 1.1 cm soft brown area to R) lateral ankle. [with] 5-6 cm redness surrounding. Is warm swollen [and] painful to touch. Feet floated on pillows. . . ."
* 02/12/12 - "Res [resident] requires that feet be checked on often due to his rotation of Rt [right] foot To the (R) side causing the bone To press against pillow which is pushed by his feet. . . ."

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weekly review by the charge nurse, quarterly review during MDS review and monthly QA, with care plans updated accordingly.

3. The Nurses Weekly Summary Guidelines were updated to include care plan review and revision to be done on a weekly basis. This is to include but is not limited to alarms, special equipment, devices, assist needed and treatments. (See exhibit F280-6) The worksheet used by the MDS coordinators during chart review has been updated to be used as a tool to ensure all areas are covered on the care plan. (See exhibit F280-7) Each resident will be reviewed weekly and quarterly. The Daily CNA care guides will be updated monthly in conjunction with the safe lift meeting and as needed as changes warrant.

4. Education will be done with nurses and CNA's at a meeting on July 5th at 1:30 pm. The care plans involved have been

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* 05/11/12 - "Res now has moon boots for protection of (L) heel . . ."

Observations made at approximately 12:35 p.m. on 05/14/12 showed Resident #4 lying on his back in bed with his heels resting directly on a pillow. Observation at 4:45 p.m. (approximately four hours later) showed two CNAs (#6 and #28) providing Resident #4's incontinence cares. The CNAs lowered the resident's pants, and showed his incontinence brief saturated with urine and soiled. Observation showed the resident was incontinent of bowel and bladder.

Observation on 05/15/12 at 2:25 p.m. and 3:08 p.m., showed Resident #4 lying on his back in bed with his heels resting directly on a pillow. Observation at 5:12 p.m. (approximately two hours and 45 minutes later) showed two CNAs (#33 and #34) providing Resident #4's incontinence cares. The CNAs lowered the resident's pants, and showed his incontinence brief saturated with urine and soiled. Observation showed the resident incontinent of bowel and bladder.

During an interview 05/16/12 at 4:40 p.m. and 5:00 p.m., when shown the progress note regarding moon boots, a managerial nursing staff member (#10) stated, "There is no orders for moon boots. To my knowledge we put heel protectors on. I found his heel protectors in his top drawer, after I searched his room. They're used at bedtime." When asked her expectations regarding toileting Resident #4, the managerial nursing staff member (#10) stated, "[Resident #4] is a check and change. We usually have them [staff] check every two hours."

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reviewed and updated. Nurses weekly summary guidelines and MDS coordinator worksheet have been updated to include care plan review. The Comprehensive Care Plan Policy has been updated and will be reviewed at the nurses and CNA meeting on July 5th (See exhibit F280-8)

5. The Resident Centered Care Plan QA has been revised and will be completed by RN's, LPN's, and nurse managers on or before July,9th 2012 and monthly thereafter (see exhibit F280-9) The results will be reviewed at the Quality Assurance meeting to be scheduled in July 9th 2012.

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Resident #4's care plan failed to identify the resident required 1) his feet be checked on often due to his rotating his right foot, 2) heel protectors/moon boots, and 3) routine/scheduled toileting.

- Review of Resident #14's medical record occurred on May 16-17, 2012. Diagnoses included diabetes, multiple sclerosis, and an unstageable pressure ulcer to both great toes.

Resident #14's medical record identified the onset of a pressure ulcer to the tip of his right great toe on 01/17/12 and the onset of a pressure ulcer to the tip of his left great toe on 03/19/12. A fax to the resident's physician, dated 05/14/12, identified the pressure ulcer to the tip of his right great toe as unstageable and measuring 1.4 centimeters (cm) by 1.9 cm and the pressure ulcer to the tip of his left great toe as unstageable and measuring 1.2 cm by 1.4 cm.

Observation on May 16-17, 2012 showed a foot cradle used on Resident #14's bed to relieve pressure to his feet/toes.

Resident #14's care plan, dated 03/09/12, stated, ". . . My lower body is paralyzed . . . I usually only get out of bed on Wednesdays but sometimes choose not to get up at all . . . My skin is at risk for breakdown . . . I have an air mattress on my bed . . . I also have a Roho cushion in my wheelchair for when I am up. I refuse a turning schedule and prefer to lay on my back. I have a history of open areas to my buttocks and ankles. I currently have a Stage I pressure ulcer to the tip of my great toe. Please float my heels as I allow. I

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also may wear Redi-grip to help if I have any swelling in my legs . . . Offer me spenko boots as well. My nurse applies a Duoderm dressing to my left ankle for protection . . ." The care plan failed to identify Resident #14's foot cradle and the current stage and/or location of present pressure ulcers.

During an interview on 05/17/12 at 10:30 a.m., an administrative nurse (#17) stated she was unsure when staff initiated Resident #14's foot cradle.

- Review of Resident #9's medical record occurred on May 14-17, 2012. A self-administration of medication (SAM) assessment, dated 02/27/12, identified the resident as capable of self-administering her medications.

During an interview on 05/13/12 at 7:40 p.m., Resident #9 stated staff leave her medication with her to take on her own at times.

Resident #9's care plan failed to identify the resident may self-administer her medications.

- Review of Resident #10's medical record occurred on May 14-17, 2012. Diagnoses included insomnia, a history of falls, compression fractures, right rib fractures (from a fall on 01/12/12), and osteoporosis.

On 09/26/11, Resident #10's physician ordered Tylenol PM as needed (PRN) at night for comfort and to promote sleep.

Observation on all days of survey showed a bed alarm on Resident #10's bed.

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Resident #10's care plan, dated 05/07/12, stated, ". . . A few months ago, I fell and sustained fractured ribs to my right side. I am declining in my ability to help myself so I rely on you to help me . . . I am at high risk for falls but if I would fall assist me off the floor using a gait belt and two staff. I use a soft-touch call light when I am in my room . . ." The care plan failed to identify Resident #10's bed alarm, diagnosis of insomnia, and PRN Tylenol PM use.

During an interview on 05/17/12 at 1:05 p.m., an administrative nurse (#17) confirmed Resident #10's care plan failed to address the bed alarm.

- Review of Resident #8's current care plan stated, "Dietary: . . . I usually like to go to the coffee shop on a daily basis where I like to have cappuccino and soft serve ice cream. . . . Nursing: . . . In October 2011, for an unknown reason, I woke up one morning unable to walk, transfer, or stand. I was using a wheelchair for mobility. . . . Activities: . . . Every morning after breakfast I like to walk to this area [coffee shop]. I like to have a cup of cappuccino with a little bit of coffee. It is fun to sit there and watch the staff . . ."

During an interview on 05/15/12 at 11:30 a.m., the CNA (#8) stated she didn't know Resident #8 liked to go to the coffee shop.

Observations on May 14-17, 2012 showed Resident #8 non-ambulatory and facility staff transported the resident by wheelchair to her

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room each morning after breakfast. Facility staff failed to ask the resident if she would like to go to the coffee shop and failed to revise her care plan when she no longer ambulated or visited the coffee shop.

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on record review, review of professional reference, review of facility policy/procedure, and staff interview, the facility failed to meet professional standards of quality for 1 of 14 sampled residents (Resident #11) and for 1 supplemental resident (Resident #20). Failure to follow the facility's bowel protocol for a resident with constipation (Resident #11); and failure to follow professionally accepted standards of practice regarding medication administration (Resident #20) may result in adverse affects to the residents.

Findings include:

Kozier and Erb's "Fundamentals of Nursing," 9th Edition, Pearson Education, Inc., New Jersey, page 860, stated, ". . . Do not leave medications at the bedside . . ."

Kozier and Erb's "Fundamentals of Nursing," 9th Edition, Pearson Education, Inc., New Jersey, page 73, stated, ". . . Nurses are expected to analyze procedures and medications ordered by

F 281 Plan of Correction — 07/09/12

It is Knife River Care Center's practice to provide or arrange services which meet professional standards of care.

Plan of Correction F281, #1

In the spirit of cooperation the facility has taken a positive action to ensure the continuation of quality care and services to its residents.

1. Upon re-entering Resident #20's room, the nurse removed the tray of medications/treatments.
2. All residents have the potential of adverse effects related to medication administration.
3. The Medication System Procedure has been updated to include; "Medications set-up for dispensing must remain in

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the physician or primary care provider . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out . . ."

Kozier and Erb's "Fundamentals of Nursing," 9th Edition, Pearson Education, Inc., New Jersey, pages 1349-1350, stated, "Constipation may be defined as fewer than three bowel movements per week. This infers the passage of dry, hard stool or the passage of no stool. . . . Many causes and factors contribute to constipation. Among them are the following: Insufficient fiber intake, Insufficient fluid intake, Insufficient activity . . . Neurologic conditions, . . . such as . . . stroke, or paralysis, Emotional disturbances such as depression . . . Medications such as opioids [for pain]. . ."

Review of the facility policy titled "Bowel Protocol (Constipation)" occurred on 05/17/12. This policy, dated August 2010, stated, ". . .
Procedure 1. The resident bowel status will be checked each shift. . . . 3. The Day Nurse is responsible for implementing, administering, and documenting interventions that may include natural laxatives such as water, prunes, prune juice, fiber added juice, benefiber powder, or other commercial soluble or insoluble fiber additives, senna tea, bran cereals, KRCC [Knife River Care Center] recipe fruitball. Other interventions may include, physician ordered medication or laxatives or enemas. . . . 5. If the resident has not had a BM [bowel movement] for 2 days one intervention will be implemented and recorded on the specific roster, 6. If the resident has not had a BM for 3 days two interventions will be implemented and recorded on the specific

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Nurse/CMA possession or line of site." (See exhibit F281-1) The Medication System Procedure updates will be reviewed at the Nurse/CMA/CNA meeting scheduled for July 5th 2012.

4. The Medication System Procedure updates will be reviewed on July 5, 2012 at the Nurse/CMA/CNA meeting.

5. A Quality Assurance assessment tool has been devised to randomly monitor the security of medications before, during and after dispensing of medications as outlined in the Medication System Procedure. (See Exhibit # F281-2). The QA tool will be completed by RN's, LPN's, CMA's and Nurse Managers in July 2012, twice monthly for three months, and then once monthly for six months. Results of QA will be reviewed at the quarterly Quality Assurance Meetings tentatively scheduled for July 9, 2012, and quarterly thereafter.

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roster, 7. If the resident has not had a BM for 4 days, further nursing assessment, intervention and documentation is necessary, 8. Natural laxatives options will be available . . . and may be dispense [sic] with meals, medication passes snack times, etc. . . ."

- During the initial tour on 05/13/12 at approximately 8:20 p.m., observation showed a plastic tray sitting on a chair in Resident #20's room containing a bottle of Fluticasone Propionate nasal spray, a bottle of Lantus insulin, a used insulin needle, and a glucometer. Observation showed Resident #20 lying in her bed with her eyes closed and a visitor sitting in a chair in the resident's room.

The facility failed to ensure Resident #20's medications remained secure at all times.
- Review of Resident 11's medical record occurred on May 16-17, 2012. Diagnoses included dementia, psychosis, depression, arthritis, and deep pitting edema to her lower extremities. The resident's annual MDS, dated 02/23/12, identified severely impaired cognition and the need for extensive assistance with toileting. The current Care Plan did not address constipation as an area of concern.

The interdisciplinary progress notes [nurses notes] identified, "05/08/12 at 4:30 p.m., 5 th day [without] BM [bowel movement] recorded. Prune juice [and] fruit ball given."

The "May 2012 BM Sheet" showed Resident #11 failed to have a bowel movement from 05/04/12 until 05/08/12.

F 281 Plan of Correction F281, #2

1. BM record shows that Resident # 11 had a BM on 5/8/12 in the evening. BM records from 5/8/12 through 6/16/12 show that nursing staff followed the Bowel Protocol for Resident #11.

2 The facility will identify residents having the potential to be affected by bowel elimination pattern irregularities by daily monitoring of each resident's bowel status and evaluating the need for additional interventions such as natural laxatives or physician ordered medications.

3 The facility has made revisions to the Bowel Protocol by assigning the Charge Nurse daily responsibility for identifying a pattern of bowel irregularity. Nursing staff will communicate the implementation of interventions and/or contact attending physician for

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roster, 7. If the resident has not had a BM for 4 days, further nursing assessment, intervention and documentation is necessary, 8. Natural laxatives options will be available . . . and may be dispense [sic] with meals, medication passes snack times, etc. . . ."

- During the initial tour on 05/13/12 at approximately 8:20 p.m., observation showed a plastic tray sitting on a chair in Resident #20's room containing a bottle of Fluticasone Propionate nasal spray, a bottle of Lantus insulin, a used insulin needle, and a glucometer. Observation showed Resident #20 lying in her bed with her eyes closed and a visitor sitting in a chair in the resident's room.

The facility failed to ensure Resident #20's medications remained secure at all times.
- Review of Resident 11's medical record occurred on May 16-17, 2012. Diagnoses included dementia, psychosis, depression, arthritis, and deep pitting edema to her lower extremities. The resident's annual MDS, dated 02/23/12, identified severely impaired cognition and the need for extensive assistance with toileting. The current Care Plan did not address constipation as an area of concern.

The interdisciplinary progress notes [nurses notes] identified, "05/08/12 at 4:30 p.m., 5 th day [without] BM [bowel movement] recorded. Prune juice [and] fruit ball given."

