STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on June 29, 2015 and completed on July 1, 2015, the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included six (6) additional residents to verify specific concerns during the survey.	F 000		
F 164	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		8/5/15

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

Electronically Signed | 07/24/2015

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F 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain privacy of resident records for 3 of 8 residents (Resident #20, #22, and #23) observed during medication pass. Failure to keep residents' medication administration records (MARs) private is an infringement of the residents' rights. Findings include: - Observation of medication pass occurred on 06/29/15 at 4:15 p.m. A nursing staff member (#1) administered medications to Resident #22, and then entered another resident's room to assist the resident. During this time, Resident #22's MAR remained open and visible to other residents/staff members walking by the medication cart. - Observation of medication pass occurred on 06/30/15 at 7:51 a.m. A nursing staff member (#7) dispensed medications for Resident #20 from the medication cart (located in the hallway). The staff member then entered the dining room to administer the medications. During this time, Resident #20's MAR remained open and visible to other residents/staff members walking by the medication cart. - Observation of medication pass occurred on 06/30/15 at 7:58 a.m. A nursing staff member (#7) dispensed medications for Resident #23 from the medication cart (located in the hallway). The staff member then entered the dining room to	F 164	1. Education provided to nurses and CMAs on 7/17/15 through email regarding providing privacy of EMAR screen. 2. The facility has determined that all residents have the potential to be affected. 3. All CMAs were audited by 7/18/15. Nursing staff received an in-service education program on information privacy. This included updated policies of Medication Systems Procedure and Pharmaceutical Services (See exhibits A and B), will be conducted by the Director of Nursing Services or designee on July 30, 2015. QA monitoring started 7/13/15. 4. The Director of Nursing Services, or designee, will conduct a random medication pass audit which includes providing privacy of the EMAR screen (See exhibit D) of 2 CMA/nurse weekly for (4) weeks starting 8/5/15, then 3 CMA/nurse monthly for (3) months, then 1 CMA/nurse monthly for (8) months to ensure compliance with facility guidelines This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 164	Continued From page 2 administer the medications. During this time, Resident #23's MAR remained open and visible to other residents/staff members walking by the medication cart. During an interview on the morning of 07/01/15, an administrative nurse (#2) agreed staff should not leave the MARs open.	F 164		
F 221	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from physical restraints not required to treat the resident's medical symptoms for 1 of 1 sampled resident (Resident #13) identified as having a velcro lap belt. Failure to evaluate the potential of the velcro lap belt becoming a safety hazard may result in serious injury/harm. Findings include: Review of the facility policy "Restraint Free Environment" occurred on 07/01/15. The policy, dated 04/15/15, stated, ". . . Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which	F 221	1. 1) MDS modified by MDS Coordinator on 7/17/2015 - Section X - item coding error - Section P0100 - G - 2 and CAA for physical restraints completed. 2) The handwritten statement "For resident safety/numerous falls after breakfast/meals from dining room chairs; staff need to toilet resident per toileting program and assist her to rock and go chair, utilizing Velcro lap belt" was removed from resident's care plan. 2. Any other residents that use physical restraints may be affected. 3. A Restraint Assessment was created and will be completed by Physical	8/5/15

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F 221	Continued From page 3 restricts freedom of movement or normal access to one's body. . . . Physical restraints may include . . . Using devices in conjunction with a chair . . . such as . . . belts, that the resident cannot remove easily, that prevent the resident from rising or leaving the chair . . . Restraints may not be used for staff convenience. . . . Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. . . . Behavioral interventions should be used and exhausted prior to the application of a restraint. . . . the facility will assess and care plan the need for restraint use on a systematic and ongoing basis. . . ." Review of Resident #13's medical record occurred on June 30-July 1, 2015. Diagnoses included Lewy body dementia, conduct disturbance, mood disorder, and falls. The annual Minimum Data Set (MDS), dated 05/07/15, failed to identify the use of a belt by marking "E. Trunk Restraint" in section P of the MDS. The current physician's orders identified, "04/14/15, Velcro Pelvic Belt to be used when resident is in Rock n Go Chair due to increased agitation and no safety awareness due to Dementia." Resident #13's current care plan stated, ". . . When resident is exhibiting behaviors of aggressive rocking, pelvic thrusting while sitting, and/or head banging when in Rock-N-Go chair and after other behavioral interventions have been unsuccessful, the nurse may give the directive to apply the Velcro lap belt. The Velcro lap belt is Only to be used while resident in the Rock-N-Go Chair and Only in a location where resident is supervised. . . . During the time the	F 221	therapy/Occupational therapy/Nursing when any physical restraint is determined to be necessary. KRCC's policy was updated to reflect the use of the Restraint Assessment. Registered Nurse to complete "KRCC Restraint Assessment" for Resident #13. Education will be provided to nursing department staff on July 30, 2015 regarding the updated restraint policy. 4. Random audits will be completed by Nurse Manager or designee starting the week of 7/27/15 using the "Physical Restraint Use" validation checklist will be completed weekly for (4) weeks, then two monthly for (3) months, then once monthly for (8) months to ensure compliance with facility policies. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 221	Continued From page 4	F 221		

Velco Lap Belt is in place, staff will check resident every 1-2 hours in conjunction with the individualized toileting schedule. Please monitor that resident does not slide under the Velcro Lap Belt. . . ." A handwritten note, dated 06/23/15, stated, "For resident safety/numerous falls after breakfast/meals from dining room chair; staff need to toilet res [resident] per toileting program & [and] assist her to rock and go chair, utilizing velcro lap belt." This conflicted with the facility's restraint policy.

Progress notes, dated May 1-July 1, 2015, identified the following:
* Resident #13 slid from her rock-n-go wheelchair on 19 occasions. Direct care staff described Resident #13 as having "slid down to the very edge" or "catepillared" from her chair to the floor. The progress notes indicated staff did not witness 12 of the 19 falls from her rock-n-go chair.
* On 51 occasions, the facility utilized a velcro lap belt restraint.
* On 8 occasions, the facility applied the velcro lap belt due to staff's inability to provide 1:1 care. [A fax to Resident #13's primary care provider, dated 05/06/15, also stated,"Res does better when staff sit [with] resident. But staff are not always able to do this. Velcro lap belt used during these times."] This conflicted with the facility's restraint policy.
* On 14 occasions, the facility applied the velcro lap belt without identifying the behavioral interventions staff attempted prior to applying it. This conflicted with the facility's restraint policy.

During an interview on 07/01/15 at 3:20 p.m., a certified nursing assistant (CNA) (#14) reported Resident #13 "slides down her wheelchair with or without the lap belt on."

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F 221	Continued From page 5 The facility failed to evaluate the potential of the velcro lap belt becoming a safety hazard due to Resident #13's pattern of "sliding down to the very edge" or "catepillaring" from her chair. The resident's care plan conflicted with the facility's policy on restraint use. The application of the velcro lap belt prior to exhausting other behavioral interventions and/or when staff were unavailable also directly conflicted with the facility's policy on restraint use.	F 221		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225		8/5/15

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F 225	Continued From page 6 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: ABUSE ALLEGATION 1. Based on record review, review of facility policy and procedure, interview with a former employee, and staff interview, the facility failed to immediately report and thoroughly investigate two incidents of alleged abuse and failed to report the results of the investigation to the State survey and certification agency for 1 of 1 sampled resident (Resident #12). Failure to report violations involving alleged abuse has the potential to place all residents at risk for abuse. Findings include: Review of the facility policy titled "Abuse Prohibition Policy" occurred on 07/01/15. This policy, revised 04/10/14, stated, ". . . Any alleged violation(s) should be recorded and reported immediately to the facility Administrator. The administrator or his/her designee will report to other officials through established procedures and in accordance with State law (including to the State survey and certification agency) as	F 225	1. Knife River Care Center does have an Abuse Policy in place. Staff will be educated at the General Staff meeting on August 5th, 2015. KRCC does have a Quality Assurance Event form that is filled out when staff discover an injury to a resident (ie: bruise, skin tear, etc.). These forms are reviewed each morning (Monday - Friday) at the morning stand-up meeting. 2. The facility has determined that all residents have the potential to be affected. 3. An in-service education program will be conducted at the Nursing Services meeting on July 30th, 2015 and at the General Staff meeting on August 5th, 2015 by the Director of Social Services addressing circumstances that require reporting including appropriate timeframes. The Abuse Prohibition Policy	

