| 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 _____ | 07/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey, started on 07/11/16 and completed on 07/14/16, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 4 additional residents to verify specific concerns during the survey. | F 000 | | |
| F 223 SS=D | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure residents remained free from verbal and mental abuse for 1 of 14 sampled residents (Resident #9) who experienced and/or perceived abuse from Resident #12. Failure to address Resident #12's behaviors resulted in Resident #9 experiencing mental abuse and does not ensure the safety of all residents in the facility.<br><br>Findings include:<br><br>Review of the facility policy titled "ABUSE PROHIBITION POLICY" occurred on 07/14/16. This policy, dated 07/21/15, stated, ". . . | F 223 | Care plans for both residents involved in the incident have been updated to reflect interventions should another incident happen. (See exhibit Soc 223-1. Review of Resident # 9 and # 12 IDT notes will occur 4x/week to ensure no new behaviors are occurring between them.<br><br>All residents of the facility have the potential to be affected by this practice. All care plans will be reviewed and interventions added if necessary.<br><br>The Abuse Prohibition Policy (See exhibit Soc 223-2)will be reviewed at the next scheduled Resident Council meeting | 8/18/16 |

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

Electronically Signed | 08/03/2016

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| F 223 | Continued From page 1<br>Residents must not be subject to abuse by anyone, including, . . . other residents . . . 'Abuse' shall mean . . . intimidation . . . with resulting physical harm or pain or mental anguish, . . . 'Verbal Abuse' shall mean any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Example of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident . . . Procedure A. Any incident of alleged resident mistreatment, neglect, and abuse or grounds for suspicion of same will result in the following: 1. The employee who witnesses or has knowledge of an act or suspected act of abuse, neglect, . . . shall notify the Administrator immediately verbally and/or in writing. . . . 2. The Administrator, Social Worker/designee, and Department Supervisor(s) will meet to determine what action is needed to ensure the safety of the residents while the investigation is conducted. . . . Examples of action for residents could include, but are not limited to, care planning to minimize or eliminate behaviors, making a room change, transfer for short term psychiatric assessment or for appropriate permanent alternate placement . . ."<br><br>- Review of Resident #9's medical record occurred on all days of survey and identified diagnosis of anxiety. The annual Minimum Data Set (MDS), dated 12/25/15, identified the resident exhibited moderate depression.<br><br>Review of Resident #9's interdisciplinary notes stated the following:<br>* 08/21/15 at 12:27 p.m.: "Was reported by staff | F 223 | scheduled for Thursday, August 11, 2016 and at the General Staff meeting held on Wednesday, August 17, 2016.<br><br>Education on the Behavior Management Policy ( See Exhibit Soc 223-5)will occur with all staff at the above stated meetings. Education on how to identify, intervene, and report such behaviors will also take place.<br><br>The Social Service referral policy and form will be updated and reviewed with staff at the above stated meetings. (See exhibit Soc 223-3)<br><br>Social Services will review the interdisciplinary notes weekly for the next four (4) weeks for all residents to capture new behaviors and interventions. This plan will continue to be monitored twice (2) a month for five (5) months and then monthly for the following six (6) months. We will then make sure they have been addressed in the resident's care plan. (See exhibit Soc 223-1)<br><br>The Director of Social Services or designee will review a random sample of care plans one (1) time per week for four (4) months and every other week for three (3) months to assure the interventions are appropriate. (See exhibit Soc 223-4)<br><br>All audits will begin the week of August 1, 2016.<br><br>Results will be reviewed by the Risk | |