The "May 2012 BM Sheet" showed Resident #11 failed to have a bowel movement from 05/04/12 until 05/08/12.

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additional review of medication regimen. See exhibit F281-7.

4. Education on the revisions of the Bowel Protocol policy will be reviewed on July 5, 2012 at the Nurse/CMA/CNA meeting.

5. A Quality Assurance assessment tool has been devised to randomly monitor for compliance with the Bowel Protocol (See Exhibit # F281-8). The QA tool will be completed by RN's, LPN's, CMA's and Nurse Managers in July 2012 and quarterly thereafter. Results of QA will be reviewed at the quarterly Quality Assurance Meeting tentatively scheduled for July 9, 2012, and quarterly thereafter.

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F 281	Continued From page 24 During an interview 05/17/12 at 1:01 p.m., when asked what interventions the facility implemented during the five day span, a managerial nursing staff member (#10) stated, "I couldn't find any documentation to support anything was done." The facility failed to follow their "Bowel Protocol" to ensure Resident #11 received effective interventions and/or further nursing assessment to prevent constipation.	F 281		
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: Based on observation, record review, confidential family interview, and staff interview, the facility failed to provide the necessary assistance to meet the needs for 1 of 4 sampled residents (Resident #2) who dine at a staff-assisted dining table and for 1 of 1 supplemental resident (Resident A) who eats meals in his/her room. Failure to provide assistance at meals limited the residents' ability to ensure good nutrition, improve their independence, and maintain dignity. Findings include: - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 312	**F-312 Plan of Correction** In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality of care for the residents, the facility states: 1. Resident #2 does slouch in his wheelchair. Resident also 'pushes' wheelchair backwards. When KRCC staff do position him correctly, either at meals or otherwise, resident does continue to push wheelchair backwards. An OT referral was sent by nursing on 3-28-12. See Exhibit F312-1. Resident also on OT caseload working with wheelchair positioning. See OT progress notes document several attempts at positioning devices,	07/09/12

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included failure to thrive and dementia. The current Minimum Data Set (MDS), dated 03/28/12, identified severely impaired cognition, the need for extensive assistance for transfers and locomotion, and set-up help and supervision for eating.

Observation on 05/15/12 at 7:45 a.m. showed Resident #2 seated in his wheelchair and positioned approximately 18 inches from the dining room table which was at chest height. The resident had to lean and reach forward to obtain his food and food fell from his spoon onto his clothing and clothing protector. Resident #2 reached for his bowl of hot cereal and held the bowl beneath his chin while he ate. Observation showed an unidentified certified nursing assistant (CNA) seated at Resident #2's table, assisting another resident with his meal. The CNA failed to position Resident #2 closer to the table, failed to provide a clean clothing protector or napkin, and the resident remained chest height to the table.

Observation on 05/15/12 at 11:35 a.m. showed Resident #2 seated in his wheelchair and leaning to the right. The table height was at the resident's upper chest. Resident #2 ate independently, but needed to extend his arm/hand upward to obtain his meal. Observation showed an unidentified CNA seated at Resident #2's table, assisting another resident with his meal. The CNA failed to reposition Resident #2 upright. The resident remained chest height to the table.

Observation on 05/15/12 at 5:50 p.m. showed Resident #2 seated in his wheelchair and positioned approximately an arms length from the dining room table. The resident leaned and

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different style wheelchair, etc. to attain correct positioning. See Exhibit F312-2. Since resident does tend to slouch in chair by himself frequently, the care plan has been modified to state, 'position me correctly up to table just before I eat meals.' Exhibit F312-3. In addition, a specialty wheelchair has been ordered which will allow Resident #2 to have better positioning. Exhibit F312-4

2. Nursing staff will continue to send Occupational/Physical Therapy, Restorative Nursing Referral forms for resident who needs further evaluation in any ADL function. See Exhibit F312-5.

3. Care plan was updated. Memo sent to care area to update the change. Exhibit. F312-6. Facility staff training was held on June 27, 2012. Exhibit.F312-7. Nurse/C.N.A education will be provided on July 5, 2012 regarding resident positioning while eating in

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reached forward to obtain his meal. Observation showed a CNA (#6) seated at the table next to Resident #2. The CNA failed to position Resident #2 closer to the table.

- On 05/14/12 at 4:25 p.m., Resident A's family member stated she visited Resident A on a Saturday evening at approximately 7:00 p.m. Upon entering the resident's room, she observed Resident A's covered, untouched meal tray sitting on the bedside table. Resident A's family member assisted Resident A by providing tray set-up. Resident A's family member stated Resident A began eating immediately following tray set-up.

- Review of Resident A's medical record occurred on May 16-17, 2012. Diagnoses included dementia, psychosis, depression, arthritis, and history of small strokes. The resident's annual MDS, dated 02/23/12, identified severely impaired cognition and the need for assistance with eating. The "Reviews and Progress Reports," dated 02/29/12, stated, ". . . She is able to feed herself independently after setup. . . ."

Resident #A's current care plan stated, "Dietary: . . . My meats need to be cut up for me. . . . I choose to eat some of my meals in my room. . . . I am able to feed myself at this time but if I would need help a feeding assistant can assist me." The "Daily Care Guide" [care guide utilized by direct care staff] further stated, ". . . Set up help for meals. . . ."

Observation on 05/16/12 at 5:50 p.m. showed Resident #A sitting in her recliner. Staff failed to provide tray set-up after delivering her room tray. Without tray set-up, Resident #11 made no effort

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dining room, and also on set up of meal trays for residents in rooms.

4. Facility education completed on June 27, 2012. Memo to staff completed June 28, 2012. Specialty wheelchair ordered, and correction complete upon arrival and placement of wheelchair.

5. Monitoring for continued compliance will be completed through observation and documented through Quality Assurance by Nurses, C.N.A staff, Activity staff, dietary personnel, housekeeping personnel, therapy personnel, maintenance staff and Administration. Revised quality assurance tools will be completed on or before July 9, 2012, weekly x 4 weeks, twice monthly x 3 months, once monthly x 6 months then quarterly, prn. (Exhibit F312-8).

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to begin eating her meal.

F 314 SS=G — 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident 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 information received from the complainant, observation, record review, review of facility policies, and staff interview, the facility failed to provide the necessary treatment and services to aid in the prevention and promote the healing of pressure ulcers for 2 of 4 sampled residents (Resident #4, and #8) with current pressures ulcers. Failure to adequately monitor and assess Resident #8 for pressure ulcers resulted in an avoidable facility aquired pressure ulcer. Failure to provide scheduled incontinence cares, reposition residents, elevate heels off the bed, utilize prophylactic devices such as heel boots, provide dressing changes as ordered by the physician, placed Resident #4 at risk for continued skin breakdown and worsening of existing pressure ulcers.

Findings include:

Review of the facility policy titled "Pressure Ulcer

F-314 Plan of Correction — 07/09/12

In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality of care for the residents, the facility states:

1. Resident #8 was seen by the physician on 2/11/12 regarding the pressure area to the left heel. New orders care and treatment were received and implemented. The weekly pressure ulcer healing record was initiated. Resident #8 was re-evaluated by the physician again on 2/14/12. Resident #4: After further assessment it was determined that Resident #4's heels did not need to be floated as a pressure relieving device, an air bed, was sufficient for pressure relief. On 7/12/12, Dr. Blacksmith wrote an order to discontinue floating Resident #4's heels.

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Policy" occurred on 05/17/12. This undated policy stated, "Knife River Care Center will provide care based on each resident's comprehensive assessment to receive the necessary treatment and services to the extent possible to prevent pressure sores from developing unless pressure sores may be expected and unavoidable due to the resident's clinical condition. . . . Residents having pressure sores will receive necessary treatment and services to promote healing and to prevent infection. Interventions may include daily monitoring, dressing changes, and medical management and interdisciplinary approach to care. The resident's care plan will be reviewed and revised as needed based on assessment and treatment.

Review of the facility policy titled "Intervention for pressure ulcer risk assessment" occurred on 05/17/12. This undated policy stated, ". . . If a resident has a score of [greater than] 8 [a score greater that eight indicates the resident is at a high risk for pressure sores]: Skin cleansing should occur at the time of soiling and at routine intervals . . . Proper positioning, transferring and turning technique, including a turning schedule will be implemented, if appropriate. Prophylactic devices may be implemented, if indicated. Examples include protective dressing and padding. . . . The use of devices that relieve pressure on heels, most commonly by raising heels off the bed should be implemented as indicated. . . . A multivitamin with minerals may be requested from the physician. . . ."

- Review of Resident #8's medical record occurred on May 14-17, 2012. Diagnoses included a left heel unstageable pressure ulcer.

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2. On admission, Knife River Care Center will continue to thoroughly assess each resident. (See exhibit # F314-11) Weekly summaries will continue to be completed; within the weekly summary any skin issues and wound care changes will be addressed.

3. Wound care nurse and Unit Manager will do weekly rounds on those residents who have skin conditions. Physician, Dietary, and Family will be updated on status of skin condition weekly.

4. A Quality Assurance tool has been reviewed and revised. (See exhibit # F314-12.) This quality assurance tool will be completed on or before July 9, 2012. This Quality Assurance tool will be completed monthly x 6 months then quarterly, prn.

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The significant change Minimum Data Set (MDS), dated 03/18/12, identified the resident as having moderately impaired cognition; required extensive assistance for transfers, bed mobility, dressing, toilet use, and personal hygiene; and a 4.0 centimeter (cm) by 6.8 cm unstageable pressure ulcer to her left heel. The prior MDS, dated 12/17/11, identified the resident as cognitively intact; required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene; and at a risk for pressure ulcers but no current ulcers.

Review of Resident #8's interdisciplinary progress notes identified the following:
* 02/03/12 - c/o [complaints of] R leg pain . . ."
* 02/04/12 - "continues to c/o leg pain . . ."
* 02/05/12 - "Medicated for leg pain 0800 [8:00 a.m.] . . ."
* 02/06/12 at 5:30 p.m. - ". . . standing lift out of recliner. States [Resident #8] 'my legs hurt' will monitor."
* 02/11/12 at 6:30 a.m. - "Resident crying out in pain . . . 1445 [2:45 p.m.] . . . crying out in pain when L [left] leg moved noted to L inner knee red swelling warm to touch . . . 1500 [3:00 p.m.] Noted pressure ulcer to L heel . . . 1515 [3:15 p.m.] Resident set to ER . . ."

Review of Resident #8's transfer document to the clinic, dated 02/11/12, stated, "Reason for Appt [appointment]: c/o pain to L leg, noted to L knee redness swelling, warm to touch . . . Also noted pressure area to L heel. Please address . . . Diagnosis: Pressure ulcer L heel [with] mild cellulitis. Dr. Orders: 1. Elevate L foot & [and] reduce pressure to L heel . . ."
A dietary progress note, dated 02/15/12, stated,

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The findings will be reviewed at the Quality Assurance meeting on July 9, 2012.

5. The QA tool will be completed by RN's, LPN's, CMA's, CNA's and Nurse Managers twice monthly for 3 months and then once monthly for 6 months. The results of the QA will be reviewed at the quarterly QA Meetings.

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"Notified of pressure area to L heel. Recommend add MVI [multivitamin] [with] minerals." Review of Resident #8's medical record failed to show the initiation of a MVI with minerals.

Resident #8's "Weekly Pressure Ulcer Healing Record" identified the following:
* (first documentation of the resident's left heel pressure ulcer) -
Date: 02/11/12
Stage: Unstageable
Size: 8 cm [by] 10 cm
Wound bed: black (eschar)
Surrounding skin color: bright red
Pain: moaning/crying
Pain location: "? c/o pain to leg crying out"
* (the most current assessment)
Date: 05/12/12
Stage: Unstageable
Size: 3.9 cm [by] 5 cm
Wound bed: black (eschar)
Surrounding skin color: normal
Pain: no

During an interview on the afternoon of 05/17/12, a licensed nurse (#18) confirmed facility staff first observed Resident #8's left heel pressure ulcer on 02/11/12 when it was identified as an 8.0 cm by 10 cm unstageable pressure ulcer.

Resident #8's heel pressure ulcer progressed to the size of 8.0 cm by 10.0 cm before facility staff identified the unstageable, facility-acquired pressure ulcer. The facility failed to initiate the MVI with minerals as recommended by the dietician. These practices resulted in an avoidable, painful pressure ulcer and may have delayed healing.

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- Review of Resident #4's medical record occurred on May 14-17, 2012. Diagnoses included diabetes, peripheral vascular disease, pain, history of/current lateral malleolus [ankle] pressure ulcer. The quarterly MDS, dated 03/21/12, identified the resident as having severely impaired cognition; requiring extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene; and a Stage 2 pressure ulcer. The "Reviews and Progress Reports", dated 04/01/12, stated, ". . . [Resident #4] currently has pressure ulcer to the outer aspect of his right ankle that was noted on 2/6/12. The skin around the right ankle has a small opening, daily care is provided to the ulcer and it is showing signs of healing in that the area is getting smaller. His heels are floated when in bed to make sure there is not pressure on the ankle bone or heel. . . ."