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F 225	Continued From page 7 warranted. The Administrator or his designee shall report the allegation to the State survey and certification agency within a 24-hour time period. . . . Allegations of mistreatment, neglect and abuse will be thoroughly investigated and documented using established procedures. . . . PROCEDURE . . . 1. The employee who witnesses or had knowledge of an act or suspected act of abuse . . . shall notify the administrator immediately . . . If the Administrator cannot be reached . . . the Director of Nursing and/or the Social Worker should receive the allegation report and proceed with established procedures. . . . 2. The Administrator, Social Worker, and Department Supervisor(s) will meet to determine what action is needed to ensure the safety of the residents while the investigation is conducted. . . . 3. All alleged acts or suspected acts of abuse . . . shall be immediately and thoroughly investigated and reported to other officials through established procedures and in accordance with State law (including to the State survey and certification agency). The report to the State survey and certification agency shall be made by the administrator and/or his/her designee . . . The appropriate department supervisor(s), with assistance from the Social Worker shall investigate the suspicion of abuse by interviewing individuals having information about the situation . . . . 4. The results of the facility investigation must be reported to the administrator or his designated representative and to the State survey and certification agency within five (5) days of the reporting of the incident. . . . A copy of the report and supporting documentation will be kept in the locked file cabinet in the Social Service office . . ." On 06/30/15 at 4:00 p.m., surveyors received information via a telephone call regarding	F 225	will be updated and reviewed with all staff. KRCC's Quality Assurance Event forms will be reviewed. Education will be provided to the nurses on documentation for the injuries of unknown source. The Director of Social Services/designee and the Director of Nursing/designee will review the QA Event Forms (see exhibit J) each morning (Monday - Friday) to follow-up on any injuries of unknown origin. An investigation checklist (see exhibit J) has been made to ensure all steps in the investigative process are completed. The form will accompany all the investigation paperwork which will be kept in the file cabinet in the Director of Social Services office. 4. The Director of Social Services, or designee, will conduct a random audit (see exhibit J) of the reported allegations weekly for four (4) consecutive weeks and quarterly thereafter for 1 (one) year to assure all allegations are investigated appropriately and reported to the State Survey and Certification Agency in a timely manner. QA monitoring began the week of 7/27/15. A random audit (see exhibit J) will be conducted on the injuries of unknown origin weekly for four (4) consecutive weeks, monthly for three (3) months, and quarterly thereafter for one (1) year to assure injuries of unknown origin are thoroughly investigated. Findings of these	

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F 225	Continued From page 8 Resident #12 and Resident #19. The caller stated in March or April of this year [2015], Resident #19 told the caller a male care giver touched her in the vaginal area, and the resident made a hand motion regarding this. The caller states Resident #19 has confusion, so the caller did not report this. A few days later, Resident #12 told the caller a male care giver put his finger 'where the penis goes' and this resident made the same hand motion as Resident #19 had made. The caller then reported the information regarding Resident #12 and #19 to the charge nurse and also verbally told the facility's social worker. The caller stated the facility never asked him/her any questions or provided caller with any follow-up. The caller stated approximately a month after the first report of information to the charge nurse, Resident #12 stated she felt a burning in her vaginal area ever since the male care giver put his finger there. The caller made a telephone call to the social worker at home to report the resident's comment, and then the social worker and a nurse manager came in to the facility that evening. The caller stated no one conducted an interview with him/her. The caller stated hhe facility changed Resident #12's care plan to have no male caregivers and he/she thinks the facility completed a urinalysis on the resident the following day. Review of Resident #12's medical record occurred on June 30 - July 1, 2015. A quarterly Minimum Data Set (MDS), dated 04/22/15, identified Resident #12 as cognitively intact and moderately impaired in vision. The current care plan stated "I prefer female caregivers only." Record review identified the following social service progress notes:	F 225	audits will be discussed with the Director of Nursing/designee and Administrator/designee. QA monitoring began the week of 7/27/15. This plan of correction will be monitored by the Director of Social Services/designee, Director of Nursing/designee, and Administrator. It will be reviewed at the quarterly QAPI meeting.	

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* 03/16/15 at 7:57 p.m. - "SSD [social service designee] and Unit Manager, [name of unit manager] were called in to visit with resident re [regarding]: concern with being touched inappropriately by male CNA [certified nursing assistant]. SSD and UM [unit manager] interviewed resident and will follow up. Chem [chemistry] strip to be competed by CN [charge nurse]."
* 03/27/15 at 3:01 p.m. - "Late entry: 3-18-15 Unit Manager [name of unit manager] and this SSD spoke with resident in regards to complaint on 3-16-15. Resident offers no complaints of staff treating her poorly or touching her inapproiately [sic] when asked how staff are treating her or if she had any concerns/complaints."

The record failed to identify notification of Resident #12's family regarding this incident.

Review of Resident #19's medical record occurred on June 30 - July 1, 2015. A quarterly MDS, dated 04/02/15, identified Resident #19 severely impaired in cognition. Record review showed no documentation of alleged inappropriate touch or notification of family.

During an interview on 07/01/15 at 1:30 p.m., an administrative (#13) and social service staff member (#22) stated they did not report the alleged abuse to the State agency because they did not feel it was an abuse situation based on their investigation. The staff members stated they visited with Resident #12 and the resident did not have any complaints or verbalize any alleged abuse. The staff members also stated they viewed the facility video camera footage, which did not show any male staff members entering the resident's room. The staff members

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confirmed they did not interview any staff members.

Review of the written investigation regarding Resident #12, dated 3/16/15, identified the following: "[Name of nurse manager] and this SSD were called in at 1930 [7:30 p.m.] to visit with resident about a complaint she had given to CNA [name of CNA]. Resident told CNA that person sticks finger in where penis goes and scratches and it burns when she pees. [Name of CNA] also reports [Resident #19] had a similar situation but "can't recall when this happened" but "it was the same hand motion." Interview with [Resident #12]: Staff ask resident if she has any concerns/complaints about staff working with her recently. Resident tells these staff members that . . . '[male care giver] talks too much.' Resident offers no information that she has been mistreated in any way. She is questioned if this male staff member puts her to bed - 'he just says he is going to wash me up and then puts me in bed.' Resident again asked if there are any other problems with this male care giver. Resident offers no complaints. Cameras were reviewed by this SSD and [name of nurse manager]. No male care givers are seen over a 2 day time period. Schedule reviewed and no male care givers scheduled to work with this resident. Care plan will be changed to female caregivers. Administrator and DON [director of nursing] also made aware of situation."

During interview on 07/01/15 at 3:07 p.m., the social service staff member (#22) stated the facility has no investigation report from the first allegation. An administrative nurse (#2) stated the facility sent an e-mail [electronic mail] in February 2015 to the charge nurse the CNA initially

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reported the allegation to. The administrative nurse (#2) stated they educated the charge nurse because she did not investigate when the CNA reported the allegation.

INJURIES OF UNKNOWN ORIGIN

2. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to immediately report two injuries of unknown origin to the administrator of the facility/the State survey and certification agency and failed to investigate the origin of each injury for 1 of 1 sampled resident (Resident #18) with a history of rib/arm bruising. This failure placed all residents at risk of potential abuse.

Findings include:

Review of the facility policy titled "Abuse Prohibition Policy" occurred on 07/01/15. This policy, revised 04/10/14, stated, ". . . Injuries of Unknown Source: Such as skin tears, bruises . . . must be reported by the staff member to the Charge Nurse as soon as they are discovered. The Charge Nurse completes the Events Assessment within the shift that it is discovered. . . . Once completed, this form is immediately routed to the Director of Nursing (DON) and/or unit supervisor for review to determine if the injury of unknown source should be investigated as potentially caused by abuse or neglect. If, in the course of the investigation, the DON or his/her designee suspects that abuse or neglect was a factor, the Abuse Prohibition Policy procedures are followed. . . ."