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| F 223 | Continued From page 2<br>that resident was in her room, in tears, over an incident which had occurred between her and [Resident #12]. Went to resident's room to visit with her. She described how [Resident #12] had walked to her door this morning, shook her finger at her, and stated 'You're going to suffer one day' then left. Resident questioned why [Resident #12] hated her so much, and went on to describe how this resident stared at her in the dining room and muttered while she ate, giving the impression she was complaining about this resident. Also described incident yesterday, when she was coming out of the dining room, where [Resident #12] almost ran into her, then accused resident of trying to run over her toes. Offered this resident reassurances that she had done nothing wrong, and that the problem did not lie with what she had or hadn't done. Told resident that I would visit with her next week to see how things were going, but if something more happened, I asked her to let staff know, and they would relay the information to me. . . ."<br>* 08/21/15 at 11:17 p.m.: ". . . Res [resident] did state that she was having a rough day. Res told this nurse that 'Every time [Resident #12] walks past my room she yells mean things at me.' 'Something bad is going to happen to you. I don't know what, but theres [sic] going to be a lot of pain.' Res now wants her door shut and feels 'she is out to get me.' TLC [tender loving care] provided to Res."<br>* 11/28/15 at 8:29 p.m.: "Was alerted by resident's CNA that resident was in her room, crying, and asked that I go visit with her. Went to resident's room and asked how I could help. She stated that [Resident #12] had been, for the last couple of weeks, stopping outside her room door and making rude comments. She stated that | F 223 | Management / Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Corrective action completion date: August 18, 2016 | |

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| F 223 | Continued From page 3<br>tonight the resident had stopped outside her room shook her finger at her, then told her that she had asked God to judge her for her deeds. Resident was very upset by this. Offered TLC and resident agreed to try to pay no attention to [Resident #12]. Will alert staff to this, so that they can intervene if it happens again."<br>* 12/24/15 at 8:49 a.m.: "Resident came to nurse concerned about another residents behavior towards this resident. Resident is 'worried of what she will do next.' Resident does not want to have to move to another room, but is afraid of other resident. Resident reports that other resident said that 'what happened to your leg is what you get and next time it will be worse. SS [social services] notified of occurrence."<br><br>Resident #9's current care plan failed to identify the problem and approaches for the verbal behaviors and perceived threats from Resident #12.<br><br>During an interview on 07/13/16 at 2:05 p.m., an administrative staff member (#6) stated the facility failed to identify the problem and implement measures to avoid further incidents to ensure the resident's well being.<br><br>The facility failed to report, identify, investigate, and implement measures for the problem of intimidation to eliminate the threats made by Resident #12 towards Resident #9. This resulted in Resident #9 experiencing fear and increased anxiety from Resident #12's behaviors which affected Resident #9's mental and psychosocial well-being. | F 223 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE | F 250 | | 8/18/16 |

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| F 250 | Continued From page 4<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to assess specific socially inappropriate behaviors exhibited, develop and implement individualized approaches/interventions, and monitor effectiveness for 2 of 14 sampled residents (Resident #9 and #12) who exhibited and/or experienced abusive behaviors.<br>The facility failed to:<br>1. Implement the facility's policy to identity residents and/or situations with potential for the occurrence of abuse, prevent resident to resident abuse, and protect residents from recurring resident to resident abuse.<br>2. Adequately assess resident behaviors and implement appropriate interventions to prevent behaviors from escalating.<br>3. Monitor the effectiveness of interventions and revise interventions as appropriate.<br>4. Implement an interdisciplinary approach to address behaviors which have the potential to result in resident to resident altercation.<br><br>This behavior has the potential for other residents to become victims of physical, verbal, and mental abuse.<br><br>Findings include: | F 250 | Care plans for both residents involved in the incident have been updated to reflect interventions should another incident happen. (See exhibit Soc 250-1) Psychiatric Nurse Practioner saw resident #12 via telemed on 7-15-16 order for MMSE was given. Med change of Risperdal 0.25mg PO Q HS was given on 7-28-16.<br><br>All residents of the facility have the potential to be affected by this practice. All care plans will be reviewed and interventions added if necessary.<br><br>The Social Service Referral form was updated. There was a behavior section added to alert social service staff of the behaviors occurring. It also indicates if the behavior was directed at staff or residents(See exhibit Soc 250-2). We have updated the Behavior Symptom Policy and renamed it Behavior Management Policy. (See exhibit Soc 250-3). This policy will help staff to identify and manage behaviors. This policy will ensure residents receive the appropriate services in attempt to correct | |