Resident #4's current care plan stated, "Nursing: . . . I'm at risk for skin breakdown because I have diabetes, decreased sensation in my feet and poor circulation. I currently have a stage II pressure area on the outer right ankle. . . . Please make sure to float my heels when I am in bed to reduce pressure. I have a pressure relieving mattress on my bed and a Roho cushion in my wheelchair. . . ." The "Daily Care Guide" [care guide utilized by direct care staff] failed to address floating the resident's heels and/or his footwear.

A summary of Resident #4's "Weekly Pressure Ulcer Healing Records" identified the following measurements for the right lateral ankle ulcer:
* 02/06/12 - 1.5 cm x 1.1 cm, brown wound bed, bright red surrounding skin color, peripheral

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tissue edema, grimacing
* 05/07/12 - .7 cm x .7 cm x .1 cm/questionable depth, yellow exudate, black/brown-yellow wound bed, pink surrounding skin color

The Physician Orders, dated 04/03/12, stated the following:
* 12/07/11- "Float heels/ankles when in bed."
* 03/27/12 - "Polymen drsg [dressing] to (R) lateral malleollus [sic] wound . . ."

The current "Treatments" record stated the following:
* 07/01/07 - "FLOAT HEELS @ HS - MAKE SURE FEET ARE OFF BED - No pressure to (R) lateral ankle when in bed. [handwritten]."
* 02/07/12 - "FLOAT HEELS/ANKLES WHEN IN BED"
* 02/08/12 - " WEEKLY PRESSURE ULCER HEALING RECORD UPDATE TO (R) LATERAL ANKLE Q [every] MONDAY
* 04/12/12 - POLYMEN DRSG COVERED WITH MEPORE TO (R) LATERAL MALLEOLUS - CHECK DAILY . . ."

Review of Resident #4's interdisciplinary progress notes [nurses notes] and fax alerts [notes to physicians] identified the following:
* 02/06/12 - "Noted 1.5 x 1.1 cm soft brown area to R) lateral ankle. [with] 5-6 cm redness surrounding. Is warm swollen [and] painful to touch. Feet floated on pillows. . . ."
* 02/12/12 - "Res [resident] requires that feet be checked on often due to his rotation of Rt [right] foot To the (R) side causing the bone To press against pillow which is pushed by his feet. . . ."
* 02/17/12 - "Completes coarse of Cephalexin . . . (R) foot floated when in bed lateral malleolus

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protected from pressure. . . ."
* 02/21/12 - ". . . Air mattress in place. (R) foot floated, (L) [left] heel also. . . ."
* 04/12/12 - ". . . air mattress. float feet to keep pressure off"
* 05/08/12 - ". . . Heels [up] on pillows."
* 05/11/12 - "Res now has moon boots for protection of (L) heel . . ."

Observations made at approximately 12:35 p.m. on 05/14/12 showed Resident #4 lying on his back in bed with his heels resting directly on a pillow.

Observation at 4:45 p.m. (approximately four hours later) showed two CNAs (#6 and #28) providing Resident #4's incontinence cares. The CNA (#6) removed the resident's blanket, showing Resident #4's heels resting directly on a pillow. When she removed the pillow from below his feet, Resident #4 grimaced and stated, "Ow! Ouch, Jesus!"

During an interview 05/15/12 at 8:00 a.m., a managerial nursing staff member (#10) stated, "The area to his right ankle is due to rubbing his shoes. [Resident #4] has several shoe options and prefers the pair that rubs."

Observation on 05/15/12 at 1:55 p.m. showed a nursing staff member (#31) changing Resident #4's dressing. The nursing staff member (#31) measured the pressure ulcer on the resident's right ankle, and stated, "It's .4 cm times .4 cm and is 2 mm [millimeters] deep."

Observation on 05/15/12 at 2:25 p.m. and 3:08 p.m., showed Resident #4 lying on his back in

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bed with his heels resting directly on a pillow.

Observation on 05/15/12 at 5:12 p.m. (approximately two hours and 45 minutes later) showed two CNAs (#33 and #34) providing Resident #4's incontinence cares. When the CNA (#34) placed his slippers/shoes on his feet, Resident #4 grimaced and stated, "Ow! My ankle is real sore!"

Observation on 05/16/12 at 1:10 p.m. and 2:05 p.m., showed Resident #4 lying on his back in bed with his heels resting directly on a pillow.

Observation on 05/16/12 at 3:53 p.m. showed an unidentified nursing staff member provided care to Resident #4. She stated, "Oh, there is no dressing on his right ankle."

During an interview 05/16/12 at 4:40 p.m. and 5:00 p.m., when shown the progress note regarding moon boots, a managerial nursing staff member (#10) stated, "There is no orders for moon boots. To my knowledge we put heel protectors on."

Facility staff failed to identify Resident #4's pressure ulcer until it was a 1.5 cm x 1.1 cm soft brown area with a 5-6 cm surrounding reddened area. Observations during survey showed staff failed to float Resident #4's heels/ankles when in bed. In addition, facility staff continued to place a pair of shoes on his feet even though staff were aware that particular pair of shoes caused friction/pressure to his ulcer. These practices may have delayed/prevented the healing of Resident #4's right ankle ulcer.

Plan of Correction F315 — 07/09/12

F 315 483.25(d) NO CATHETER, PREVENT UTI, F 315

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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 information received from the complainant, observation, record review, review of facility protocol, and staff interview, the facility failed to implement or follow a scheduled toileting plan for 3 of 10 sampled residents (Resident #2, #4, and #13) incontinent of bladder and dependent on facility staff to meet toileting needs and provide incontinence cares. Failure to implement and/or follow a scheduled toileting plan placed these residents at increased risk for avoidable bladder incontinence and skin breakdown and has the potential to compromise their dignity.

Findings include:

Review of a facility protocol titled "Admission Nursing Incontinence Protocol" occurred on 05/17/12. This undated protocol stated, ". . . 2. If a resident is incontinent on admission complete the following forms: A. Nursing Admission Incontinence Evaluation B. Physician

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1. The corrective action for residents #2, #4 and #13 is in place. Resident #4's toileting schedule was implemented 5/23/12. Resident #2's toileting schedule was implemented 6/7/12, and resident #13 had a toileting schedule implemented 4/30/12. All toileting schedules are care planned.

2. Residents who are coded on the MDS as frequently incontinent or occasionally incontinent of bowel or bladder will have a Urinary Continence Management Evaluation completed, followed by a 7 day Bowel and Bladder Patterning Worksheet. After assessments are completed the appropriate program will be implemented and care planned. Upon admission each resident will have a Urinary Continence Management Evaluation completed,

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Incontinence Evaluation . . . 3. Initiate 2 [two] Bowel and Bladder Patterning Worksheets . . ."

- Information submitted by a complainant identified concerns regarding facility staff failing to provide toileting cares for residents in a timely manner.

- Review of Resident #2's medical record occurred on May 14-17, 2012. Diagnoses included failure to thrive, dementia, anxiety, and pressure ulcers to his right heel and coccyx.

Resident #2's admission Minimum Data Set (MDS), dated 03/28/12, identified severely impaired cognition, extensive assistance for transfers, personal hygiene, and toilet use, no trial completed for a urinary toileting program, and frequently incontinent of urine.

Resident #2's medical record contained one, not two "Bowel and Bladder Patterning Worksheet," dated March 23-29, 2012. The facility staff thoroughly completed the worksheet for 03/23/12, however, random shifts sporadically completed the worksheets for the remaining six days. Based on this documentation, Resident #2 remained dry 67 percent (%) of the seven day period and remained continent of bowel 100% of the time. The nursing staff failed to complete the admission incontinence evaluation and Resident #2's medical record lacked the physician incontinence evaluation.

Resident #2's current care plan stated, "Nursing: . . . I am frequently incontinent of bladder usually continent of bowel and wear a brief, however, please assist me toileting also. I have multiple

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followed by a 7 day Bowel and Bladder Patterning Worksheet. After assessments are completed the appropriate program will be implemented and care planned.

3. A Urinary Incontinence Management Evaluation (See Exhibit # F315-1) will be completed on each incontinent resident. Information from the evaluation will be used to determine if a resident is a candidate for bladder training program, toileting program or consideration of other treatment modalities. If the resident is a candidate for a toileting program, the 7 Day Bowel and Bladder Patterning Worksheet (See Exhibit # F315-2) will be completed. The appropriate program will then be implemented by the unit manager, and evaluated

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skin issues . . ."

Observation on 05/15/12 showed Resident #2 positioned in his wheelchair from 7:45 a.m. to 1:05 p.m. (five hours and 20 minutes) At 1:05 p.m., a certified nursing assistant (CNA) (#19) utilized a sit to stand lift and assisted Resident #2 into the bathroom. The CNA removed his saturated brief and he voided in the toilet. Observation showed his buttocks were reddened.

Observation on 05/16/12 showed Resident #2 positioned in his wheelchair from 7:55 a.m. to 5:10 p.m. (nine hours and 15 minutes). A (CNA) (#8) stated she assisted the resident out of bed about 7:00 a.m. At 5:10 p.m., a CNA (#12) utilized a sit to stand lift and assisted Resident #2 to the bathroom. The CNA removed his saturated brief and he voided and had a bowel movement in the toilet. Observation showed his buttocks were reddened.

During an interview on 05/16/12 at 5:05 p.m., the nurse manager (#17) stated she would expect facility staff to assist Resident #2 to the toilet at least every three hours.

Failure to adequately assess and implement a scheduled toileting program at times consistent with the residents' determined voiding habits/patterns placed Resident #2 at risk for skin breakdown and at risk for avoidable increased bladder incontinence.

- Review of Resident #4's medical record occurred on May 14-17, 2012. Diagnoses included incontinence of urine/occasional incontinence of bowel. The quarterly MDS, dated

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quarterly with the resident's MDS review by the resident care coordinators. The resident's care plan will alert staff of the type of program in place. Nurses and C.N.A's will be educated regarding Knife River Care Center's Incontinence Management Policy (See Exhibit # F315-3), as well as the plan to review and assess current residents with incontinence.

4. The education in-service will take place at the nurse and C.N.A meeting scheduled July 5th, 2012. The Incontinence Management Policy will be reviewed, as well as the Incontinence Management Evaluation Form and QA materials.

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03/21/12, identified the resident has severely impaired cognitive skills and requires extensive assistance for transfers, dressing, toilet use, and personal hygiene. The "Reviews and Progress Reports," dated 04/01/12, stated, ". . . He is frequently incontinent of urine and was incontinent of bowel once during this review period. He wears a brief for protection. He uses the urinal in bed but also does attempt to use other items such as cups to void in. His alertness varies throughout the day. Staff continue to encourage him to ask for assistance as needed. . . ."

Resident #4's current care plan stated, "Nursing: . . . I am frequently incontinent of bladder and occasionally incontinent of bowel. I wear a brief. I do still prefer to use the urinal but need help at times due to my impaired vision. I have an elevated toilet seat on the toilet in my bathroom. Do not leave me alone in the bathroom. . . ."

Observations made at approximately 12:35 p.m. on 05/14/12 showed Resident #4 lying in bed. Observation at 4:45 p.m. (approximately four hours later) showed two CNAs (#6 and #28) providing Resident #4's incontinence cares. The CNAs lowered the resident's pants, and showed his incontinence brief saturated with urine and soiled. Observation showed the resident was incontinent of bowel and bladder.

Observation on 05/15/12 at 2:25 p.m. and 3:08 p.m., showed Resident #4 lying in bed. Observation at 5:12 p.m. (approximately two hours and 45 minutes later) showed two CNAs (#33 and #34) providing Resident #4's incontinence cares. The CNAs lowered the

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5. A quality assurance study will be completed by RN's, LPN's and Nurse Managers to assure the new policy is being implemented. (See Exhibit 315-4). A separate quality assurance study will be completed by the CMA's and C.N.A trainers to ensure toileting schedules are being followed. (See Exhibit #F315-5). The quality assurance studies will be completed on or before July 9, 2012 and reported at the Quality Assurance meeting on July 9, 2012. Quality assurance studies will continue to be completed twice monthly x 3 months, then once monthly x 6 months, then quarterly, prn. Findings and results will be reported at the regular quarterly Quality Assurance Meetings.

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resident's pants, and showed his incontinence brief saturated with urine and soiled. Observation showed the resident incontinent of bowel and bladder.

During an interview 05/16/12 at 4:40 p.m. and 5:00 p.m., a managerial nursing staff member (#10) stated, "[Resident #4] is a check and change. We usually have them [staff members] check him every two hours."

Failure to adequately assess and implement a scheduled toileting program, consistent with the resident's determined voiding habits/patterns, placed Resident #4 at risk for avoidable increased bladder incontinence.

- Review of Resident #13's medical record occurred on May 16-17, 2012. The resident's significant change MDS, dated 04/24/12, identified severe cognitive impairment, extensive assistance for toilet use, and occasionally incontinent of urine. Resident #13's current care plan identified the facility initiated a toileting schedule on 04/30/12. The schedule identified staff should assist the resident to the toilet at 8:00 a.m., 9:30 a.m., 11:00 a.m., 12:30 p.m., 2:30 p.m., 5:00 p.m., 6:30 p.m., 8:00 p.m., midnight, 4:00 a.m., and 6:00 a.m.

Observation on 05/16/12 at 1:25 p.m. showed Resident #13 lying on his bed with his eyes closed. The resident remained in bed until 5:20 p.m. when the CNA (#12) asked Resident #13 if he needed to use the toilet and he said, "no." The CNA then walked the resident to the dining room. Facility staff failed to offer, encourage, and/or assist Resident #13 to the bathroom at 2:30 p.m.