- Review of Resident #18's medical record occurred on June 30-July 1, 2015. The quarterly

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Minimum Data Set (MDS), dated 01/11/15, identified severely impaired cognition and the need for extensive assistance for transfers and total assistance for locomotion.

The progress notes identified the following:
* 07/29/14, "9:00 a.m. - CNA [certified nursing assistant] called nurse to room to assess. Nurse noted bruising to L) [left] medial forarm measureing 2.2 cm [centimeters] x [times] 1.3 cm and deep purple in color. Bruising also noted to R) [right] side rib area measuring 7.4 cm x 8.3 cm. Color is deep purple in the center with yellow bruising around it. Also noted semi hard round area about nickle size in center of bruise. Tender to touch. Skin tear noted to L) forarm measuring 4 cm x 0.9 cm area cleansed with NACL [saline], scant amt [amount] of bleeding noted. Polymem with mepore placed. No s/s [signs/symptoms] infection No complaints of pain. Dr. [name] here on rounds and updated on area. . . ."
* 11/09/14, "Resident has a bruise noted to her right hand and arm, measuring 20 cm x 10 cm. bruise is dark purple in color. Residents ROM [range of motion] is wnl [within normal limits] to hand and wrist, no swelling noted to area. Will continue to monitor. . . . Physician notified. Resident voices no c/o [complaints of] pain or discomfort to area."

On 07/01/15 at 12:15 p.m., an administrative nurse (#8) reported the facility failed to report/investigate Resident #18's injuries of unknown origin (07/29/14 bruised ribs and 11/09/14 bruised arm).

On 07/01/15 at 5:30 pm, an administrative nurse (#2) confirmed the facility failed to report/investigate Resident #18's injuries of

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F 225	Continued From page 13 unknown origin (07/29/14 bruised ribs and 11/09/14 bruised arm). She stated, "[Resident #18] had fragile skin and bruised easily." Failure to immediately report Resident #18's injuries of unknown origin (rib/arm bruising) to the Administrator of the facility and to the State survey and certification agency limited the facility's ability to ensure her safety and placed all residents at risk of potential abuse.	F 225		
F 241	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, review of facility policy, and staff interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 4 of 18 sampled residents (Resident #1, #2, #9, and #12) and 2 supplemental residents (Resident #21 and #24). Failure to knock on doors prior to entering residents' rooms (Resident #1, #2, and #12) and treat residents with respect in the dining room (Resident #9, #21, and #24), does not promote the residents' dignity and/or enhance their quality of life. Findings include: KNOCKING/ANNOUNCING SELF PRIOR TO ROOM ENTRY	F 241	1. Overview of Resident dignity was discussed at the General Staff meeting on July 15th, 2015. 2. The facility has determined that all residents have the potential to be affected. 3. Knife River Care Centers "Maintaining Resident Dignity Policy" (see exhibit K) and "Feeding the Resident Policy" (see exhibit K) were updated and will be reviewed at the nursing services meeting on July 30th, 2015 and at the General Staff meeting on August 5th, 2015.	8/5/15

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F 241	Continued From page 14 Review of the facility policy titled "Guidelines for Maintaining Resident Privacy" occurred on 07/01/15. This undated policy stated, ". . . Always knock before entering, wait for a response from resident if he/she can respond. If someone knocks while personal cares are being done, please ask them to wait as resident is busy and privacy needs to be provided while care is being given. . . ." Observation identified the following: * 06/29/15 at 3:50 p.m., a certified nursing assistant (CNA) (#3) toileted Resident #2. The bathroom door remained open while Resident #2 sat on the toilet. A volunteer opened the door to Resident #2's bedroom without knocking and/or announcing herself. She looked at the resident sitting on the toilet, walked over to and placed a candy bar on her night stand, walked back to the open bathroom door, and conversed with the CNA (#3) prior to exiting the bedroom. The volunteer entered Resident #2's room without knocking on the door and/or announcing herself, and the CNA failed to close the bathroom door in an effort to maintain Resident #2's privacy. * 06/30/15 at 9:20 a.m., a CNA (#4) entered Resident #1's room without knocking on the door and/or announcing herself. * 06/30/15 at 4:37 p.m., a CNA (#3) entered Resident #2's room. As she entered, she looked at Resident #2's roommate and stated, "It's me." The CNA entered Resident #2's room without waiting for permission from the resident or her roommate. * 07/01/15 at 8:45 a.m., a CNA (#16) entered Resident #12's room without knocking on the door and/or announcing herself.	F 241	The Activity Director updated the "Volunteer Orientation Checklist" (see exhibit K) and the "Volunteer Reminders" (see exhibit K) and will send a copy to each volunteer of KRCC. 4. The Director of Social Services, or designee, will conduct random audits of staff weekly over the next four (4) weeks, then monthly over the next three (3) months, and then quarterly for one (1) year to ensure staff are promoting and maintaining resident dignity in accordance with our facility's practice guidelines and regulatory requirements. See QA tool F-241 Dignity/Promoting and Maintaining Resident Dignity Exhibit. QA monitoring began the week of 7/27/15. Observation reports will be reviewed by the Social Service Director/designee, Director of Nursing/designee, and Administrator/designee. The observation will also be reviewed quarterly at the QAPI meeting.	

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TREATING RESIDENTS IN THE DINING ROOM WITH RESPECT

Review of the facility policy titled "Ambulating a Resident with a Gait Belt" occurred on 07/01/15. This policy, revised 09/09/03, stated, ". . . 9. Assist the resident back to the chair or bed when resident begins to tire. 10. Remove gait belt and make the resident comfortable. . . ."

- Observation on 06/29/15 at 4:32 p.m. showed Resident #21 seated at a dining room table with a gait belt around her waist. A nursing staff member (#1) approached the resident and removed the gait belt.

Observation on 06/30/15 at 9:30 a.m. showed Resident #21 seated at a dining room table with a gait belt around her waist. The gait belt remained in place while the resident ate breakfast.

During an interview on the morning of 07/01/15, an admnistrative nurse (#2) identified staff should not leave gait belts on residents at the table.

Review of the facility policy titled "Maintaining Resident Dignity" occurred on 07/01/15. This policy, dated 06/10/13, stated, "Objective: . . . Staff is to carry out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. . . . staff will 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/her individuality. . . . 4. . . . Promoting resident independence and dignity in dining; to avoid the following: . . . e. Using a spoon or clothing protector to wipe food from a resident's face. . . ."

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F 241	Continued From page 16 - Dining observations in the Shady Lane Unit occurred on 06/30/15 at 11:45 a.m. Observation throughout the meal showed the CNA (#15) rushed Resident #24 during the dining experience by holding spoonfuls of food in front of his mouth, stating "open up [Resident #24]" while the resident was still chewing food from the last spoonful. The CNA (#15), on two occasions, used Resident #24's clothing protector to wipe food from his face, instead of using a napkin. - Dining observation in the Shady Lane Unit occurred on 06/29/15 at 09:05 a.m. Observation showed Resident #9 seated in her wheelchair at the dining room table sleeping. The resident's dishes from breakfast remained on the table in front of the resident. At 9:50 a.m. an unidentified CNA asked the resident if she was ready to go back to her room. The resident slept at the dining room table for forty-five minutes while other residents were eating in the dining room.	F 241		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		8/5/15

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F 278	Continued From page 17 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 7 of 7 sampled residents coded as on a turning/repositioning program (Resident #1) and/or on nutrition or hydration interventions to manage skin problems (Resident #1, #2, #7, #8, #13, #14, and #17). Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs, and may affect the development of a comprehensive care plan. Findings include: M1200C Turning/Repositioning Program The Long-Term Care Facility RAI User's Manual, October 2014, page M-38-39 stated, "M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the	F 278	1. The appropriate modifications and/or corrections to sections M1200 C and/or D have been made to resident #1, #2, #7, #8, # 13, and #14. Resident #17 is a closed record. 2. The facility has determined that all residents have the potential to be affected. All residents current MDS's will be reviewed and the appropriate modifications and or corrections to sections M1200C and/or D will be made as necessary. 3. The Policy/Procedure for Positioning/Repositioning of Resident has been revised (see exhibit L) and a Nutritional Assessment Policy/Procedure developed (see exhibit L). These policies will be reviewed at the Nursing Department education meeting on 7-30-15, conducted by the Director of	

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F 278	Continued From page 18 approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." M1200D Nutrition or Hydration Intervention The Long-Term Care Facility RAI User's Manual, October 2014, page M-38-39 stated, "M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US [United States] Recommended Daily Intake (US RDI) of nutrients . . . Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individuals intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed' . . . It is important to remember that additional supplementation is not automatically required for pressure ulcer	F 278	Nursing Services or designee. These same policies will be reviewed with the MDS IDT members on or before August 3, 2015. 4. The medical record documentation will be reviewed to determine appropriate coding of the MDS section M1200C & D. The Director of Nursing Services, MDS Coordinator, MDS IDT members, or designee, will conduct a random audit of three (3) residents per week for four (4) consecutive weeks, then monthly x 3 months, then quarterly x 6 months. (See exhibit L). This audit began the week of 7/27/15. This plan of correction will be monitored at the quarterly QAPI meeting until such time consistent substantial compliance has been met.	