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| F 250 | Continued From page 5<br><br>Review of the facility policy titled "BEHAVIOR SYMPTOM POLICY" occurred on 07/14/16. This policy, revised during the survey, stated, ". . . When behavior symptoms negatively affect the quality of life of a resident/residents, a team approach is required. . . . Care planning is developed and implemented to maximize the resident's potential to function in a least restrictive environment. Procedures . . . 3. The care plan should be updated to address the change in behavior. . . . 4. Behavior charting will be established by Social Services or Nursing to establish target behavior symptoms for baseline data. All caregivers should be informed of target behaviors symptoms to help identify antecedents [factors that occur just prior to the negative behavior] and implement approaches designed to decrease the negative behavior. Report and Neighborhood notebooks can be used to pass along this information. The CNAs [certified nursing assistants] and/or charge nurses will document the frequency of the behavior, interventions tried and the success of those interventions. . . ."<br><br>- Review of Resident #9's medical record occurred on all days of survey and identified a diagnosis of anxiety. The annual Minimum Data Set (MDS), dated 12/25/15, identified the resident exhibited moderate depression and no behaviors.<br><br>Review of Resident #9's interdisciplinary notes between 08/21/15 and 12/24/15 identified threats made to Resident #9 by Resident #12 and failure of the facility to address the behaviors. | F 250 | the behavior. This policy also has examples of challenging behaviors and behavioral intervention tips. Staff education to include behavior identification/intervention, care planning, and use of the Social Service Referral form will be provided at the Nurse/CNA meeting held on Wednesday, August 10, 2016 and Thursday, August 11, 2016 and at the General Staff meeting held on August 17, 2016.<br><br>Audits:<br><br>1. Social Services will review the interdisciplinary notes weekly for the next four (4) weeks for all residents to capture new behaviors and interventions. This plan will continue to be monitored twice (2) a month for five (5) months and then monthly for the following six (6) months. We will then make sure they have been addressed in the residents care plan. (See exhibit Soc 250-1)<br><br>2. The Director of Social Services or designee will review a random sample of care plans one (1) time per week for four (4) months and every other week for (3) months to assure the interventions are appropriate. (See exhibit Soc 250-4)<br><br>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 250 | Continued From page 6<br>Review of Resident #12's medical record occurred on July 13-14, 2016.<br>Diagnoses included dementia with behavior disturbances. The annual MDS, dated 12/29/15, identified Resident #12 cognitively intact with verbal behaviors that impacted other residents. Resident #12's current care plan stated, ". . . I like to cause problems amongst the staff and other residents at times. . . . " with no approaches.<br><br>Review of Resident #12's interdisciplinary notes stated the following:<br>* 09/01/15 at 10:56 p.m.: ". . . states 'You better get me outta here or I'm gonna go nuts.' . . ."<br>* 09/27/15 at 10:39 a.m.: "Resident [Resident #12] behaviors have not been observed by staff, however residents were grouped together in Harvest entry area next to nurses office discussing continued complications with this resident [Resident #12]. Concerns verbalized, and date of events unclear. Residents involved encouraged to talk to [name of social workers]. . . ." The record lacked evidence this occurred.<br>* 09/28/16 at 9:37 a.m.: "Resident in foul mood this am . . ."<br><br>Review of the nurse practitioner notification letters identified the following altercations with other residents in addition to the above mentioned altercations with Resident #9:<br>* 08/21/15 : ". . . I learned today that [Resident #12] has been having problems with a resident in her wing. I was called to this resident's rooms because she was in tears over an event that happened this morning. Resident described that she was in her room, sitting in her recliner, when [Resident #12] walked up to her door. She stood | F 250 | committee.<br><br>All audits will begin the week of August 1, 2016.<br><br>Corrective action completion date: August 18, 2016 | |