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F 315	Continued From page 40 and 5:00 p.m. as identified on his toileting schedule.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, review of facility policy, and review of manufacturer's instructions, the facility failed to assess and implement fall prevention measures, assess causative factors following a fall, ensure bed and chair alarms functioned/activated properly, and provide adequate monitoring and supervision for 2 of 7 sampled residents (Resident #10 and #12) who experienced falls and resulted in avoidable falls and injury for Resident #12. The facility failed to ensure safe stand lift transfers for 2 of 5 sampled residents (Resident #4 and #5), failed to correctly use a gait belt during transfers for 2 of 4 sampled residents (Resident #8 and #10), and failed to ensure safe wheelchair transport for 1 of 1 sampled resident (Resident #3) and 1 supplemental resident (Resident #21). Failure to ensure bed and chair alarms function properly; assess the causative factors following a fall; and utilize assistive devices and/or use them correctly may have resulted in avoidable falls, injury and/or	F 323	**F-323 – Plan of Correction** 1. The bed and chair alarms for Resident #12 were assessed and found to be in working order on May 10, 2012 during the monthly alarm system check. Resident #10's phone, call light and bed control cords were removed from the floor on May 17, 2012 by Harvest Lane Unit Manager. Resident #4 and #5 were evaluated and changed to hoyer lift with assist of two staff on May 23, 2012. Resident #3 was evaluated by OT and refused to use wheelchair pedals. Resident #21 was evaluated by OT and has wheelchair pedals for long distances only. The wheelchair pedals are removed at all other times as resident will self transfer and the pedals pose a potential injury. Resident #8's transfers have been re-evaluated and resident is appropriate for assistance of	07/09/12

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pain.

Findings include:

Falls

Review of the facility policy titled "Accident and Fall Prevention Policy" occurred on 05/17/12. This policy, dated May 2010, stated, ". . .Policy Interpretation . . . 3. A witnessed fall or finding someone on the floor as a result of a presumed fall requires an assessment of the circumstances regarding the fall and the resident's condition after the fall. . . . Document in the residents [sic] record, assessment of facts related to a witnessed fall or finding someone on the floor as a result of a presumed fall. . . ."

Review of the facility protocol titled "Falls Protocol" occurred on 05/17/12. This undated protocol stated, ". . . 2. Document: 1] time and describe scene; 2] residents behavior if know [sic] prior to event; 3] objective statements made by resident; 4] head to toe assessment and ROM [range of motion] check; 5] resident injury; 6] pain issues and treatment; 7] first aid given; 8] VS [vital signs], orthostatic BP's [blood pressures]; 9] neuro checks if head injury; 10] call light placement; 11] physician and family notification. . . ."

- Review of Resident #12's medical record occurred May 16-17, 2012 and identified the facility admitted the resident on 01/18/2012. Diagnoses included Parkinson's disease, history of transient ischemic attack/stroke without residual weakness, gait disturbance, mild dementia, confusion, and restlessness.

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one staff and use of standing lift for transfers. Resident #10 is appropriate for transfer assistance of one staff and use of gait belt.

2. All bed and chair alarms in use throughout the facility are assessed for proper working order on a monthly basis or if concerns arise. Resident rooms will be checked for safety and environmental hazards. All resident transfers and mobility devices are evaluated monthly at safe lift committee and quarterly by PT/OT staff with each MDS review.

3. KRCC has developed a fall investigation form that requires documentation to indicate if alarms were activated. (See Exhibit # F323-1). These forms are forwarded to the Risk Manager to be reviewed at the weekly Events Committee Meeting. Nurses and CNA's will be educated on resident safety, accident, hazard identification and proper gait

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Review of Resident #12's interdisciplinary progress notes (IDP) revealed the following:
* 01/19/12, 7:15 a.m. - "Summoned to day room (Elm Grove) found resident on the floor with his walker beside him. Resident c/o [complained of] pain [left] shoulder denies hitting head. [No] other injury noted. Lifted to w/c [wheelchair] [with] hoyer [and] 3 assists. . .[vital signs]. . . very hard to communicate [with] resident, very hard of hearing [with] aids in both ears."
* At 8:20 a.m. - "To [local hospital's name] ER [emergency room] via KRCC [Knife River Care Center] van."
* At 10:30 a.m. - "Informed by [local hospital name] ER nurse resident will be transferred to [another hospital name] . . . Resident has fx [fracture] [left] shoulder."
* 01/23/12 at 3:30 p.m. - "Returned from [hospital's name]. . . ."
* 01/23/12 at 8:00 p.m. - ". . . Cont [continue] to be assisted by 2 when transferring on/off toilet [and] to bed. [Left] shoulder immobolizer [sic] remains secure. . . ."

During an interview on 05/17/12 at 11:35 a.m., an administrative nurse (#10) stated Resident #12 had a bed and chair alarm placed at the time of admission, however, the alarm failed to sound at the time of the fall on 01/19/2012.

On Resident #12's return from the hospital, the facility completed a significant change Minimum Data Set (MDS), dated 01/30/12. The MDS identified moderately impaired cognitive skills; required extensive assistance of two for transfers, bed mobility, toilet use, hygiene, walking in the corridor; required extensive assistance of one for

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belt usage at the Nurse/CNA meeting scheduled for July 5, 2012. Areas of concern are also addressed in the monthly safety meeting. Resident transfers will be evaluated by PT/OT quarterly with MDS review and monthly at safe lift committee meeting.

4. Education on resident safety, accident, hazard identification and proper gait belt demonstration at the Nurse/CNA meeting scheduled for July 5, 2012. Gait belt demonstration is evaluated with each CNA during annual competency evaluations.

5. Quality Assurance tools on bed and chair alarms, resident room safety and gait belt competency have been developed and will be completed by Nurse Managers, RN's LPN's, CMA's, and CNA's by July 9, 2012, twice monthly for three months, and then once monthly for six months. (See Exhibits #F323-2, # F323-3, # F323-4).

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walking in the room and locomotion on and off the unit; frequently incontinent of urine and occasionally incontinent of bowel.

Resident #12 current care plan, dated 04/27/12, stated, ". . . I had a fall just after I moved into KRCC and fractured my humerus [upper arm]. My arm is healed now. I did fall prior to coming to your facility and I continue to be at risk for falls. I do have a bed alarm and chair alarm to alert staff when I get up. If I should fall to the floor, please help me up with a gait belt and 2 staff persons. I am not safe walking so I self propel myself in my wheelchair. I use a wheelchair for most of my mobility. I am able to pivot transfer from bed/wheelchair/toilet. . . . Do not leave me alone in the bathroom. When I am anxious I ask to toilet frequently and will attempt to self transfer and not wait for assistance. . . ."

Further review of Resident #12's IDP identified the following:
* 02/11/12 at 12:00 p.m. - "Fall . . ." A faxed document to Resident #12's physician, dated 02/11/12, stated, "[in the] EG [Elm Grove] bathroom sitting on floor - no evidence of injury." The information failed to identify if the resident's wheelchair alarm sounded.
* 02/14/12, 4:00 p.m. - "Summoned to room res [resident] on floor lying on [left] side. Transferred [with] [two] assist into wc [wheelchair] . . . Arm immobilizer in place. Skin tear [left] lateral upper arm . . . Tegaderm applied denies discomfort did not hit head. . . ."
Following this fall, the facility completed a "Falls Protocol," dated 02/14/12, which stated, "remind res to ask for assist."
* 02/19/12, 8:40 p.m. - "Summoned to public

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Results will be reported at each quarterly QA meeting. The next QA meeting is scheduled for July 9, 2012.

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bathroom Elm Grove Res found lying on his back inside front of door. Res has attempted to self toilet [and] fell. Upon assessment Res is offering c\o [right] Hip pain . . ."
* At 9:10 p.m. - "Ambulance here [and] Res transfer to hospital . . ."
* At 11:00 p.m. - "Rec'd [received] call from [physician's name] that Res x-rays are negative [and] will send Res back to our facility. . . ."
The record failed to identify if Resident #12's chair alarm sounded, or what interventions the facility implemented to prevent further falls. This was the second fall Resident #12 experienced attempting to use a public bathroom. The plan of care did not include any planned approaches/interventions for monitoring/providing Resident #12 toileting assistance at specific times/intervals based on the resident's prior toileting habits/patterns.
* 03/09/12, 4:15 p.m. - "CNA [certified nurse aide] found resident on floor [and] summoned nurse. Laceration to [right] side of head . . . Neuro [neurological checks] good. . . . was reaching for something on bed [and] fell out of w/c . . ." The record failed to identify if an alarm sounded.
* 03/20/12, 7:30 a.m. - "Walked by res room found him lying on floor on his back by the bed he states he slipped off the bed . . . States did not hit head confused difficult to redirect . . . denies discomfort from the fall."
Following this fall, the facility completed a "Falls Protocol," dated 03/20/12, which stated, "bed alarm did not activate."
* 04/11/12, 10:40 p.m. - "Res found on floor in hallway bottom half naked, brief was dry, skin tear noted to [left] elbow . . . Stated he may have bumped head or just slid it on carpet . . . [neurological checks] started . . ."

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* 04/16/12, 7:00 a.m. - "Summoned to room. Resident on the floor denies pain states 'Had I known I was going to fall I would not have gotten up.' Very alert, appropriate responding to questions. Denies injury, denies hitting head. . . ."

Resident #12's medical record identified the following falls when the bed or chair alarm did not sound: 01/19/12, 02/11/12, 02/19/12, 03/09/12, and 03/20/12. The facility's investigations of these falls failed to include any determination of the reason the alarms failed to sound. Failure to adequately investigate the cause/reason the alarms did not sound/work may have resulted in the occurrence of avoidable falls/injuries.
Assisted Transfers/Tripping Hazards

Review of the facility policy/procedure titled "Ambulating a Resident With a Gait Belt" occurred on 05/17/12. This policy, dated 09/09/03, stated, ". . . Procedure: . . . 4. While resident is seated attach gait belt securely around resident's waist. . . . 5. Assist resident to a standing position. Stand in front of the resident. Grasping both side [sic] of the gait belt and help resident on count of 3. . . ."

- Review of Resident #10's medical record occurred on May 14-17, 2012. Diagnoses included a history of falls, compression fractures, right rib fractures (from a fall on 01/12/12), and osteoporosis. The quarterly MDS, dated 04/28/12, identified intact cognition, the need for limited assistance of one staff member for transfers and bed mobility, two falls without an injury, and two falls with an injury since the prior assessment.

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Resident #10's care plan, dated 05/07/12, stated, ". . . A few months ago, I fell and sustained fractured ribs to my right side. I am declining in my ability to help myself so I rely on you to help me. I need help with dressing, personal hygiene, bathing, walking, and locomotion. I pivot transfer with one staff using a gait belt and front-wheeled walker . . . I can still walk with help using my walker, depending how I feel . . . I am at high risk for falls but if I would fall assist me off the floor using a gait belt and two staff. I use a soft-touch call light when I am in my room . . ."

A nurse's note, dated 05/03/12, stated, "nurse summons [sic] to room by CNA. Res [resident] laying on floor on her [right] side by computer desk. CNA saw her walk et [and] stumble et fall. Didn't hit head. Denies any pain . . ."

An additional nurse's note, dated 05/04/12, stated, "Bruises noted to bilat [bilateral] knees . . . Res states she got tangled up in cords in her room and that is what caused her to fall . . ."

Observation throughout the survey showed cords from the resident's phone, call light, and bed control coiled on the floor by the head of the bed. Occasionally Resident #10's phone sat on a small table by her recliner. When this occurred, her phone cord stretched from the wall by her bed to the table. During an observation of cares on 05/16/12 at 8:35 a.m., Resident #10's walker caught on the looped cords on the floor as the resident stood up from her bed to finish dressing.

During an interview on 05/16/12 at 5:00 p.m., Resident #10 stated she fell twice from the excess cords by her bed, the most recent fall

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occurring on 05/03/12. (She was unsure when the first fall occurred.) The resident stated she told staff about the tripping hazard, but they never addressed her concerns.

During an interview on 05/17/12 at 10:30 a.m., an administrative nurse (#17) verified staff failed to assess the cords in Resident #10's room after the fall on 05/03/12 when the resident reported getting "tangled up" in the cords.

Observation on 05/15/12 at 5:25 p.m. showed a CNA (#25) assisting Resident #10 to stand from her recliner. During the observation, the CNA (#25) pulled up on the resident's right arm to assist her to a standing position. After Resident #10 stood, the CNA (#25) applied a gait belt around the resident's waist, and assisted her to ambulate to the dining room using her walker. The CNA (#25) failed to apply the gait belt prior to assisting Resident #10 to stand and instead pulled on the resident's arm to assist her to stand.

Failure to properly use a gait belt and failure to assess Resident #10's room for tripping hazards may result in additional falls and harm to Resident #10.

- Review of Resident #8's medical record occurred on May 14-17, 2012. Medical diagnoses included a history of falls, convulsions, fatigue, and osteoarthritis. The resident's current MDS, dated 03/18/12, identified moderately impaired cognition and the need for extensive assistance for transfers, locomotion, and toilet use.

Resident #8's current care plan stated, "Nursing: . . . I woke up one morning unable to walk,

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transfer, or stand. I was using a wheelchair for mobility. Some days I need the standing lift for transfers; . . ."