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management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis . . . "

- Review of Resident #1's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 04/05/15, identified extensive-to-total assistance of two or more persons required for bed mobility and transfers, on a turning/repositioning program, one stage 2 pressure ulcer, and nutrition or hydration interventions. The nutrition or hydration interventions to manage skin problems, established for Resident #1, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

The resident's current care plan stated ". . . Please make sure I get repositioned every two hours . . ." The resident's medical record failed to identify an individualized repositioning program.

- Review of Resident #2's medical record occurred on all days of survey. An annual MDS, dated 04/02/15, identified nutrition or hydration interventions. The nutrition or hydration interventions to manage skin problems, established for Resident #2, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

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- Review of Resident #13's medical record occurred on June 30-July 1, 2015. An annual MDS, dated 05/07/15, identified nutrition or hydration interventions. The nutrition or hydration interventions to manage skin problems, established for Resident #13, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Review of Resident #17's medical record occurred on 07/01/15. A significant change MDS, dated 01/31/15, identified nutrition or hydration interventions (to manage skin problems). The nutrition or hydration interventions to manage skin problems, established for Resident #17, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

Resident #17's dietary progress note, dated 11/05/14, stated, "Diet Mechanical Soft with Ground Meats. . . . 6oz [sic] Vanilla Mighty Shake TID [three times a day] (meals) with 95-100% acceptance. Nursing reports no edema, skin is intact . . . no new labs on chart. . . ."

- Review of Resident #7's medical record occurred on all days of the survey. A quarterly MDS, dated 05/08/15, and a significant change MDS, dated 06/05/15, identified nutrition or

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hydration interventions (to manage skin problems). The nutrition or hydration interventions to manage skin problems, established for Resident #7, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Review of Resident #8's medical record occurred on all days of the survey. An annual MDS, dated 06/15/14, a quarterly MDS, dated 03/16/15, and an annual MDS, dated 06/15/15, identified nutrition or hydration interventions (to manage skin problems). The nutrition or hydration interventions to manage skin problems, established for Resident #8, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

Resident #8's dietary progress notes, dated 12/22/14, stated, " . . . Diet: Consistent Carbohydrate . . . supplement acceptance-0-100% . . . Nursing reports skin is intact . . ."

- Review of Resident #14's medical record occurred on all days of the survey. An annual MDS, dated 11/20/14, and a quarterly MDS, dated 05/28/15, identified nutrition or hydration interventions (to manage skin problems). The nutrition or hydration interventions to manage skin problems, established for Resident #14, failed to meet the criteria for coding item M1200D

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F 278	Continued From page 22 on the MDS. The medical record lacked an inividualized nutritional assessment that determined whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.	F 278		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of nursing practice for 1 supplemental resident (Resident #20) observed during medication administration. Failure to directly observe residents to ensure they take all medications may result in medication errors and adverse health effects. Findings include: Review of the facility policy titled "Pharmaceutical Services" occurred on 07/01/15. This policy, revised 01/19/15, stated, ". . . The resident must be observed taking their medication unless they have been assessed to self-administer their medications and are care planned to self-administer medications. . . ." Gauwitz, "Administering Medications: Pharmacology for Healthcare Professionals," 7th ed., McGraw-Hill Companies, Inc., New York,	F 281	1. On 6/30/15 1:1 education was provided to CMA who had been observed to leave medication at table with resident who had been assessed not able to self-administer medications. 2. The facility has determined that all residents have the potential to be affected. 3. All CMAs were audited on a medication pass, which included the monitor of self-administration of medication by residents, individually by the DON and designees by 7/18/15. An in-service education program on the facility's current policy for resident self-administration of medications (See exhibit C) was conducted by the Director of Nursing Services or designee on July 30, 2015. QA monitoring began 7/13/15. 4. The Director of Nursing Services, or	8/5/15

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F 281	Continued From page 23 page 136, stated, ". . . Right Time . . . Never leave a drug at the patient's bedside. To make sure all medications are taken, observe while the patient takes the medication. . . ." Observation of medication pass occurred on 06/30/15 at 7:51 a.m. A nursing staff member (#7) dispensed medications for Resident #20, who was in the dining room. The staff member identified the resident could self administer medications. The staff member left the medications with Resident #20 and returned to her medication cart, located in the hallway outside the dining room. Review of Resident #20's medical record on 06/30/15 identified an assessment titled "Competence to Self Administer Medications." The assessment stated, ". . . 05/07/15 My cognition is declining and I am no longer safe to self administer medications. . . ." During an interview on the morning of 07/01/15, an administrative nurse (#2) agreed staff should not leave medications at the table if residents are unable to self administer.	F 281	designee, will conduct a random medication pass audit. This audit tool includes monitoring of self-administration of medications (See exhibit D) of 2 CMA/nurse weekly for (4) weeks starting 8/5/15, then 3 CMA/nurse monthly for (3) months, then 1 CMA/nurse monthly for (8) months to ensure compliance with facility guidelines. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/5/15

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F 309	Continued From page 24 This REQUIREMENT is not met as evidenced by: DYSPHAGIA 1. Based on record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled residents (Resident #2) identified as having lost consciousness following a choking episode received the care and services necessary to attain the highest degree of safety possible during meals. Failure to formally assess Resident #2's swallow following her choking episode placed her at an increased risk of further aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, page 8, identified, ". . . Coughing and choking are very obvious symptoms of dysphagia . . . If a patient has aspirated, he may develop pneumonia . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and pneumonia. The annual Minimum Data Set (MDS), dated 04/02/15, identified severely impaired cognition and set-up assistance required for eating. The current physician's orders and care plan identified Resident #2 received "a regular diet." The care plan also stated, ". . . I have a history of choking - please monitor and notify my nurse if I have any problems. . . ." Resident #2's progress notes identified the following: * 12/09/14, "Resident had a choking episode at	F 309	1. Dysphagia: Resident #2 was noted to have a choking episode in December of 2014. Evaluation was done by therapy the week of July 20, 2015. Constipation: Resident #5 care plan updated to reflect constipation. Senna S 1 tab PO BID scheduled on 7/10/15 for constipation. Dietary interventions to prevent constipation of offering prune juice, prunes, or fruit ball as allowed/received by resident. Foley Catheter: Resident #8 catheter bag is covered. Bed, wall, and floor deep cleaned by housekeeping prior to July 20, 2015. 2. All residents are at risk for swallowing complications. All residents are at risk for constipation. All residents with Foley Catheters are at risk for catheter care/maintenance problems. 3. Dysphagia: On July 30, 2015 all nursing staff were educated on communication of any changes with swallowing, including use of Event Form/communication sheet/therapy referral, and re-educated on current policy Notification of Change (see exhibit E) by the DON and/or designee. All resident charts were audited on 7/20/15 by DON for any documentation without previous	