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| F 250 | Continued From page 7 | F 250 | | |

there, shaking her finger at this other resident and told her 'you're going to suffer one day'. She then continued on down the hall. This resident stated that she didn't understand why [Resident #12] hater [sic] her so, that she hardly knew the women. When asked if there had been other incidents, the resident went on to describe how [Resident #12] sits by herself, at a table of her own, in the dining room, but her place setting faces toward this resident's table. She stated that [Resident #12] often will look at her and scowl, sometimes shaking her finger at her. . . .
Yesterday, resident reported that [Resident #12] almost ran into her coming out of the dining room, and that [Resident #12] had accused her of trying to run over her toes. A resident who witnessed the incident said that it almost appeared as if [Resident #12] had tried to run into the other resident. . . . [Resident #12] continues to ask me to move her back to her old room. Although one of the resident [sic] she was terrorizing there is deceased now, the gentlemen she was stalking still lives in that area. . . .
[Resident #12] seems to have the need to bully others, . . ."
The nursing progress notes on this date at 11:23 p.m. stated, "No mood/behaviors noted or reported this evening."
* 01/07/16: ". . . She continues to verbally abuse/attack certain resident periodically, the most recent occurrence taking place on 12/23. . . ."
The nursing progress notes for 12/23/15 at 11:02 p.m. stated, ". . . reported that resident used vulgar language towards residents in [two room numbers listed] while passing rooms. . . ."
* 02/08/16: ". . . On Friday, 2/5/16, staff documented that she was walking down the hall

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| F 250 | Continued From page 8<br>with another resident (male) to the dining room and she was yelling at him. . . . The C.N.A. asked her to calm down and [Resident #12] scratched her. The C.N.A. opened the doors to the dining room and asked the male resident to go inside. The C.N.A. went on to state that she went into the dining room after the incident and [Resident #12] was screaming and swearing at other residents. . . ."<br><br>During an interview on 07/13/16 at 2:05 p.m., an administrative staff member (#6) stated the facility failed to place measures for Resident #9 and Resident #12. The administrative staff member (#6) stated she notified the nurse practitioner to implement medication changes for Resident #12's behaviors, but no changes were made.<br><br>The facility failed to address the behaviors between Resident #9 and #12, identify the underlying causes of the behaviors, implement effective interventions to manage conflict between Resident #9 and #12, and review/revise interventions as needed to prevent future behaviors. These failures resulted in repeated altercations between Resident #9, and threats against other residents which placed all residents at risk of abuse. | F 250 | | |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. | F 278 | | 8/18/16 |

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| F 278 | Continued From page 9<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 7 of 14 sampled residents (Resident #1, #3, #5, #6, #7, #10 and #14). Failure to accurately complete portions of the MDS, Section H (Bowel Toileting Program) (Resident #1, #3, #5, #6, #7 and #14), Section H (Urinary Toileting Program) (Resident #5 and #14), and Section E (Behaviors) (Resident #10 and #14), does not allow each | F 278 | On 7-29-16 a Memo was distributed to all Neighborhoods with Subject title: Bowel and Bladder Toileting Schedules. (See Exhibit Nsg 278-1). Residents #1, #3, #5, #6, #10 and #14 will be reevaluated for appropriate toileting programs by implementing a new toileting trial starting on 8/1/16. Resident #7 is non-weight bearing and not appropriate for toileting schedule. The care plan has been updated for resident #7. On 8-4-16 Nurse Manager will review results of toileting trial and determine the appropriate | |