Observation on 05/15/12 at 12:20 p.m. showed Resident #8 seated in the recliner in her room. A CNA (#8) applied a gait belt around the resident's waist. The CNA assisted the resident to an upright position by placing her left hand under Resident #8's left axilla and pulling upward and placing her right hand under the resident's buttocks and pushing upward. The CNA (#8) failed to properly utilize the gait belt.

Stand Lift Transfers

Review of the facility policy titled "Transferring Using a Mechanical Full Body Lift or Standing Lift" occurred on 05/17/12. This undated policy stated, ". . . Standing Lift 1. Can be used if the resident can bear some weight on their feet and can follow instruction on how to hold the handles. . . ."

Review of the Sara 3000 (a mechanical sit-to-stand lift) Standing Sling operating instructions occurred on 05/17/12. The instructions stated, ". . . Patients who can only hold on with one hand, i.e. those who have suffered a 'stroke' may still be lifted with the Sara 3000, but their disabled arm should be held down in front of the body during the lift by the attendant (or a second attendant), while their functioning hand holds the patient support arm in the normal way. . . ."

- Review of Resident #4's medical record occurred on May 14-17, 2012. The quarterly MDS, dated 03/21/12, identified severely impaired

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cognition and the need for extensive assistance for transfers and locomotion on/off the unit. The "Reviews and Progress Reports," dated 04/01/12, stated, ". . . [Resident #4] has a difficult time walking and no longer walks, he will stand to pivot transfer from surface to surface or a standing lift is used for safe transfers. . . ."

Resident #4's current care plan stated, "Nursing: . . . I have very impaired vision and decrease in physical strength. . . . I transfer with assist of one and a gait belt at times, other times I need the standing lift for transfers. I still try to transfer myself and have a clip alarm on my chair to alert staff when I try. I had a fractured left hip in the past. . . . I am at risk for falls."

Observation on 05/14/12 at 4:45 p.m. showed two CNAs (#6 and #28) transferring Resident #4 into his wheelchair utilizing a stand lift. The CNA's cued and/or assisted the resident to hold onto the patient support arms on the lift. Resident #4 repetitively let go of one or both of the support arms as staff lowered the lift and reached for the armrests on his wheelchair. Staff failed to ensure the resident followed instructions to hold the support arms.

Observation on 05/15/12 at 8:22 a.m. showed a CNA (#30) preparing to transfer Resident #4 into his wheelchair utilizing a stand lift. The CNA (#30) cued/assisted the resident into a sitting position, and attached the sling to the lift on the resident's right side. Resident #4 was fatigued and repetitively attempted to lie back down on the bed. The CNA (#30) then braced herself behind the right side of the lift, grabbed the resident's left hand, pulled him into a sitting position, and

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attached the sling to the lift on his left side. Staff failed to request assistance when transferring the resident, instead pulling him into a sitting position.

Observation on the morning of 05/15/12 showed a CNA (#35) transferring Resident #4 into the bathroom utilizing a stand lift. The CNA cued and/or assisted the resident to hold onto the patient support arms on the lift. Resident #4 let go of both support arms prior to the CNA (#35) lowering him onto the toilet, and attempted to lower his pants without assistance as the CNA (#35) gloved her hands. Staff failed to ensure the resident followed instructions to hold the support arms.

Observation on 05/15/12 at 5:12 p.m. showed a CNA (#33) preparing to transfer Resident #4 into his wheelchair utilizing a stand lift. The CNA (#30) cued/assisted the resident into a sitting position, and attached the sling to the lift. Resident #4 was fatigued and repetitively attempted to lie back down on the bed, letting go of one or both of the support arms and pushing the lift away with his feet as he did so. After making several attempts to prepare the resident for transfer, the CNA (#33) requested assistance from the managerial nursing staff member (#10) observing cares. The managerial nursing staff member (#10) then exited the room, to obtain additional staff to assist with the transfer. Staff failed to ensure the resident followed instructions to hold the support arms and place his feet on the foot support.

The facility continued to use the stand lift to transfer Resident #4, often with one staff member present, even though the resident had severely impaired cognition and decreased physical

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strength. Observation showed the resident was unable to follow instructions consistently and required a two person assist to transfer safely.

- Review of Resident #5's medical record occurred on May 14-17, 2012. Diagnoses included cerebrovascular accident (stroke), left hemiplegia (paralysis), severe arthritis in both shoulders (especially on the right side), and seizures. The annual MDS, dated 04/28/12, identified moderately impaired cognition and the need for total assistance for transfers and locomotion on/off the unit.

Resident #5's current care plan stated, "Nursing: . . . I had a stroke which caused my left side to be paralyzed . . . it is very difficult for me to bear weight so I am transferred in and out of bed with a Hoyer lift and two staff assisting. I use the standing lift and two staff to assist me to the bathroom for toileting. . . . I have difficulty staying on task . . . Please cue me and direct me to stay on task. . . . I am at risk for falls . . ."

Observation on 05/15/12 at 3:57 p.m. showed two CNAs (#33 and #34) preparing to transfer Resident #5 into the bathroom utilizing a stand lift. The CNAs (#33 and #34) cued/assisted the resident into a sitting position, and attached the sling to the lift. The CNA (#34) then cued and/or assisted the resident to hold onto the patient support arm on the right side of the lift, and placed the resident's left hand (already in a contracted position) around the support arm on the left. Resident #5's left arm fell to his side and swung back and forth as they neared the toilet. Following cares, the CNAs (#33 and #34) transferred the resident from the bathroom back

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to his wheelchair. Observation showed the resident's knees bent at an approximate 80-90 degree angle, and the sling pushed up into his axilla, causing his shoulders to shrug upward. Following the transfer, the CNAs (#33 and #34) asked Resident #5 (identified by the facility as interviewable) if he was comfortable in his wheelchair, and he replied, "A lot more than in the standing lift." Staff failed to ensure the resident's disabled arm was held down in front of his body and failed to ensure he was able to bear weight during the lift.

The facility continued to use the stand lift to transfer Resident #5, dispite his difficulty staying on task, left hemiplegia, severe arthritis in both shoulders, and difficulty bearing weight. In addition, staff failed to assist the resident with his paralyzed arm during transfer with the stand lift.

Wheelchair Transport

- Review of Resident #3's medical record occurred on May 14-17, 2012. Diagnoses included osteoporosis, bone and cartilage disease, dystonia/involuntary movements, and history of falls. The annual MDS, dated 03/02/12, identified moderately impaired cognition and the need for extensive assistance for locomotion on the unit.

Observation on 05/14/12 at approximately 4:15 p.m. showed an activity staff member (#37) transporting Resident #3 down the hallway to her room via wheelchair. The heels of Resident #3's shoes slid along the surface of the floor.

- Review of Resident #21's medical record

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F 323	Continued From page 53 occurred on May 16-17, 2012. Diagnoses included depression, anxiety, and history of pathological fracture. The annual MDS, dated 04/27/12, identified severely impaired cognition and the need for extensive assistance for locomotion on the unit. Observation on 05/14/12 at approximately 12:30 p.m. showed an activity staff member (#36) transporting Resident #21 down the hallway to her room via wheelchair. Initially the toe of the resident's left shoe slid along the surface of the floor. Half way down the hallway, the resident shifted her position and both of the her heels slid along the surface of the floor. The staff members failed to place the residents' foot pedals on their wheelchairs, cue the residents to lift their feet/shoes, and ensure the residents' feet/shoes cleared the floor during transport to avoid catching the residents' feet on the floor and causing pain and/or injury.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	**F 325 Plan of Correction** In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality care for the residents, the facility states: 1. Resident #1 is now being read his menu choices even if he has already made his choices. This helps to ensure he understands his menu choices and provides the opportunity for staff to	07/09/12

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This REQUIREMENT is not met as evidenced by:

Based on observation, review of facility policy/procedure, record review, and staff interview, the facility failed to encourage meal intake and provide nutritional supplements for 1 of 6 sampled residents (Resident #1) with weight loss. Failure to offer supplements and encourage meal intake may have contributed to Resident #1's weight loss.

Findings include:

Review of the facility procedure titled "Nutritional Supplements" occurred on 05/17/12. This procedure, dated June 2009, stated, ". . .
Nutritional Supplements shall include the following:
Commercial products used to promote weight gain or promote improved nutrition such as: . . .
Supplement ice creams . . .
Purpose and Objectives
A. To promote weight gain or improve nutritional status of residents who are underweight or who have inadequate nutritional intake . . .
Procedure . . .
2. . . . Acceptance of supplements shall be reviewed on a regular basis and each plan revised as needed to provide for good acceptance.
3. The supplement shall be offered . . . and charted . . . on the dietary meal charts when served with meals . . ."

- Observation of the supper meal on 05/14/12, and the lunch meals on 05/15/12 and 05/17/12, showed Resident #1 received his meal 20-40 minutes past the scheduled serving time. (Refer

F 325

encourage resident to try other food items.

2. All residents who make or have made minimal selections at meal time will be read their menus so choices are clear and more encouragement can be given.

KRCC will continue to offer, encourage residents to eat and monitor resident meal, snack and supplement intakes. Resident choices will continue to be honored.

Residents who trigger significant weight loss will receive complete QA monitoring (See exhibit F325-7).

3. Intakes record will continue to provide information for LRD to assess. Dietary/Nursing to provide supplements as indicated.

Supplements/Offering and Encouraging education was provided at General Staff meeting (see exhibit F325-2) on 06/27/12. Education will be provided to all new staff at the time of facility orientation (See

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to F166). Resident #1 exhibited agitation and would leave the dining room and come back until staff served him his meal.

Review of Resident #1's medical record occurred on May 14-17, 2012. Diagnoses included Alzheimer's dementia, depression, and anxiety. The annual Minimum Data Set (MDS), dated 12/31/11, identified the resident weighed 142 pounds (lbs). The quarterly MDS, dated 03/31/12, identified the resident experienced a seven pound weight loss and weighed 135 lbs. Both MDSs showed the resident ate independently with setup help only.

The care plan, dated 04/05/12, stated, "I receive a regular diet. My appetite is fair. I have lost weight. I don't care too much for milk but like hot chocolate at all of my meals. I eat the same thing for breakfast every morning and a little less at lunch and supper. I get supplements every day to help me maintain my weight. I am able to feed myself but if I need help a feeding assistant can help me. Please offer me snacks and fluids throughout the day as I am forgetful. I will request only bread with butter and jelly at most meals. I like lettuce salads and bacon. I sometimes get upset if I have foods offered to me that I have not requested. Please encourage me to eat - especially meat/protein as I will allow. I may accept summer sausage and cheese at times . . ."

Review of a dietary progress note, dated 05/14/12, stated, "Wt. [weight] 126.6 # [pounds] (5/13/12); 129.8 # (05/06/12); 132.4 # (04/15/12); 143.5 # (02/11/12); 144 # (11/26/11). Wt. [down] [approximately] 17 # in 6 mo. [months] ([down]

F 325

exhibit F325-), and departmental orientation (see exhibit F325-). Dietary will offer an In-Service at least once a year on the same.

4. The Quality Assurance Director or designee will be responsible to monitor for compliance with use of the F325 Nutrition Audit and by use of the Unintended Weight Loss Investigative Protocol (see exhibit F325-6).

5. QA tool (see exhibit F325-7) will be completed July 9, 2012. This QA tool will be completed twice monthly for three months, then once monthly for six months, then quarterly thereafter, or as necessary. Results will be reported to at the next Quarterly Quality Assurance Meeting on July 9, 2012.

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11.8 % in 6 mo.) [and] [down] [approximately] 5 # in 1 mo. ([down] 3.7% in 1 mo.). Meal intakes (avg) [average] - B [breakfast] - 65-70%, L [lunch] - 35-40%, S [supper] - 75-80%. Is offered 4 oz [ounces] Enlive [every day] [with] [approximately] 75% acceptance; 4 oz JC [juice] suppl [supplement] [every day]; 4 oz ice cream supplement tid [three times a day] [with] [approximately] 70-75% acceptance. LRD [licensed registered dietician] visited [with] resident. He reports that he gets enough to eat [and] drink [and] he can't eat or drink anymore than he does. He reports the food is good. He gets the foods he wants. No problems [with] chewing or swallowing. LRD informed him of wt [loss] [and] he shook his head 'no' [and] said 'no.' - 'I don't think so.' LRD encouraged him to eat [and] drink as much as he can. He shook his [sic] 'yes' to trying to eat [and] drink as much as he can. LRD sent fax to physician re: [regarding] wt [loss]. Resident did have adjustments to Remeron . . . Regular diet. Will continue [with] current supplements. Will try afternoon [and] morning snack [in addition to other supplements] . . ."

Resident #1's current menu card stated, "Note: Set up help. Encourage intake. May accept summer sausage/cheese as substitute at times . . ." Review of the menu cards and snack logs identified Resident #1 received ice cream at lunch, supper, and before bed.