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F 309	Continued From page 25 supper meal. Staff reported Resident momentarily lost consciousness. Res [resident] was breathing when this nurse came over to her but was still struggling with coughing and trying to breath. Resident coughed some more and was able to resume normal breathing. Resident did not remember if she had taken a drink of water just before this happened. Will continue to monitor Resident." * 12/15/14, ". . . Resident had a choking episode on 12/09/14. No choking episode reported since." During interviews on 07/01/15 at 1:15 p.m. an administrative nurse (#9) reported she found no evidence staff formally assessed Resident 2's swallow following her choking episode. The facility failed to notify Resident #2's primary care provider regarding her choking episode and failed to formally assess her swallow in order to determine the safest/least restictive diet for her. The care and services provided placed Resident #2 at an increased risk of further aspiration. CONSTIPATION 2. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #5) who lacked interventions for constipation. Failure to asses, identify a continued pattern, and provide dietary interventions for constipation may have caused Resident #5 increased constipation. Findings include: Review of the facility policy titled "Bowel Protocol"	F 309	follow up related to dysphagia. Constipation: On July 30, 2015 all nursing staff were educated on current policy "Bowel Protocol" (see exhibit F) by the DON and/or designee. All resident charts were audited on 7/20/15 by DON for use of PRN bowel medications. Requests for scheduled medications sent to physicians. (See exhibit H-1). PRN bowel medication usage will be reviewed monthly by a nurse and updates on excessive use sent to physicians with request for scheduled medications/or adapted currently scheduled medications. Foley Catheters: On July 30, 2015 all nursing staff were educated by the DON and/or designee on current policy of Foley catheter cares and maintenance (See exhibit G). All residents with Foleys were monitored on 7/20/15 by DON for proper storage of Foley bags. 4. The Director of Nursing Services (DNS), or designee, will complete random Quality of Care audits for each area: 1. Monitor for residents with swallowing problems. 2. That Foley bags are covered and stored appropriately. 3. Resident's use of PRN bowel medications, care plan reflecting constipation, and MD notification (See Exhibit H), to monitor for compliance; five (5) or more residents a week for four (4) consecutive weeks, five (5) residents monthly for three (3) months, and five (5) residents quarterly for two (2) quarters. QA monitoring started 7/20/15.	

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F 309	Continued From page 26 occurred on 07/01/15. This policy, dated 07/03/14, stated, ". . . Each resident will be assessed at time of admission and as needed for constipation. 2. In conjunction with Nursing, Dietary will assist in providing interventions for the routine bowel care plan. . . . 8. If nurse identifies a continued pattern of bowel irregularity, the attending physician will be contacted for review of medication regimen. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included multiple sclerosis. Current medications included milk of magnesia (MOM) 30 milliliters (ml) on day two if no bowel movement (BM), bisacodyl 10 milligrams (mg) suppository on day three of no BM, and natural laxative prn (as needed). Resident #5's current care plan lacked interventions for constipation. Review of Resident #5's medication administration record identified staff administered the following bowel medications: * April 2015 - MOM seven times - Bisacodyl suppository eight times * May 2015 - MOM seven times - Bisacodyl suppository ten times * June 2015 - MOM six times - Bisacodyl eight times During an interview on the afternoon of 07/01/15 a dietary manager (#12) stated Resident #5 does not receive dietary interventions to prevent constipation. During an interview on 07/01/15 at 1:00 p.m. an administrative nurse (#13)stated Resident #5 has not received routine medications to prevent constipation.	F 309	Audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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The facility failed to care plan or provide routine medications and dietary interventions for Resident #5's constipation.

FOLEY CATHETER

3. Based on observation, record review, and review of facility policy, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for 1 of 2 sampled residents (Resident #8) with a Foley catheter. Failure to provide appropriate catheter care placed Resident #8 at risk for injury.

Findings include:

Review of the facility policy titled "MAINTAINING RESIDENT DIGNITY POLICY" occurred on 07/01/15. This policy, dated 06/10/13, stated, ". . . Staff will assist in creating and sustaining an environment that humanizes and individualizes each resident . . . Resident's catheter bag is not exposed and tubing is not touching the floor . . ."

Review of Resident #8's medical record occurred on all days of the survey. Diagnoses included bladder dysfunction, urine retention, benign prostatic hyperplasia, neurogenic bladder, and dementia. An annual MDS, dated 06/15/15, identified an indwelling catheter.

Observation on 06/30/15 at 5:24 p.m. showed a CNA (#20) and a licensed practical nurse (LPN) (#21) transferring Resident #8 from the recliner to his wheelchair using a stand lift. As the resident was raised to a standing position, blood was noted in the catheter bag. The LPN (#21) left the

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F 309	Continued From page 28 resident in the stand lift in a standing position, placed the catheter bag on the floor, and attempted to flush the catheter. Unable to clear the catheter tubing, the CNA moved the resident in the stand lift towards his bed. The stand lift wheels rolled over the catheter tubing and bag laying on the floor, causing the bag valve to open. After placing the resident in bed, the CNA lifted the catheter bag above the resident's head and the urine with blood spilled onto the wall, bed, floor, and the resident's clothing.	F 309		
F 323	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: GAITBELT USE 1. Based on observation, record review, and review of facility policy, the facility failed to provide adequate assistance devices (gait belt) for 2 of 4 sampled residents (Resident #2 and #12) using staff assistance during pivot transfers and one supplemental resident (#21) during ambulation. Failure of the facility to ensure staff properly used a gait belt placed the residents at risk for accident and/or injury. Findings include:	F 323	1. Gait Belt Use - Assessed residents for appropriate size gait belts. All staff have regular gait belts. Larger/heavier residents given large gait belts to be kept in their rooms. Burns - Nurse assessed resident's skin for burns on 6/29/15 at 3:30 pm and again at HS (See Exhibit M). KRCC Quality Assurance Event form was completed at the time of the incident. Weekly events meeting was held on 7/8/15 and it was determined that this was an isolated	8/5/15

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F 323	Continued From page 29 Review of the facility policy titled "Ambulating a Resident with a Gait Belt" occurred on 07/01/15. This policy, revised 09/09/03, stated, ". . . While resident is seated attach gait belt securely around resident's waist. Gait belt should be comfortable for the resident yet allow enough room for the staff person to put the palm of hand snugly between the belt and the resident. . . ." - Review of Resident #2's medical record occurred on all days of survey. The annual minimum data set (MDS), dated 04/02/15, identified severely impaired cognitive skills and a history of falls. The progress notes identified the following: * On 06/26/15 at 11:38 a.m., "@ [at] 10:45 a.m. nurse summonded to resident room. . . . CNA [certified nursing assistant] reports resident was being assisted with AM [morning] cares and lost her balance and felll [sic] down onto resident's bottom. . . ." * On 06/28/15 at 3:36 p.m., ". . . diagnosis of: L [left] hip contusion, L inf [inferior] pubic ramus fx [fracture]. . . ." The care plan identified a handwritten entry, dated 06/29/15, stating, "[I] walk with a FWW [front-wheeled walker] & [and] staff assist x [times] 1 short distances . . . Pivot transfer staff assist x 1 . . ." Observations showed the following: * On 06/29/15 at 3:50 p.m., a CNA (#3) assisted Resident #2 to stand-pivot onto the toilet. Resident #2 had difficulty adjusting her feet and was bent forward, leaning heavily to her right side, throughout the transfer. After the resident	F 323	incident. 2. Gait Belt Use - All residents that are care planned for use of a gait belt have the potential to be affected. Burns - The facility has determined that all residents that drink hot fluids have the potential to be affected. 3. Gait Belt Use - Ambulating Resident with a gait belt procedure updated (See Exhibit M). Education will be provided to nursing staff on July 30th, 2015 regarding the updated procedure. Education will be provided to all staff regarding the updated procedure on August 5th, 2015. Burns - Education will be provided to nursing department staff on July 30th, 2015 and to all staff on August 5th, 2015 regarding the use of Styrofoam cup lids that are placed in the coffee shop to prevent spills. Education will be provided to all staff regarding the use of Styrofoam cup lids that are placed in the coffee shop to prevent spills. Residents will be reminded that there are lids available at the Resident Counsel meeting on July 29th, 2015. A sign was hung in the coffee shop reminding residents to use lids when having hot beverages (See Exhibit M). 4. Gait Belt -Random audits will be completed by Nurse Manager or designee starting the week of 7/27/15 using the "Accident Hazards/Supervision/Devices" validation checklist (See Exhibit M Part #1) will be completed weekly for (4)	