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| F 278 | Continued From page 10<br>resident's assessment to reflect the resident's current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and to affect the care provided to all residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, page 2-1 states, ". . . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident . . ." Chapter 3, page H-5 states, ". . . Look for documentation in the medical record showing that the following three requirements have been met:<br>* implementation of of an individualized, resident specific toileting program that was based on an assessment of the resident's unique voiding pattern<br>* evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report<br>* notations of the resident's response to the toileting program and subsequent evaluations, as needed."<br>Chapter 3, page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice . . ."<br>Chapter 3, page H-12 states, ". . . Look for documentation in the medical record showing that the following three requirements have been met:<br>* implementation of of an individualized, | F 278 | toileting program for these residents. Policy implemented titled; Conducting an Accurate Resident Assessment. (See Exhibit Nsg 278-2) MDS's for Residents #10 and #14 will have corrections in Section C-Re: Delusions and be resubmitted on 8/11/2016.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>Review and updates to the Bladder Assessment Policy (See Exhibit Nsg 278-3) and Bowel Assessment Policy (See Exhibit Nsg 278-4) were completed. An in-service education program for nursing service staff on these policies will be conducted by the Director of Nursing Services or designee on August 10th and August 11th, 2016. Review of Conducting an Accurate Resident Assessment policy (See Exhibit Nsg 278-2) will be completed with the Multidisciplinary MDS Staff on August 1, 2016.<br><br>1. Education on behaviors including delusions will be completed at the Nursing Service Staff meeting on August 10, 2016 and August 11, 2016.<br><br>2. Behavior documentation tool will be located at each charting kiosk and report book (See exhibit Nsg 278-6<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits for accuracy with coding section H and | |

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| F 278 | Continued From page 11<br>resident specific bowel toileting program based on an assessment of the resident's unique bowel pattern<br>* evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report<br>* notations of the resident's response to the toileting program and subsequent evaluations, as needed."<br>Chapter 3, page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for:<br>* the development of an individualized care plan<br>* the Medicare Prospective Payment System<br>* Medicaid reimbursement programs<br>* quality monitoring activities . . .<br>* the data-driven survey and certification process<br>* the quality measures used for public reporting<br>* research and policy development."<br>*Chapter 3 Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it | F 278 | section E of the MDS and care plans reflecting the resident current status/needs. Audits will be completed prior to MDS submission weekly for four (4) weeks, twice a month for 5 months, monthly for 6 months (See exhibit Nsg 278-5)<br>Audit records will be reviewed at the quarterly QAPI committee meetings until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin July 25, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 278 | Continued From page 12 | F 278 | | |

as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion."

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included disorder of the kidney and ureter and retention of urine. A quarterly MDS, dated 05/08/16, indicated the resident had an indwelling catheter in place and on a bladder and bowel toileting program. The current care plan stated, " . . . I am on an Individualized Bowel Program at 10 am, 1 pm and as needed. Please help me with good cath[catheter] cares . . ."

Observation on July 12-13, 2016, showed staff failed to toilet Resident #5 at or near 10:00 a.m. as identified on his individual bowel program.

During an interview on 07/13/16 at 11:30 a.m. a nurse manager (#5) stated Resident #5 would not qualify for a toileting plan due to having a foley catheter and she would expect staff to toilet Resident #5 as stated in his bowel program.

- Review of Resident #14's medical record occurred on July 13-14, 2016. Diagnoses included Alzheimer's disease and dementia. A quarterly MDS, dated 05/12/16, identified the resident on a urinary and bowel toileting program and exhibited delusional behavior during the seven day look back period.

The CNA charting identified the following times to toilet Resident #14: 12 a.m., 2 a.m., 4 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m., and 10 p.m.

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| F 278 | Continued From page 13<br><br>During an interview on the afternoon of 07/14/16 an administrative nurse (#1) confirmed Resident #14 is not on an individualized bowel and bladder toileting program.<br><br>The nursing progress notes stated, 05/04/16, "Weekly Summary: Cognition is moderately to severely impaired. Had disorganized thinking at times. Frequently looks for spouse and wants to know if he has been here. . ."<br><br>During an interview on 07/14/16 at 10:07 a.m., a social service staff member (#6) stated she based Resident #14's delusional behavior from the above charting and failed to correctly interpret it.<br><br>- Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 05/24/16, indicated frequent bowel incontinence and on a bowel toileting program.<br><br>The facility provided a toileting flowsheet, completed from 02/25/16 to 03/02/16, used to determine Resident #6's toileting programs. The flowsheet indicated urine incontinence seven times in seven days, but no bowel incontinence. An undated care plan problem stated, "Bowel and Bladder Patterning and plans" with an approach to toilet the resident at "2 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., and 11 p.m."<br><br>The facility failed to develop an individualized bowel toileting program, or consider whether a bowel toileting program was necessary based on the above toileting flowsheet indicating no bowel incontinence at the time staff completed the | F 278 | | |

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| F 278 | Continued From page 14 | F 278 | | |

flowsheet.