Observations of Resident #1 from May 14-17, 2012 showed the following:
*Supper on 05/14/12 - a CNA (#29) instructed another staff member to make the resident two pieces of toast. The resident ate one-half piece of

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toast and drank all of his supplement and hot chocolate. Staff failed to offer/encourage the resident to try the chicken drummies or chef salad being served to the other residents and failed to offer the resident ice cream.
*Lunch on 05/15/12 - A staff member (#32) brought Resident #1 a cheeseburger, fries, ice cream, and a cream puff. The resident consumed 80% of his ice cream, a few fries, one-half of his hamburger patty, the filling in the cream puff, and drank all of his hot chocolate and 80% of his juice. The staff member (#32) stated when Resident #1 first sat down he requested a piece of bread, but after a little encouragement, agreed to try the meal being served. The resident responded well to staff encouragement.
*Supper on 05/15/12 - the resident consumed all of his peaches, cottage cheese, and hot chocolate, and drank one-fourth of his supplement. Staff failed to encourage the resident to finish his supplement and failed to offer him ice cream.
During an interview on 05/17/12 at 5:15 p.m., an administrative nurse (#17) stated she spoke with a staff member working over the supper meal on May 14-15. The staff member stated she gave the resident his ice cream on the 14th and offered it to the him on the 15th, which he refused. Discrepancies exist between staff interview and surveyor observations.
*Lunch on 05/16/12 - staff encouraged the resident to try a hot dog, ice cream, and a piece of apple pie before offering him toast. Resident #1 agreed and ate one-fourth of the hot dog, one-half of the ice cream, and a few bites of the pie. Observation showed the resident responded well to staff encouragement.

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F 325	Continued From page 58 Observation during all days of survey showed staff failed to offer Resident #1 summer sausage and cheese identified in his care plan and on his menu card. During an interview on 05/17/12 at 1:45 p.m., a dietary staff member (#2) stated she expected staff to encourage Resident #1 to eat the meal being served first before preparing his toast. She verified staff should offer/encourage the resident to drink his supplements and eat his ice cream. The facility failed to consistently offer Resident #1 encouragement to eat his meals and drink his supplements; failed to offer his ice cream three times daily as identified by the LRD; failed to serve the resident his meals in a timely manner; failed to consistently attempt to serve the resident meals from the menu before offering toast; and failed to offer the resident summer sausage and cheese identified on his care plan and menu card. These failures may have contributed to Resident #1's weight loss.	F 325		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353	**F-353 Plan of Correction** 1. Knife River Care Center will continue to recruit employees through newspaper advertising, offering of sign-on bonuses and through referrals to meet our staffing needs.	07/09/12

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Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on information received from the complainant, observation, record review, review of resident council (RC) and food committee (FC) minutes, resident interview, family interview, group interview, and staff interview, the facility failed to ensure availability of qualified nursing staff on a daily basis to meet the needs of residents for 2 of 3 resident neighborhoods (Harvest Lane and Shady Lane). Failure to ensure availability of staff may have contributed to concerns regarding call light and meal service (Refer to F166); avoidable pressure ulcers (Refer to F314); incontinence (Refer to F315); and falls/fractures (Refer to F323).

Findings include:

The Centers for Medicare and Medicaid Services has defined "staff" as "licensed nurses (RNs and/or LPNs/LVNs), and nurse aides."

Information submitted by a complainant indicated the facility is short staffed on the evening and weekend shifts, and staff are not providing cares in a timely manner.

F 353

2. If Knife River Care Center is unable to recruit new staff to maintain the current scheduling needs, a decision may need to be made to decrease the number of residents residing in this facility.

3. Dietary services are adding two positions to assist in meal service; Nursing is currently interviewing staff and offering a Certified Nurse Assistant course in July, 2012. We plan to continue collaboration with our Dakota Nurse Program partnership in the hope that those students will take advantage of the Loan repayment program offered by Knife River Care Center. We will also utilize staffing services as a stopgap until these goals are reached.

4. A quality assurance tool has been developed on resident satisfaction with staffing. This Quality assurance tool will be completed on or before July 9, 2012 by Nurses, C.N.A staff,

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During the initial tour, on the evening of 05/13/12, observation revealed the following:
* Resident F identified new staff and/or traveling staff often work on the same unit (without other staff who are more familiar with the facility and the residents) and seemed to lack adequate training.
* Resident H (identified by the facility as interviewable) sitting in his wheelchair looking out his window. When asked if he felt he received assistance from staff when needed, Resident H stated, "They sometimes work short." He further stated he has had to "wait up to 30-60 minutes" for staff to answer his call light.

Review of the RC and FC minutes revealed resident grievances' concerning staffing as follows:
* RC February 2012: ". . . A concern was addressed by a resident on all of the agency staff working in the building, it was also stated the care is not as good and another resident proceeded to agree. . . ."
* RC March 2012: ". . . A resident is wondering who or where you file the complaints. Her bed is not being made so she makes her bed once she returns from breakfast. A concern was brought up about how the CNA's are being treated. They are expected to work, work, work. Some don't even take a break. . . ."
* FC April 2012: ". . . Residents feel there are no staff in the Cottonwood dining room at supper."
* FC Mary 2012: "The residents said they would like better service in the dining rooms and want the CNA [certified nurse aide] not to rush and then be gone. [Staff member's name] explained that the dietary department is working on trying to

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Activity staff, dietary personnel, housekeeping personnel, therapy personnel, maintenance staff and Administration. (Exhibit F353-4). In addition, the quality assurance tool will be completed monthly x 6 months and quarterly, prn thereafter.

5. Quality Assurance Findings will be reported at the quarterly Quality Assurance meeting in August, 2012 and quarterly thereafter, prn.

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have 2 dietary servers in the neighborhood dining rooms for all meals. . . . Residents mentioned that they feel staff is too busy to read the "fine print" about what they want and need from the menus. . . ."

Statements made by residents during the group interview on 05/14/12 at 4:00 p.m., included they don't always get fresh water related to staff shortage.

Confidential resident and family interviews identified the following:
* Resident C's family member stated, "I think they [the facility] need more staff." This family member stated Resident C has had several falls since admission to the facility. The resident's bed and chair alarm work as they should but facility staff don't always come promptly when the alarms sound. The family member stated Resident C's chair alarm sounded for 15 minutes before facility staff answered it and found Resident C in another resident's room.
* Resident B's family stated the facility is short on CNAs and nurses, stating "They run their legs off." This family member identified her mother frequently has dry matter around her eyes, dry skin on her face and repeatedly requests staff to wash her mother's face and apply facial cream. The family member stated "If I ask them they will do it. But it seems I have to be on them to get these things done."
* Resident D's family member stated there have been several occasions when she or another family member have initiated the call light in Resident D's room and have waited 15 minutes or more for a staff member to come to the room. This family member stated on 01/05/12, she

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initiated Resident D's call light twice for staff assistance. They were told the call light system must not be working. Resident D's family member identified several days in March and April 2012 when facility staff failed to answer the call light and the family member assisted the resident to the bathroom.

* Resident E identified the facility often placed new staff and/or traveling staff on the same unit (without staff who are more familiar with the facility and the residents) and they "don't know what they are doing." Resident E stated the afternoon shift often failed to offer him water in the afternoons and identified staff failed to routinely re-stock the supplies in the resident's room, resulting in a lack of wipes, briefs, etc. Last evening (05/15/12) the resident identified he asked a staff member to reposition him in bed. The CNA told the resident she would go and find someone to assist her, but never returned. Resident E waited for another staff member to assist him which occurred approximately one to two hours later.

* Resident F and her family member both identified the facility needed more staff and stated staff take a long time to answer call lights during the evening and night shifts. At times, Resident F stated she searched for staff herself at night and it took a long time before she finally found assistance.

During confidential staff interviews during the week of survey:

* A staff member (A) stated, "In the evenings, we are very short staffed. It can be overwhelming. One person for 15-16 residents. We can't be everywhere."

* A staff member (B) stated, "There's not enough

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F 353	Continued From page 63 staff. That's an understatement. Lights are on for a long time. We have had more falls, because they're waiting. They [the residents] don't wanna be incontinent so they try to do it themselves. Room trays are delivered late too. If called in at 5:30 p.m., trays don't go out until 6:00 p.m." * A staff member (C) stated, "I think they could use more staff here and there. I think they are short a lot of times. When asked if residents have had to wait for assistance, she stated, "I'm sure they have, not for an unreasonable amount of time. They may be sitting there a half an hour." * When asked if the facility maintains enough staff to meet resident needs, a staff member (D) stated, "It depends on the staff. There are more travelers on in the evening. Some residents have behaviors or falls. We may have to run baths at night. It just depends." * When asked if the facility maintains enough staff to meet resident needs, a staff member (E) stated, "It depends on the staff, if they are new or agency staff it's harder to get things done." During an interview on 05/17/12 at 2:35 p.m. with administrative staff members (#10, #11, #17, #18, #25, and #26), the staff member (#25) stated the facility utilizes several travel agency nursing staff. Failure to ensure residents residing at the facility received quality care in accordance with their needs and failure to ensure sufficient staffing and supervision of this care resulted in resident, family, and staff concerns regarding the care and services provided to the residents who reside in the facility.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	**F 364 Plan of Correction** In the spirit of cooperation and consistent with Knife River Care	07/09/12

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Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, sampled test trays, resident interview, resident comments at meals, review of resident Food Committee minutes, and staff interview, the facility failed to provide palatable and flavorful food for 4 of 7 residents who attended the group interview (Resident #37, #40, #41, and #42); 5 of 14 sampled residents (Resident #5, #6, #7, #9, and #10) and 10 supplemental residents (Resident E, F, G, #23, #24, #34, #35 #36, #38, and #39). This resulted in residents' refusal and distaste for meals served and may cause weight loss, poor nutrition, and affect the overall well-being of all residents.

Findings include:

Interviews during the initial tour on the evening of 05/13/12 identified the following:
* Resident E verbalized the food tasted "terrible" and identified he/she expressed concerns to staff but nothing ever changed.
* Resident F stated the food over-all tasted "bad," cold, and staff overcooked the vegetables.
* Resident G identified the food tasted "bad" and stated the knoephla soup "tastes like rubber." The resident stated he/she verbalized complaints to staff but nothing ever changed.

- During an interview on 05/15/12 at 8:25 a.m.,

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Center's historical and current commitment to quality care for the residents, the facility states:

1. Resident # 9 is able to voice her concerns and is able to ask for substitutions or let someone know her banana was too ripe so that she can be provided another. Resident #9 has her breakfast meal in her room everyday and has a banana everyday for breakfast. Dietary Manager and LRD have had conversation with her and have encouraged her to let staff know when her bananas are too ripe so she can be given another one.

   Residents #5, #10, #23, #34, #37, #38, #40, #41, #42 onion rings and chicken nuggets were both determined to be non-palliative. Chicken nuggets have been removed from the menu and the onion rings have been replaced with a new brand and type.

2. KRCC Dietary Manager will be monitoring the quality of food products more closely so that poor quality food is not given to KRCC residents.

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Resident #9 stated she ate a banana for breakfast every morning. The resident complained the banana she received that morning was "mush." Observation showed the banana was dark and over-ripened.

Review of the food committee minutes identified resident concerns regarding the food served at the facility. The minutes stated the following:
* January 2012: ". . . at times the vegetables leave a lot to be desired because of how they are cooked . . . no chicken in the chicken and dumplings . . ."
* April 2012: ". . . Dinner today was dry, it was like cardboard, ribs in sauerkraut, . . . Why were we short on meal portions last evening when we ordered the day before? . . . Supper on 4-2-12: ran out of both options for the residents. [Staff member's name] discussed this was an error on the cooks end with the count and she had visited with this cook. An apology was given to the residents and the cooks will try hard so this doesn't happen again. . . ."
* May 2012: ". . . Knoephla continues to be a concern. They want knoephla and not spaetzel in their soups and dishes made with knoephla. . . . Residents stated that the meatloaf is sometimes dry and that they would like some kind of sauce on top. . . ."

The menu for the supper meal on 05/14/12, identified the following foods to be served: "Honey Br [Breaded] Chicken Drummie & [and] Onion Rings or Chef Salad & Assorted Crackers, Tangy Coleslaw, Wheat Bread/Marg [with margarine] or White Bread/Marg, Apricot Halves, Milk 2%." Observation showed chicken nuggets served, not chicken drummies.

F 364

We work hard to provide good food to our residents, but our cooks here are human and do make mistakes. Action was taken to offer alternatives and because our resident menus allow them two choices of the meat/entrée/vegetable and starch, there is always another option for them them. In addition to giving them that second choice, we always have soup an sandwiches available to them.

3. A revised communication form with dietary has been implemented for resident meal concerns (see exhibit#364-4) A new Food Committee Meeting Form for documenting the Food Meetings has been devised and used and seems to be lending the opportunity to document more appropriately (see exhibit#364-5). Palliative Food Education has been added to new employee orientation as of 05/25/12 and has 05/23/12 a new Policy, Quality Food and Service/Preparation/Serving/Reporting Concerns" (exhibit #F364-6) was put into place. In addition, a standard dietary

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- On 05/14/12 at 5:45 p.m., observation showed Resident #5 sitting in the Shady Lane dining room and an unidentified CNA, who assisted the resident, had difficulty cutting the onion rings into bite sized pieces. Following the meal, when asked if he had enjoyed it, Resident #5 (identified by the facility as interviewable) stated, "The coffee was the best part of my meal."