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F 323	Continued From page 30 voided, the CNA (#3) stated, "Before you stand up, I'm putting my gait belt on you." After she applied the gait belt, she assisted Resident #2 to stand-pivot back into her wheelchair. * On 06/30/15 at 4:37 p.m., a CNA (#3) assisted Resident #2 into a standing position by placing the front-wheeled walker in front of the resident and pulling up on the back of her pants. Resident #2 stated, "It [hip] hurts." The CNA (#3) followed Resident #2 into the bathroom, with one hand placed on each of the resident's hips. Once Resident #2 reached the toilet, the CNA (#3) applied her gait belt and assisted her to sit down. The facility failed to ensure staff held onto the gait belt when assisting Resident #2 into a standing position and/or when transferring her from one surface to another. - A random observation in Resident #21's room on the evening of 06/29/15 showed a nursing staff member (#1) applied a gait belt around Resident #21's waist and assisted her to stand. The staff member assisted Resident #21 to ambulate with a walker from her room to the dining room. Observation showed the gait belt loose around the resident's waist, with approximately 12 inches of space between the belt and the resident's back. - Review of Resident #12's medical record occurred on June 30 - July 1, 2015. The quarterly MDS, dated 04/22/15, identified the resident required extensive assist with transfers, walking in room, toilet use, and personal hygiene. Resident #12's current care plan stated, ". . . I am having trouble with my legs now and I don't walk like I used to. I am able to pivot transfer with a staff assist of one and use of gait belt. . . ."	F 323	weeks, then two monthly for (3) months, then once monthly for (8) months to ensure compliance with facility policies. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Burns - Random audits will be completed by Nurse Manager or designee starting the week of 7/27/15 using the "Accident Hazards/Supervision/Devices" validation checklist(Exhibit M Part #2) will be completed weekly for (4) weeks, then two monthly for (3) months, then once monthly for (8) months to ensure compliance with facility policies. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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Resident #12's "Daily Care Guide" identified "Risks: Falls . . . Interventions: Transfers: Gait belt x 1 . . ."

Observation on 07/01/15 at 8:35 a.m. showed a CNA (#17) assisted Resident #12 to pivot transfer from her wheelchair to the recliner. The CNA placed her hands on the resident's hips during the transfer. The CNA (#17) failed to apply a gait belt prior to the transfer.

Observation on 07/01/15 at 9:45 a.m. showed a CNA (#18) assisted Resident #12 to pivot transfer from the toilet to her wheelchair and from the wheelchair to her recliner. The CNA placed her hands on the resident's hips during the transfer. The CNA (#18) failed to apply a gait belt prior to the transfer.

BURNS

2. Based on observation, record review, and staff interview, the facility failed to provide supervision and/or assistive devices necessary to attain the highest degree of safety possible while consuming hot liquids for 1 of 1 sampled resident (Resident #2) with an episode of spilled coffee. Failure to evaluate the residents' ability to handle hot liquids placed them at risk of sustaining a burn.

Findings include:

Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia. The annual Minimum Data Set (MDS), dated 04/02/15, identified severely impaired cognition and set-up assistance required for eating. The current care plan stated, ". . . I can

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feed myself at this time but if I would need help a feeding assistant can help me. . . ."

Observation on 06/29/15 at 3:50 p.m. showed a nurse (#10) and a certified nursing assistant (CNA) (#3) transporting Resident #2 to her room on the special care unit. The nurse (#10) stated, "We're going to check her legs to make sure there is not a burn." Observation showed the resident's pant leg was wet and the skin directly under was pink.

During an interview on 06/29/15 at 4:07 p.m., an activity aide (#11) reported Resident #2 had been drinking coffee from a Styrofoam cup at the time the incident occurred.

During an interview on the morning of 06/30/15, when asked how the facility followed up on Resident #2's coffee spill, a managerial nurse (#9) reported she was unaware Resident #2 had spilled coffee the day before.

Observation on 06/30/15 at 4:37 p.m. showed a CNA (#3) toileting Resident #2. During the observation, an administrative nurse (#2) knocked and entered the resident's room in order to inform the surveyor "the nurse forgot to make a note in the chart regarding the [coffee] spill."

Resident #2's progress note, dated 06/30/15 at 4:46 p.m "LATE ENTRY FOR 06/29/15," identified, "At 3:30 p.m. nurse was made aware of an event involving the resident spilling coffee on herself in the coffee shop. Resident was taken to her room to have her clothes changed by CNA and to have her Skin evaluated by Nurse. Coffee was mainly spilled on residents thighs. During skin check nurse found no redness or burns on

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F 323	Continued From page 33 residents skin. Resident stated that some of the coffee splashed on the bridge of her nose near her eye and no bruises, redness, or burn was noted. Another skin [sic] was done at HS [hour of sleep] and no burn marks or redness noted. Resident has no complaints of pain or discomfort due to coffee spill at this time." During an interview on 07/01/15 at 1:15 p.m., when asked how the facility followed up on Resident #2's coffee spill, an administrative nurse (#9) reported the team had not met yet to discuss the incident. The facility failed to assess Resident #2's risk of injury from hot beverages, care plan appropriate interventions based on the assessment, and provide staff education, which placed Resident #2 at an increased risk for further spills with/without injury.	F 323		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 8 residents (Resident #20) observed during medication pass. Two errors occurred during staff administration of 26 medications, resulting in a seven percent error rate.	F 332	1. Two OTC medications were missed by CMA on initial pass of medications. Resident was given all medications on prompting of surveyor. 2. All residents receiving medications by CMA have the potential to be affected by this practice.	8/5/15

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F 332	Continued From page 34 Findings include: Review of the facility policy titled "Medication System Procedure" occurred on 07/01/15. This policy, revised 03/01/15, stated, ". . . The Certified Medication Aide is responsible for: . . . Administering all ordered medications to residents at appropriate times . . ." Observation of medication pass occurred on 06/30/15 at 7:51 a.m. A nursing staff member (#7) dispensed several medications for Resident #20, who was seated in the dining room. After the staff member administered the medications, she returned to the medication cart and signed off the medications, including Tylenol and Preservision (an eye vitamin). When asked by the surveyor, the staff member identified she administered the Tylenol and Preservision. The staff member reviewed the medication administration record (MAR) again and stated, "I forgot those [indicating the Tylenol and Preservision]." The staff member then dispensed the Tylenol and Preservision and administered them to Resident #20. The staff member failed to ensure the administration of all ordered medications according to the MAR, which resulted in two errors of omission.	F 332	3. On July 30, 2015 the Director of Nursing Services and /or designee educated medication aides and nurses on preventing medication errors and reviewed the updated policies of Medication Systems Procedure and Pharmaceutical Services (See exhibits A and B). The Director of Nursing Services and/or designee monitored medication passes for all CMAs individually by July 18, 2015 using audit tool "Preventing Medication Errors" (see exhibit D). QA monitoring began 7/13/15. 4. The Director of Nursing Services, or designee, will conduct a random medication pass audit to monitor for medication errors and ensure that nursing staff who are responsible for passing medications are following protocol (See exhibit D) for 2 CMA/nurse weekly for (4) weeks starting the week of 8/3/15, then 3 CMA/nurse monthly for (3) months, then 1 CMA/nurse monthly for (8) months to ensure compliance with facility guidelines. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 356	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		8/5/15

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F 356	Continued From page 35 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care on 1 of 3 days (06/30/15) of survey. Findings include:	F 356	1. Daily staffing sheet was updated with current staff hours 2. On 7/15/15 education was provided to Reception Staff on updated protocol of receptionist doing a daily check of posting of nursing staff form; if form is not completed, receptionist will have the	

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F 356	Continued From page 36 Observations throughout the day on 06/30/15 identified nurse staffing information dated 06/29/15. Facility staff failed to provide current staffing information on 06/30/15. During an interview on the morning of 07/01/15, an administrative nurse (#2) identified the night shift nurse is responsible for posting staffing information.	F 356	charge nurse complete form for immediate posting. On 7/30/15, education was provided to the nursing staff of regulation F356 and re-educated on Knife River Care Center form used to document daily staffing hours. Nursing staff/charge nurse will post and update daily staffing sheet on a daily basis. QA monitoring was initiated on 7/14/15. 3. The receptionist will check to ensure the form is updated every day of the week. The Director of Nursing Services (DNS), or designee, will conduct random audits to ensure the form is posted daily. Random audits will be done 3 times a week for four (4) weeks, 6 times a month for three (3) months, and quarterly for six (6) months. Observation reports and validation checklists will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		8/5/15