- Review of Resident #7's medical record occurred on all days of survey. The quarterly MDS, dated 04/14/16, indicated the resident as frequently incontinent of bowel and on a bowel toileting program. The annual MDS, dated 08/07/15, indicated the resident continent of bowel and on a bowel toileting program.

The facility provided a toileting flowsheet, completed from 04/23/14 to 04/30/14, used to determine Resident #7's toileting programs. The flowsheet indicated frequent urine incontinence, and bowel incontinence during one of six bowel movements. An undated care plan problem stated, "Bowel and Bladder Patterning and plans" with an approach to toilet the resident at "2 a.m., 8 a.m., 12 p.m., 4 p.m., 7 p.m., and 10 p.m."

The facility failed to develop an individualized bowel toileting program, separate from the bladder toileting program.

- Review of Resident #1's medical record occurred on all days of survey. The annual MDS, dated 04/29/16, indicated frequently incontinent of bowel and on a bowel toileting program.

The facility provided the last toileting flowsheet, completed from 06/09/14 to 06/13/14 [two years old], used to determine Resident #1's toileting programs. The flowsheet indicated frequent urine incontinence, and bowel incontinence during four of six bowel movements. An undated care plan problem stated, "Bowel and Bladder Patterning and plans" with an approach to toilet the resident at "2 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2

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| F 278 | Continued From page 15<br>p.m., 4 p.m., 6 p.m., 8 p.m., and 9 p.m."<br><br>The facility failed to develop an individualized bowel toileting program, separate from the bladder toileting program.<br><br>- Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 06/29/16, indicated bowel continence and on a bowel toileting program.<br><br>The facility provided a toileting flowsheet, completed from 04/12/16 to 04/18/16, used to determine Resident #3's toileting programs. The flowsheet indicated frequent urine incontinence, and bowel incontinence during three of six bowel movements. An undated care plan problem stated, "Bowel and Bladder Patterning and plans" with an approach to toilet the resident at "12 a.m., 5 a.m., 9 a.m., 2 p.m., 6 p.m., and 9 p.m."<br><br>The facility failed to develop an individualized bowel toileting program, separate from the bladder toileting program.<br><br>During an interview on 07/13/16 at 11:25 a.m., a nurse manager (#5) agreed the facility developed the bowel toileting programs based on the same seven-day toileting assessment for bladder incontinence, the program was not individualized according to the residents' bowel habits, and should not be coded on the MDS.<br><br>- Review of Resident #10's medical record occurred on all days of survey. The quarterly MDS, dated 04/23/16, indicated the resident experienced delusions. | F 278 | | |

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| F 278 | Continued From page 16<br>Resident #10's departmental notes, dated 04/21/16 at 4:36 p.m., stated, "Assisted resident in placing a telephone call to his wife, he was insistent she was in this building." The record lacked evidence staff provided the resident a reasonable alternative explanation and whether the resident continued to believe his wife was in this building.<br><br>During an interview on 07/13/16 at 10:25 a.m., a social services staff member (#6) stated Resident #10 continued to believe his wife was at the facility even after this staff member called the wife and confirmed she was not at the facility. The staff member (#6) stated she failed to document the resident's response and continued delusion as required to code delusions on the MDS. | F 278 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of | F 280 | | 8/18/16 |