- Observation during the evening meal on 05/14/12 in the Harvest Lane dining room identified the following:
* Resident #24 stated the chicken nuggets and onion rings tasted "awful" and pushed them away without eating. A staff member offered Resident #24 a piece of toast with jelly which she accepted.
* Resident #10 stated the chicken nuggets tasted "bad" and described the onion rings as soggy and limp. The resident ate two small pieces of chicken and a few bites of the onion rings.
* Resident #23 stated the onion rings tasted "so soggy and greasy" and did not eat them.
* Resident #34 stated, "What are these anyway," as she pointed to the chicken nuggets. She stated they were tough and hard to chew.
* Observation showed Resident #35's chicken nuggets untouched. Resident #36 stated, "Can't eat it," referring to the nuggets. Resident #37, #38, and #39 dropped their nuggets on their plates in unison and Resident #38 stated, "They're as hard as rocks."

At 6:00 p.m., a Harvest Lane dietary staff member (#27) provided a test tray which contained chicken nuggets and onion rings. The

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communication can be filled out and forwarded for any food related concerns (see exhibit#F364-7). Education given at all staff 06/27/12 regarding "Palliative Foods, Offering Supplements and Food items (see exhibit #F364-8"). Dietary Manager to assure Dietary Training Checklist is utilized (see exhibit#F364-9").

Dietary Manager to provide periodic and ongoing education to dietary staff regarding the quality of food. Annual Dietary In-service on Food Safety and Cooking and Holding of Foods and Temperatures (see exhibit#F364-10) will be provided.

Palliative Food Education has been added to new employee orientation as of 05/25/12 and has already been utilized.

The chicken nuggets have been removed from the menu. A different brand of onion ring that the residents like and the ribs mentioned in survey had already been replaced (see exhibit#4F364-2).

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nuggets tasted cool, dry, and hard to chew and the onion rings tasted cool and soggy.

- Observation, on 05/14/12 at 5:25 p.m., in the Whispering Wind dining room showed the following:
* Resident #6 began to leave the dining room table and a nurse (#14) intervened and persuaded the resident to sit. Observation showed the resident had not eaten any of the chicken nuggets. The nurse cut one of the nuggets into pieces and encouraged Resident #6 to eat. The resident ate two bites of the cut nugget.
* A CNA (#15) assisted Resident #7 with her meal. The CNA assisted the resident from the dining room at the end of the meal and observation showed the resident's chicken nuggets untouched.
* A random observation showed a resident attempted to take a bite of a chicken nugget but failed and placed it back on her plate.

- Observation on 05/15/12 at 11:43 a.m. in the Whispering Wind dining room showed the following:
* A random observation showed a resident attempting to bite a cooked baby carrot. The resident held the carrot with her fingers but could not bite through the carrot.
* Comments heard from random residents concerning the carrots included, "rubbery" and "They are not good very often."
* A sample of the carrots from the steam table were cool to touch, hard to bite, and stringy.

- On the afternoon of 05/16/12 and the morning of 05/17/12, when asked about the chicken served

F 364

Dietary Manager will monitor food temperatures and quality more closely and document doing so (see exhibit#F364-11 he deficiency cited in F-tag 364 included concerns that were corrected or addressed immediately by the offering of a choice menu, by offering alternate items outside of the menu and by counseling and coaching staff.

Dietary Manager has acted in good faith and taken great effort to implement corrections and develop tools to help identify potential under this tag.

4. The Quality Assurance Director or designee will be responsible to monitor for compliance with Food Temperatures (see exhibit #F364-12).

5. This QA tool will be completed weekly for four weeks, twice monthly for three months, once monthly for six months and quarterly thereafter. QA results will be reviewed at the quarterly QA meetings.

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for the supper meal on 05/14/12, residents identified the following:
* Resident #37 stated, "Hard as rocks. They clunked on the plate when you dropped them."
* Resident #40 stated, "Hard as rocks."
* Resident #41 stated, "They weren't chicken nuggets."
* Resident #42 stated, "That was no chicken drummie. They were not eatable, could not bite it or chew it."

During an interview on 05/16/12 at 5:15 p.m., a dietary administrative staff member (#2) stated the facility substituted chicken nuggets for the chicken drummies for the supper meal on 05/14/12, and staff assisting the residents to order their meals were to share this information with the residents. This staff member (#2) stated the cook on 05/14/12 burned the chicken nuggets and knew the residents did not like them.

F 365 SS=D 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS

Each resident receives and the facility provides food prepared in a form designed to meet individual needs.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy/procedure, record review, and resident, family, and staff interview, the facility failed to provide the appropriate food to meet the individual dietary needs for 1 of 1 sampled resident (Resident #9) on a physician-prescribed gluten-free diet. Failure to consistently offer and provide gluten-free foods to Resident #9 may

F 365

F 365 Plan of Correction 07/09/12

In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality care for the residents, the facility states:

1. There were no negative outcomes. Resident was out on therapeutic leave from 05/20/12 through 05/29/12. LRD has been expanding the gluten free diet (see exhibit F365-4). LRD and Dietary

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result in weight loss, pain, discomfort, and exacerbation of the resident's Celiac disease.

Findings include:

Review of the facility policy titled "Therapeutic Diets" occurred on 05/17/12. This policy, dated June 2009, stated, ". . . Policy Interpretation and Implementation:
1. The resident's attending physician must prescribe therapeutic diets.
2. Prescribed therapeutic diets are reviewed regularly along with other orders.
3. Routine therapeutic diets are noted on the master menu and reviewed by the dietary manager and approved by the dietician; however, the dietician plans unusual or complex therapeutic diets in writing.
4. A menu card using the Dietmaster Menu program is provided for each resident to ensure that each resident receives his or her diet as ordered.
5. The dietician and dietary manager record in the resident's medical record significant information relating to the resident's response to his/her therapeutic diet."

- During the initial tour on the evening of 05/13/12, Resident #9 identified staff at times failed to provide gluten-free foods according to her diet. The resident stated she gets "terribly sick" when she eats too much gluten.

Review of Resident #9's medical record occurred on May 14-17, 2012. Diagnoses included irritable bowel syndrome and Celiac disease. The admission Minimum Data Set (MDS), dated 02/21/12, identified the resident received a

F 365

Manager have been writing in gluten free food items on the resident's menu.

Resident #9 is receiving a menu that provides her with Gluten Free food choices only. Resident will continue to be allowed to make her own food choices. If resident chooses to write on her menu a food item that is no gluten free or asks to have a non gluten free food not listed on her menu, she will be reminded of her gluten free diet order an her choice of non gluten free foods will be documented and physician will be notified.

2. All diets ordered by a physician will be provided per facility policy. If a resident chooses not follow his/her prescribed diet, documentation will be done and physician notified.

QA: Physicians' Orders for Therapeutic Diets and QA: Substitutes for refused foods

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therapeutic diet.

The care plan, dated 03/05/12, stated, ". . . I am on Gluten Free diet due to my celiac disease. I need to avoid products that have gluten in them such as wheat, rye and barley. I allow myself some items with gluten at times - such as - I like to eat Ritz crackers with cheese for an evening snack. I know they have gluten in the crackers but I only allow myself four. My family has provided the Ritz crackers for me . . . I only have one tooth on my bottom gum and I do have an upper denture . . . Monitor me for chewing problems . . . I am able to make my menu choices at all my meals . . ."

A physician's progress note, dated 02/15/12, stated, " . . . She [Resident #9] needs to be on a gluten-free diet . . ."

Review of a dietary progress note, dated 03/07/12, stated, ". . . Resident states she wants to be given a regular menu with nothing changed to 'gluten free' as she knows what she can and can't have and will make the appropriate choices. Will cont. [continue] to visit with her as needed."

Observations on May 14-17, 2012 showed Resident #9 received the same menu as residents on a regular diet. The facility failed to provide Resident #9 with a gluten-free menu as stated in their policy. Resident #9's current diet card identified her diet as gluten-free, small portion and stated, "Note: Set up help as needed. Gluten intolerance. Needs to avoid all wheat products. Use Gluten Free products as substitute. Give resident non gluten free products when she requests."

F 365

(See exhibits F365-5 and F365-6) will be completed by July 9, 2012 and quarterly thereafter.

3. Dietary staff have been instructed to document on resident's menu when she chooses to have food containing gluten.

4. LRD, Dietary Manager, Nursing staff, managerial staff to conduct QA twice monthly for three months, once monthly for six months and then quarterly thereafter, or as necessary.

5. QA results will be reviewed at the quarterly Quality Assurance meeting.

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Observation of the supper meal on 05/14/12 at 5:40 p.m. showed Resident #9 received honey breaded chicken nuggets, breaded onion rings, and cole slaw. The resident became visibly upset, raised her voice, and verbalized her inability to eat the food due to the breading and stated she wished staff cut up the cole slaw so she could chew it. Resident #9's family member entered the dining room and stated "that's ridiculous," and indicated the resident couldn't eat the breading on the chicken nuggets or onion rings. Resident #9 explained when she selected the "chicken drummies" that morning, she assumed staff would provide a chicken breast without breading. Staff then served the resident soup as a substitute. The resident asked staff for some butter and gluten-free crackers to go with the soup, but the facility staff failed to provide them as requested. The resident ate approximately ten spoonfuls of soup and then went back to her room.

During an interview on 05/14/12 at 6:02 p.m., a dietary staff member (#27) stated Resident #9 usually picked the breading off her food and continued to eat the meal.

During an interview on 05/15/12 at 9:10 a.m., Resident #9 and her family member verbalized their frustration over the lunch that day, which included a cheeseburger, fries, and a lettuce salad. Resident #9 identified she doesn't like any of the items, stated she can't chew lettuce, and was upset staff failed to provide any other choices.

On 05/17/12 at 10:00 a.m., Resident #9 stated

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she wished her menu listed gluten-free options and wanted the dietary department to have a plan ahead of time, rather than it being an issue at the time staff served each meal. The resident's family member agreed with Resident #9's request.

During an interview on 05/15/12 at 1:50 p.m., an administrative dietary staff member (#2) stated the facility does not have a gluten-free menu. The dietary staff member provided a packet given to dietary staff describing the limitations of a gluten-free diet and encouraged the staff to use the resource to modify meals for Resident #9.

On 05/16/12 at 3:15 p.m., a consulting staff member (#13) stated Resident #9 often chooses to eat foods with gluten and will at times refuse certain brands of gluten-free products. The staff member (#13) identified she thought dietary staff met with Resident #9 prior to meals regarding what she wanted for the next meal and stated she was unaware this wasn't being done.

The staff members (#2 and #13) acknowledged Resident #9's frustration with the food served.

The facility failed to follow their own policy and provide Resident #9 with a gluten-free menu and failed to work with Resident #9 and her family to develop a plan to ensure the resident consistently received foods according to her gluten-free diet.

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

F 371 — **F 371 Plan of Correction** — 07/09/12

In the spirit of cooperation and consistent with Knife River Care Center's historical and current commitment to quality care for the residents, the facility states:

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(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observation, review of the manufacturer's manual, record review, and staff interview, the facility failed to maintain food service equipment under sanitary conditions for 1 of 1 soft-serve ice cream machine (Taylor Freezemaster 750 Ice Cream Machine). Failure to follow safe food sanitation practices has the potential to result in a foodborne illness and can affect all residents, guests, and staff who eat ice cream from the facility soft-serve ice cream machine.

Findings include:

Review of the facility's manufacturer's manual regarding procedures for the soft-serve ice cream machine occurred on 05/17/12. This manual, page 23, stated, "WE RECOMMEND DAILY CLEANING AND SANITIZING."

Review of the staff training minutes for the Taylor - Freezemaster 750 Ice Cream Machine, held 01/08/04, stated, "Recommended Daily Cleaning".

- Observation on 05/13/12 at 7:22 p.m. showed an unidentified resident and a guest eating a soft-serve ice cream cone in the facility coffee shop. At that time, an unidentified staff member

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1. A new form has been made to use starting in July 2012 (see exhibit #1). The Dietary Manager has reviewed the policy on the cleaning of the ice cream machine and has updated it to reflect the importance of cleaning and sanitizing, documenting doing so and action to be taken if for some reason it does not get cleaned. This policy was put into place 5/24/12(see exhibit F 371-1). Dietary Manager has also developed a "Dietary Manager's Check List" that includes a check on the ice cream machine cleaning and documentation to be used at least 3 times per week and to will be implemented July 2, 2012 (see exhibit F371-2). Dietary Manager has included Cleaning/Sanitizing of the Ice Cream Machine in Dietary Department In-service scheduled for 6/28/12(see exhibit F371-3). There was no negative impact on KRCC residents.

2. Cleaning and Sanitizing and the documentation of doing so will be monitored more closely by the Dietary Manager and

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F 371 Continued From page 73

(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observation, review of the manufacturer's manual, record review, and staff interview, the facility failed to maintain food service equipment under sanitary conditions for 1 of 1 soft-serve ice cream machine (Taylor Freezemaster 750 Ice Cream Machine). Failure to follow safe food sanitation practices has the potential to result in a foodborne illness and can affect all residents, guests, and staff who eat ice cream from the facility soft-serve ice cream machine.

Findings include:

Review of the facility's manufacturer's manual regarding procedures for the soft-serve ice cream machine occurred on 05/17/12. This manual, page 23, stated, "WE RECOMMEND DAILY CLEANING AND SANITIZING."

Review of the staff training minutes for the Taylor - Freezemaster 750 Ice Cream Machine, held 01/08/04, stated, "Recommended Daily Cleaning".

- Observation on 05/13/12 at 7:22 p.m. showed an unidentified resident and a guest eating a soft-serve ice cream cone in the facility coffee shop. At that time, an unidentified staff member

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immediate action will be taken if needed to prevent negative outcomes.