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F 363	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, and staff interview, the facility failed to meet the nutritional needs of the residents by serving incorrect portion sizes in 3 of 3 dining rooms (Harvest Lane, Shady Lane, and Whispering Winds). Failure to follow recommended portion sizes as outlined in the facility's menus may result in weight changes and/or inadequate nutritional intake for all residents. Findings include: - On 06/29/15 at 5:33 p.m., observation in Whispering Winds showed an unidentified certified nursing assistant (CNA) used tongs to dish the residents' french fries and vegetables. (Tongs do not allow staff to ensure the correct portion size.) - Observation of tray line occurred in the Shady Lane dining room on 06/30/15 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Broccoli served with a 3 ounce (oz) spoon. The menu identified 4 oz. *Turkey Tetrazzini served with a 1/2 cup scoop. The menu identified 2/3 cup. *Tapioca pudding served with a 2 oz scoop. The menu identified 4 oz. *Mechanical soft turkey tetrazzini served with a 1/3 cup scoop. The menu identified 2/3 cup. *Pureed turkey tetrazzini served with a 1/3 cup scoop. The menu identified 2/3 cup. *Pureed steak served with a 2 oz scoop. The	F 363	1. Portion sizes of all foods on the facility menus have been re-evaluated by the Registered Dietitian and the Dietary Manager to assure accuracy and adequacy of planned meals. Foods are being served using proper serving and scoop sizes for the accurate delivery of portion sizes. The correct portion sizes are served to all residents. 2. The facility has determined that all residents have the potential to be affected. 3. On (July 8,2015.) Dietary Manager in-serviced the dietary staff on the facility guidelines for portion sizes. Observations were made for (3) consecutive meals for (4) consecutive days with compliance noted. 4. The Dietary Manager or designee will conduct (4) food preparation and service audits weekly to ensure compliance. QA has been in effect as of July 9, 2015, with two meals being monitored daily. This has been listed as our dietary QAPI and will be ongoing until such a time that it is consistently correct. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the	

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F 363	Continued From page 38 menu identified 3 oz. *Pureed broccoli served with a 1/4 cup scoop. The menu identified 1/3 cup. - Observation of tray line occurred in the Harvest Lane dining room on 06/30/15 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Pureed broccoli served with a 1/4 cup scoop. The menu identified 1/3 cup. *Pureed turkey tetrazzini served with a 1/3 cup scoop. The menu identified 2/3 cup. *Turkey tetrazzini served with a 1/2 cup scoop. The menu identified 2/3 cup. - Observation of tray line occurred in the Whispering Winds dining room on 06/30/15 during the evening meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: *Pureed peas served with a 1/4 cup scoop. The menu identified 1/3 cup. *Pureed Philly steak sandwich served with a 1/4 cup scoop. The menu identified 2/3 cup. *Philly steak meat served with tongs. The menu identified 3 oz of meat. *Three bean salad served with a 3 oz scoop. The menu identified 4 oz. *Pureed potato soup served with a 1/2 cup ladle. The menu identified 3/4 cup. During an interview on the morning of 07/01/15, a dietary supervisory (#12) stated staff should follow portion sizes listed on the menus.	F 363	committee. Findings of this audit will be discussed with the resident council.	

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F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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, group interview, resident interview, and review of facility policy, the facility failed to serve foods at palatable temperatures in 2 of 2 serving kitchens tested (Whispering Winds and Shady Lane). Failure to ensure foods served to residents are held at appropriate serving temperatures may impact their food consumption related to palatability. Findings include: Review of the facility policy titled "Taking Accurate Temperatures" occurred on 07/01/15. This undated policy stated, ". . . Temperature should be taken periodically to assure hot foods stay above 135 [degrees] F [Fahrenheit] and cold foods stay below 41 [degrees] F during the portioning, transporting, and serving process until received by the customer. . . ." - During the group interview conducted on 06/29/815 at 1:30 p.m., three residents (Resident A, B, and C) identified the food served at meal times is sometimes "cold." - During a resident interview on 06/30/15 at 2:25 p.m., Resident #9 stated the food is not served at a temperature she likes. The resident stated the	F 364	1. Food items that were not at the proper temperatures were removed from the steam table and re-heated to the correct temperature of 165 degrees (See Exhibit F364). 2. All of our residents have the potential of being affected if the quality and palatability of the foods served isn't up to standards. 3. A temperature log has been set up as of July 8, 2015 in each individual unit and the servers have been recording the temperatures of the items brought to them to serve, which will ensure proper temperatures after transport from the central kitchen. Dietary staff were educated on July 8, 2015. A food quality form has been set up and will be completed by the Dietary Manager/designee bi-weekly for the next four weeks starting on August 6,2015. This will check food temperatures and palatability. A test meal will be set up at close to the time the last resident on the unit is served and begins eating. All forms will be kept in a separate binder and	8/5/15

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F 364	Continued From page 40 juices are warm and the food is lukewarm. - Observation of tray line occurred in the Whispering Winds kitchen on 06/30/15 at 5:54 p.m. Observation showed pureed peas, pureed Philly steak, and pureed barbequed beef in foil pans on top of the stove, which was not turned on. At the conclusion of tray line, the surveyor requested a test tray. Temperatures obtained were as follows: *Pureed Philly steak - 81 degrees F *Pureed barbequed beef - 117 degrees F *Peas - 122 degrees F The survey team tasted the above items and agreed they were not hot and were unpalatable. - Observation of tray line occurred in the Shady Lane kitchen on 07/01/15 at 12:07 p.m. At the conclusion of tray line, the surveyor requested a test tray. Temperatures obtained were as follows: *Knoephla casserole - 122 degrees F *Fish sticks - 101 degrees F The survey team tasted the above items and agreed they were not hot and were unpalatable. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 364	shared with the staff at our next Dietary Meeting, which will take place on August 26, 2015. Corrective action will be taken immediately during any food quality inspection if needed. 4. Monitoring on various meals by the Dietary Manager/designee starting on July 8,2015. This will be done weekly for four (4) consecutive weeks, then monthly x 3 months, then quarterly x 6 months. (See Exhibit F364). This plan of correction will be monitored at the quarterly QAPI meeting until such time consistent substantial compliance has been met.	
F 389	483.40(d) PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.	F 389		8/5/15

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F 389	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy, and staff interview, the facility failed to provide physician services in a timely manner for 2 of 15 sampled residents (Resident #2 and #7) who experienced a fall with an injury. Failing to provide these services resulted in the residents' untreated pain and delay in the treatment of an acute medical condition. Findings include: Review of the facility policy titled "Notification of Changes" occurred on 07/01/15. This policy, dated 09/30/14, stated, ". . . The facility . . . consult with the resident's physician . . . when there is a change requiring such notification . . . 1. Accidents a. resulting in injury. b. potential to require physician intervention . . ." Review of the facility policy titled "FALL MANAGEMENT", occurred on 07/01/15. This policy, dated 06/02/15, stated, ". . . If a resident falls, the nurse will . . . begin the 'Falls Protocol': . . . Notify physician in accordance with facility guidelines . . . For an injured resident, call physician . . ." -Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, bone disease disorder, lumbosacral disc degeneration, history of falls, and fractured femur. The progress notes identified the following: * 01/25/15 at 8:59 a.m.: ". . . Resident was laying on her left side on the floor with only a brief on . . . Resident does have a large dark purple bruise	F 389	1. Resident #2 and #7 have been assessed by physicians. 2. The facility has determined that all residents have the potential to be affected. 3. On July 30, 2015 an in-service education program was conducted by the Director of Nursing Services, and/or designee with all licensed staff/nursing staff regarding the Notification of Change policy (See exhibit E) and addressing circumstances that require notification of the resident's physician, legal representative or family member. Nursing staff will also be educated on the necessity of timeliness and the process in contacting physicians when an acute medical condition has occurred. This may include a call to the Emergency Department Physician if unable to receive direction from resident physician. QA monitoring began on 7/21/15. 4. The Director of Nursing Services, or designee, will conduct a random chart audit, reviewing for any event that may require immediate response by a physician, of five (5) residents weekly for four (4) consecutive weeks, five (5) residents monthly for three (3) months, and five (5) residents quarterly for three (3) quarters. These residents will be newly assessed to ensure that any declines in condition have been identified, properly evaluated and communicated to	