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| F 280 | Continued From page 17<br>qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the care plan for 6 of 14 sampled residents (Resident #3, #6, #7, #9, #10 and #12). Failure to revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled "CARE PLAN POLICY" occurred on 07/14/16. This policy, dated 09/11/15, stated, ". . . 5 . . . Review of care plans by individual members is expected to occur at the time of the quarterly care conference and on an ongoing basis as the resident's condition changes so that additions or deletions can be made . . ."<br><br>- Review of Resident #3's medical record occurred on all days of survey. The "Paid Feeding Assistant Assessment" dated 05/25/16 identified a paid feeding assistant cannot feed Resident #3.<br><br>The care plan stated, ". . . A PFA [paid feeding assistant] can assist me with eating if needed. . . ."<br><br>The facility failed to update the care plan to | F 280 | The care plans for the identified 6 residents (#3, #6, #7, #9, #10, and #12) were updated to reflect changes needed. (See exhibit Soc 280-1)<br><br>All residents of the facility have the potential to be affected by this practice.<br><br>The interdisciplinary care plan team will be updating care plans into the new format starting the week of August 1, 2016 with each residents quarterly MDS and any new admissions. (See exhibit Soc 280-2). The Charge Nurse will review the care plan weekly and update as needed.<br><br>Review of the Care Plan Policy (See exhibit Soc 280-3) will be at the Nurse/CNA meeting held on Wednesday, August 10, 2016 and Thursday, August 11, 2016 and at the General Staff meeting on Wednesday, August 17, 2016.<br><br>Audits will be completed weekly for the next four (4) weeks on random care plans to ensure they are reviewed and updated timely. This plan will continue to be monitored twice (2) a month for five (5) months and then monthly for the following six (6) months. (See exhibit Soc 280-4) | |

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| F 280 | Continued From page 18<br>reflect Resident #3's current needs.<br><br>- Review of Resident #6's medical record occurred on all days of survey. Observation throughout the survey showed the resident wore glasses and ambulated with one assistance and a gait belt, and at times transferred and ambulated per self without calling for assistance.<br><br>Resident #6's current care plan stated, "I need extensive staff assistance with all of my ADL's [activities of daily living] including . . . transfers, ambulation . . . Problem: Self-Care Deficit . . . Interventions . . . Standby assist PRN [as needed] with ambulation (5/16/16) . . . Problem: Alteration in mental status . . . Interventions: . . . Structured walker 3x [times] daily . . . "<br><br>Resident #6's care plan failed to identify the resident wore glasses and contained conflicting interventions related to ambulation.<br><br>- Review of Resident #7's medical record occurred on all days of survey. Observation throughout the survey showed an air mattress on the resident's bed.<br><br>Resident #7's current care plan stated, ". . . I am on a turning and repositioning schedule because I'm not able to move around as I should. . . ." The care plan lacked the intervention of an air mattress.<br><br>- Review of Resident #10's medical record occurred on all days of survey. Observation throughout the survey showed a motion sensor by the bed, the resident ambulated/transferred with a walker and assistance of one staff, had a | F 280 | Audits to begin the week of August 1, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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pressure ulcer to the right 2nd toe, and wore Pedore (special wide-toe) shoes.

Resident #10's current care plan stated, ". . . I can walk with 4WW [four wheeled walker] independently . . . I am at risk for falling [record showed multiple falls in past 6 months]. . ." The care plan failed to include the motion sensor, assistance with ambulation, pressure ulcer, and special shoes.

During an interview on the afternoon of 07/14/16, an administrative nurse (#1) confirmed the staff's failure to update or revise Resident #6, #7, and #10's care plans with the above issues.

- Review of Resident #9's medical record occurred on all days of survey. Review of the interdisciplinary progress notes indicated the resident was fearful of another resident's behaviors toward her from August 2015 to December 2015.

The resident's current care plan failed to identify the history of resident to resident verbal behaviors and/or altercations.

- Review of Resident #12's medical record occurred on July 13-14, 2016. Diagnoses include dementia with behavior disturbances. The annual MDS, dated 12/29/15, identified Resident #12 to be cognitively intact with verbal behaviors that impacted other residents. Review of Resident #12's medical record indicated the resident was verbally abusive towards other residents.