3. The new policy on Cleaning and Sanitizing the Ice Cream Machine is already in place. New Documentation Form (part of exhibit F371-1) will be put in place July 1, 2012. Dietary Manager has already as of this date and will continue to monitor more closely. Annual Dietary In-service from #1 above has already been done. Daily checks lists of at least 3 xs per week will be implemented July 2, 2012. QA has been established (exhibit F371-3 "Cleaning and Sanitizing the Ice Cream Machine".

4. The Quality Assurance Director or designee will be responsible to monitor for compliance of Cleaning, Sanitizing and the documentation of doing so of the Ice Cream Machine. An Ice Cream Machine Cleaning-Infection Control Tool has been developed and will be implemented and will be completed for the months of July, August and September,

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F 371 Continued From page 74
filled a food container with ice cream from the soft-serve machine. When asked, the staff member identified staff will serve the ice cream for the evening snack.

- Observation on 05/14/12 at 7:35 a.m. showed the soft-serve ice cream machine with a sign indicating ice cream is available. Throughout the day, observation showed residents and visitors eating soft-serve ice cream in the coffee shop.

- Observation, on 05/16/12 at 7:40 a.m., showed staff cleaning the ice cream machine. When asked if staff had cleaned and sanitized the machine between Sunday and Monday, the staff member (#3) referred to a cleaning schedule for the ice cream machine. Review of the cleaning schedule, with an administrative dietary staff member (#2) showed staff failed to clean and sanitize the soft-serve ice cream machine between Sunday and Monday.

The dietary tour occurred on 05/16/12 at 3:30 p.m., with an administrative dietary staff member (#2). During the tour, the staff member (#2), identified staff are to clean and sanitize the soft-serve ice cream machine after each use or daily if in continuous use. This staff member (#2) identified the facility used the soft-serve ice cream machine on Sunday, Monday, Wednesday, and daily in the summer. Review of the cleaning and sanitization records with the dietary staff member (#2) showed the facility had records for August 2011, and March and May 2012. These records failed to show facility staff cleaned and sanitized the soft-serve ice cream machine daily and/or after each time used.

F 441 483.65 INFECTION CONTROL, PREVENT

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then quarterly thereafter, or as necessary.

The deficiency cited in F-tag 371 was corrected immediately when discovered and ongoing correction will be made as noted in #'s 1, 3, and 4 above.

5. Results of the findings will be discussed with the Dietary Manager or designee and reported at the next scheduled Quarterly Quality Assurance Meeting on July 9, 2012.

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F 371	Continued From page 74 filled a food container with ice cream from the soft-serve machine. When asked, the staff member identified staff will serve the ice cream for the evening snack. - Observation on 05/14/12 at 7:35 a.m. showed the soft-serve ice cream machine with a sign indicating ice cream is available. Throughout the day, observation showed residents and visitors eating soft-serve ice cream in the coffee shop. - Observation, on 05/16/12 at 7:40 a.m., showed staff cleaning the ice cream machine. When asked if staff had cleaned and sanitized the machine between Sunday and Monday, the staff member (#3) referred to a cleaning schedule for the ice cream machine. Review of the cleaning schedule, with an administrative dietary staff member (#2) showed staff failed to clean and sanitize the soft-serve ice cream machine between Sunday and Monday. The dietary tour occurred on 05/16/12 at 3:30 p.m., with an administrative dietary staff member (#2). During the tour, the staff member (#2), identified staff are to clean and sanitize the soft-serve ice cream machine after each use or daily if in continuous use. This staff member (#2) identified the facility used the soft-serve ice cream machine on Sunday, Monday, Wednesday, and daily in the summer. Review of the cleaning and sanitization records with the dietary staff member (#2) showed the facility had records for August 2011, and March and May 2012. These records failed to show facility staff cleaned and sanitized the soft-serve ice cream machine daily and/or after each time used.	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	**F - 441 Plan of Correction**	07/09/12

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F 441 SS=E

Continued From page 75
SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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It is Knife River Care Center's practice to provide residents with a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.

1. For residents #2, #6, #8, #10, #12, and #14 affected by the deficient practice, and any other residents, corrective action will be taken by reviewing and revising the following policies: Standard Precautions, Hand-washing, Procedure for Hand-washing, Hand Cleanser (Antiseptic), Procedure for Using Alcohol-based Hand Rub, Linen Handling, Perineal Care, Foley Catheter Insertion/Maintenance/Removal, and Changing Urinary Bag to Urinary Leg Drainage Bag. (See Exhibit F 441-1 through 9 for policies)

2. There is always a potential for any resident to be affected by failure to follow Infection Control procedures. KRCC

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This REQUIREMENT is not met as evidenced by:
Based on information received from the complainant, observation, record review, review of facility policy, and staff interview, the facility failed to follow proper infection control procedures for 5 of 10 sampled residents (Resident #2, #8, #10, and #12, and #14) observed receiving pericares; 1 of 4 sampled residents (Resident #10) observed receiving morning cares; and 1 of 1 sampled resident (Resident #6) with an indwelling catheter. Failure to follow infection control procedures related to hand hygiene, glove usage, handling of linens, and catheter cares has the potential to result in the spread of infection to other residents, family or staff members.

Findings include:

Review of the facility policy titled "Hand Washing" occurred on 05/17/12. This policy, revised 2003, stated,
". . . General Instructions:
1. Hands should be thoroughly washed before and after providing resident care. . . .
4. Wash your hands before and after all procedures. . . .
7. Wear gloves when coming in contact with blood or body fluids. Wash hands or use hand cleanser (Antiseptic) after removal of gloves. . . ."

Review of the facility policy titled "Perineal Care" occurred on 05/17/12. This policy, updated 2003, stated, ". . . This procedure promotes cleanliness and prevents infection. Standard precautions must be followed when providing perineal care. . . ." The policy for both female and male residents

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feels that through training, education and observation of the policies stated in #1, no resident would be affected.

3. KRCC has put into place the following measures to ensure that Infection Control is followed:
   a. Infection Control Education was held at the General staff meeting on June 27th, 2012. (See Exhibit F441-10)
   b. Review above stated policies and procedures at the Nurse/CNA meeting on July 5th, 2012.
   c. Training will include questionnaire of proper glove usage when caring for residents at the Nurse/CNA meeting on July 5th, 2012. (See Exhibit F441-11)
   d. Hand-washing return demonstrations will be done at the Nurse/CNA

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stated, ". . . Put on disposable gloves . . ." After the completion of perineal cares, "Remove gloves and wash hands. If ointment or cream is necessary, new gloves should be applied and cream applied on the perineum . . . Remove gloves and wash hands. . . ."

- Observation on 05/14/12 at 1:00 p.m. showed a certified nursing assistant (CNA) (#8) applied gloves, assisted Resident #2 to bed, removed his brief saturated with urine, and provided pericares. With the same gloves, the CNA applied a clean brief, fastened the resident's trousers, and positioned him on the bed. The CNA removed her gloves, applied a clean pair, gathered the trash, and exited the room. The CNA (#8) disposed of the trash and sanitized her hands. The CNA (#8) failed to wash/sanitize her hands after completion of pericares.

- On 05/15/12 at 12:20 p.m., a CNA (#8) applied gloves and assisted Resident #8 to the bathroom. Observation showed the resident's brief, pants, and front and back peri-area soiled with stool. Resident #8 placed her hand in her groin area and the CNA (#8) stated, "Oh, you need to be wiped some more." After the CNA completed pericares, she applied an ointment to the resident's peri-area and wiped the excess ointment off her gloves with toilet paper. The CNA (#8) applied a clean brief and pants, assisted Resident #8 to her recliner, removed the gait belt, obtained the resident's water cup and offered the resident water, and then removed her soiled gloves. She applied clean gloves to bag the resident's soiled clothing and trash. The CNA (#8) exited the room, disposed of the trash and clothing, removed her gloves, and sanitized her

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meeting on July 5th, 2012. (See Exhibit F441- 12)

4. Policy on Standard Precautions was reviewed with staff at the General Staff meeting on June 27th, 2012. Review of policies; Standard Precautions, Hand-washing, Procedure for Hand-washing, Hand Cleanser (Antiseptic), Procedure for Using Alcohol-based Hand Rub, Linen Handling, Perineal Care, Foley Catheter Insertion/Maintenance/Removal, and Changing Urinary Bag to Urinary Leg Drainage Bag will be done at the Nurse/CNA meeting on July 5th, 2012. Hand Hygiene Competencies and Questionnaire for Proper Glove Usage will be completed at the Nurse/CNA meeting on July 5th, 2012.

5. The Quality Assurance tools will be completed by Dietary Manager, Dietary Staff, Nursing Staff (LPN,

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F 441	Continued From page 78 hands. The CNA (#8) failed to remove her soiled gloves and donn clean gloves before applying ointment to the residents' peri-area; failed to remove her gloves and perform hand hygiene after ensuring the residents' safety; and failed to provide hand hygiene for Resident #8. - Observation on 05/16/12 at 8:30 a.m. showed a CNA (#12) applied gloves and assisted Resident #8 to the bathroom. After the resident voided, the CNA provided pericares and sat the resident back on the toilet. Without removing her gloves, the CNA obtained a walkie talkie from her pocket and asked for assistance from another staff member. After a knock on the resident's door, the CNA (#12) opened the door and received a brief from another staff member. CNA (#12) then removed her gloves, applied clean gloves, and assisted Resident #8 with her clean brief and pants. The CNA (#12) removed her gloves and transported Resident #8 to the dining room. The CNA (#12) failed to remove her soiled gloves after completion of pericares and failed to wash/sanitize her hands prior to exiting the resident's room. - Observation on 05/15/12 at 10:45 a.m., showed a CNA (#4) assisted the Resident #6 with morning cares. Upon entering the room, observation showed the catheter bag was lying on the floor. The CNA (#4) obtained the leg bag/tubing from the bathroom. The leg bag/tubing lacked a protective cap on the end of the tubing. The CNA (#4) drained the catheter bag to the leg bag and stored the catheter bag/tubing in the resident's bathroom without placing a protective cap on the end of the tubing.	F 441	RN, CMA, C.N.A, RCC, C.N.A Trainers, and Nurse Managers), Activity, Laundry, Housekeeping, Maintenance and Administrative Staff. Random observations are included in the QA process. The QA tools will be completed on or before July 9th, 2012, weekly for 4 weeks, twice monthly for 3 months, and then once monthly for 6 months. Quality assurance findings will be reviewed at QA meeting on July 9th, 2012. In addition findings will be reported at quarterly QA meetings.	

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During an interview, on 05/16/12 at 3:05 p.m. with an administrative nursing member (#11) showed the manufacturer of the catheter bags provided protective caps for the end of the tubing. The nursing staff member (#11) confirmed covering the end of the tubing may decrease the possibility of contamination.

- On 05/16/12 at 8:35 a.m., a CNA (#22) assisted Resident #10 with morning cares as the resident sat on the edge of her bed. The CNA (#22) used washcloths to wash the resident's body, cleanse the resident's perineal area, and wipe stool from the resident's buttocks. After she used a washcloth, the CNA (#22) placed the soiled washcloths on a small table by the resident's recliner. During this observation, the CNA (#22) dropped a washcloth on the floor, picked it up, and then placed the washcloth on the same table. After performing perineal cares, the CNA (#22) removed her gloves, finished dressing the resident, and put the resident's shoes on. Then the CNA (#22) donned a new pair of gloves, handed the resident her dentures and some mouthwash, removed her gloves, brushed the resident's hair, bagged the soiled linen with her bare hands, transferred the resident to her wheelchair, pushed the resident in the hallway, disposed of the garbage and linen bags, and then washed her hands in the soiled utility room. The CNA (#22) failed to bag the dirty linen rather than set it on the resident's table, failed to disinfect the table after placing the soiled washcloths on it, failed to perform hand hygiene after perineal cares and after bagging the soiled linen with her bare hands, and failed to perform hand hygiene prior to exiting the resident's room.

(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 441	Continued From page 80 - Observation on 05/16/12 at 2:35 p.m. showed three CNAs (#22, #23, and #24) in Resident #14's room assisting him with cares. As the resident lay in bed, a CNA (#23) gloved, removed Resident #14's brief, incontinent of stool, completed perineal cares, applied cream to the resident's buttocks, and then placed on a new brief. The CNA (#23) then removed her gloves, repositioned the resident, positioned his urinal, used pillows to elevate his legs, adjusted his blankets, assisted Resident #14 with a drink of water, put the resident's supplies away, and then washed her hands. The CNA (#23) failed to perform hand hygiene immediately after completing perineal cares prior to performing other tasks. - Observation showed a CNA (#9) assisted Resident #12 with cares on 05/16/12 at 5:30 p.m. The CNA (#9) assisted Resident #12 onto the toilet. As the resident began to sit down, the resident held his genitals. At the completion of toileting cares, the CNA (#9) failed to assist and/or offer Resident #12 the opportunity to wash his hands. The CNA (#9) transported the resident in his wheelchair to a lounge. The CNA (#9) applied a gait belt to the resident's waist and with an administrative nurse (#10) assisted the resident to stand. The CNA (#9) and Resident #12 ambulated to the dining room. The CNA failed to assist Resident (#9) to wash his hands after toileting and before he began to eat.	F 441		