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F 389	Continued From page 42 behind her left ear which extends onto left side of head . . . Resident does state she has pain all over 'that I always have', was medicated . . . assisted to her bed with assist x 2 . . . MD [medical doctor] faxed . . . Resident was helped to get dressed . . ." There was no response from the physician concerning the fax sent. The facility failed to follow up with the physician. * 01/25/15 at 3:44 p.m.: ". . . Resident helped to the bathroom with assist x 2 and gaitbelt. Resident was able to bear weight on bilateral legs but states her buttock hurts which is a chronic complaint for her . . ." * 01/25/15 at 5:02 p.m.: ". . . Resident does state her left leg is more sore than her right with pain in her left buttock . . ." *01/26/15 at 12:17 a.m.: ". . . Resident resistive with cares . . . Resident could not stand for more than 5 seconds and had to sit back on bed . . . Resident had trouble getting her left foot/leg to move when trying to help with transfer. She c/o [complaint of] pain to right side of neck and right shoulder down right arm. She also c/o [sic] in left hip and down left leg and throughout back . . . She seemed confused and had a hard time with communicating but may be due in part to her hearing and lack of . . . Fax sent to Physician . . . with her c/o pain . . ." There was no response received from the physician concerning the fax sent. The facility failed to follow up with the physician. * 01/26/15 at 11:17 a.m.: ". . . 0800 Resident with disorientation has difficulty following cueing . . . Unable to bear weight due to pain in the left hip and low back. Transferred with a standing lift. Resident barely able to hold on due to pain in left hip and low back. Resident moaning with pain . . . speech is slightly slurred . . . Fax to [name of doctor] with change in mobility and continued	F 389	the appropriate people. This plan of correction will be monitored at Quality Assurance meetings until such time consistent substantial compliance has been met.	

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disorientation and pain . . ." There was no response received from the physician concerning the fax sent.
* 01/26/15 at 11:35 a.m.: ". . . Continues to complain of pain to left hip/low back. Remains disoriented . . ."
* 01/26/15 at 3:40 p.m.: ". . . Res. [resident] is unable to bear wght [weight] at this time has had some falls. nsg. [nursing] is attempting to get her into clinic . . ."
* 01/26/15 at 10:26 p.m.: ". . . Resident complaining of severe pain from left hip downward her legs with any slight movement . . . pain on the Left side hip and legs with movement or turning . . ."
* 01/27/15 at 12:12 p.m.: ". . . 0800 Resident crying out in pain with slightest movement to left leg . . ."
* 01/27/15 at 12:16 p.m.: ". . . pain is a 10 on the 0-10 scale . . ."
* 01/27/15 at 2:00 p.m.: "1100 [name of doctor] here to see resident. Orders Transfer to [name of hospital] ER [emergency room]. . ."
* 01/27/15 at 4:18 p.m.: "Informed by [name of hospital] that resident has a fx'd [fractured] femur and was admitted to acute care for pain control and immobilization . . ."

The facility fax notices identified the following:
* 01/25/15: "Fall Fax Alert . . . Physician: [name of doctor] . . . nurse comment: nurse went by room and resident was laying on the floor beside her bed . . ."
* 01/25/15: "Fax Alert . . . Physician: [name of doctor] . . . Resident c/o pain to right side of neck; jaw and has pain to right shoulder and down arm; she is unable to stand up straight and after 5 seconds is unable to stand at all. She is having trouble moving left foot/leg and c/o pain in left hip

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and down left leg. She took Tylenol but it was not effective. She c/o pain with swallowing. Would like her seen at clinic! Please advise."
* 01/26/15: "Fax Alert . . . Physician: [name of doctor] . . . disoriented, unable to stand, staff using standing lifts, resident complains of L [left] hip/ low back pain moans with transfers. 0 bruising to area . . . She was able to bear wt [weight] and walk with 2 staff assist yesterday. today her mobility status has changed from yesterday . . ."

During a telephone interview on 07/01/15 at 3:20 p.m., a staff nurse (#19) stated she called the clinic during her shift on 01/26/15 after she recognized the physician had not responded to a fax on the previous day. The staff nurse stated when she spoke with the physician's nurse, the clinic was unable to see the resident at the clinic and the physician's nurse instructed the staff nurse to fax the information and the physician would be in to see the resident the next day. The staff nurse (#19) faxed the information on 01/26/15 but did not receive a response before the end of her shift. The resident's condition worsened, but no further attempt to notify the physician was made during the next shifts.

During an interview on 06/30/15 at 5:38 p.m., an administrative nurse (#13) stated the expectation after faxing a physician and not getting a response is to call the physician's office. The administrative nurse stated that when the physician's office was called with this incident, the physician's office responded with directions to fax the information to the physician's office and the physician would see the resident during rounds. The administrative nurse (#13) stated it has been an ongoing situation of not being able to reach

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the physician for emergency situations and that there was no other on call physician available to reach. She stated the physician's office always requests all information to be faxed to his office, and there is no other way to contact the physician for emergency situations.

The facility failed to provide physician services in a timely manner for Resident #7 following her fall with injury. The resident experienced continued worsening left leg/hip pain and was unable to stand and bear weight on this leg.

- Resident #2's medical record, reviewed on all days of survey, identified diagnoses including dementia and history of falls.

The progress notes identified the following:
* 06/26/15 at 11:38 a.m., "@ [at] 10:45 a.m. nurse summoned to resident room. . . . CNA [certified nursing assistant] reports resident was being assisted with AM cares and lost her balance and felll [sic] down onto resident's bottom, but resident hit her head on the left of the bedside table. . . . Bump noted to the back R) [right] side of residents head. Cool pack applied. . . . prn [as needed] Tylenol 325 mg [milligrams] was administered . . . Notified MD [medical doctor] of fall via fax."
* 06/26/15 at 12:55 p.m., "@ 12:40 p.m. cool pack removed. Bump continues to decrease in size. Bruising noted [to] area at this time."
* 06/26/15 at 3:46 p.m., "MD notified of fall via e-mail, per MD preference. Resident is now c/o [complaining of] L) [left] sided groin/hip/buttock pain. Pain is only when resident is walking/putting pressure on it. MD was notified of this information as well in the e-mail."
* 06/28/15 at 12:57 a.m., ". . . Bump continues to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	07/01/2015

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

(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 389	Continued From page 46	F 389		

back of head. . . . Bruise noted under L) eye. . . . PCP [primary care provider] has not returned email at this time. . . ."
* 06/28/15 at 10:43 a.m. with Addendum at 10:51 a.m., ". . . Resident continues to c/o pain to L) side hip/groin area. PRN Tylenol 325 mg administered . . . CNA reports when resident was walking in room to the bathroom this AM resident was dragging L) leg. Bruising noted L) hip area at this time. . . . MD e-mailed again to notify of L) groin/hip pain, and that it is not resolving."
* 06/28/15 at 1:15 p.m., "Resident continues to c/o pain to L) hip/groin area. Phone call made to [Physician], and unable to get through, as there has not been any response to the e-mails. E-mail sent to other e-mail address, and received response from MD. . . ."
* 06/28/15 at 1:48 p.m., "PO [physician's order] received: X-RAY L) hip."
* 06/28/15 at 3:36 p.m., ". . . diagnosis of: L hip contusion, L inf. [inferior] pubic ramus fx [fracture]. . . ."

The facility failed to provide physician services in a timely manner for Resident #2 and Resident #7 following falls with injury (attempts made over a 2 day period without success). Resident #2 had experienced avoidable continued left groin/hip pain reaching a level of 10 on a pain scale of 0-10 where pain at 10 is excruciating. Resident #7 was unable to stand or bear weight on her left leg. The facility staff indicated during interview that emergency physician services were not available.