Resident #12's current care plan stated, ". . . I like to cause problems amongst the staff and

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| F 280 | Continued From page 20<br>other residents at times. . . ." The care plan failed to identify interventions for Resident #12's verbal abuse and behaviors toward other residents.<br><br>During an interview on the afternoon of 07/13/16, an administrative nurse (#6) confirmed the staff's failure to update or revise Resident #9 and #12's care plans with the above issues. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow proper standards of practice regarding 3 of 8 observations of medication administration. Failure to stay with the resident while administering their medications and pre-dishing multiple residents' medications does not ensure the safety of the resident or of other residents taking the medication and does not reflect the current standards of practice for medication administration.<br><br>Findings include:<br><br>Review of facility policy, titled, "Self Administration of Medications" occurred on 07/13/16. This policy, revised 05/21/15, stated, ". . . Each resident . . . has the right to self administer their own medication. Residents will be evaluated by the Interdisciplinary Care Team, and determined whether they are physically and | F 281 | Resident #18 received an order from the physician updating his medical record to reflect that it is acceptable to disguise medications in his food/drink. Communication done via shift report and email, that staff are not to leave unattended medications with resident on 7/27/16.<br><br>Education will be provided to nurses and CMAs on making note of the indication of self-administration of medications on the EMAR screen and/or care plan for each resident prior to giving medications, no prefilling of medications for multiple residents, and no medications will be left unattended.<br><br>The facility has determined that all residents have the potential to be affected. | 8/18/16 |

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| F 281 | Continued From page 21<br>cognitively capable of self-administration of medication. . . ."<br><br>Review of facility policy, titled, "Pharmacy Services: Medication Administration-General Guidelines" occurred on 07/14/16. This policy, revised April 2014, stated, ". . . Medications are administered at the time they are prepared. Medications are not pre-poured. . . . Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with facility procedures for self-administration of medications. . . . The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate. . . ."<br><br>- Review of Resident #18's medical record occurred July 12-14, 2016. Medications included Metoprolol Tartrate (blood pressure medication) 25 MG (milligram) TAB (tablet) PO (by mouth) BID (twice a day). The physician's orders failed to The "Competence to Self Administer Medication Assessment", dated 05/04/16, identified, ". . . No, Resident is NOT competent to self administer Medication. . . ." Resident #18's "Request for designation of guardian and protective services", dated 01/28/2016, stated, ". . . [physician name] Certainly concur that the patient is not capable to make specific rational decisions regarding his care and medical decisions. . . ."<br><br>Observation on 07/12/16 at 12:04 p.m., showed a certified medication assistant (CMA) (#9) crushed a Metoprolol Tartrate 25 mg tablet, disguised the medication inside a cup of ice cream, poured chocolate syrup on the top, and replaced the lid. | F 281 | An in-service education program on the facility□s current policy for resident self-administration of medications (See exhibit Nsg 281-1) and on the current policy of Medication Administration□General Guidelines (See exhibit Nsg 281-2) will be conducted by the Director of Nursing Services or designee on August 10,2016 and August 11, 2016.<br><br>The Director of Nursing Services, or designee, will conduct a random medication pass audit (See Exhibit Nsg 281-3) of one CMA/nurse weekly for (4) weeks, then two CMA/nurse monthly for (3) months, then one CMA/nurse monthly for 6 months to ensure compliance with facility guidelines.<br><br>This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin August 6, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 281 | Continued From page 22<br>The CMA (#9) left the ice cream cup in Resident #18's room on his bedside table and left the room. At 12:30 p.m. an empty ice cream cup was observed on a bedside table located in the hallway outside Resident #18's room. The CMA (#9) failed to stay with the resident to ensure he ate all of the ice cream with the medication.<br><br>During an interview on 07/12/16 at 12:05 p.m., the CMA (#9) stated Resident #18 will only take his medications if he is left alone.<br><br>- Observation on 07/13/15 at 4:30 p.m. showed a CMA (#11) in the hallway holding four medication cups in her hands. The CMA (#11) took the four prefilled cups into the rooms of Resident #8, #19, #20, and #21 to administer the medications.<br><br>- Observation on 07/14/16 at 9:27 a.m., showed two prefilled medications cups labeled with resident's names sitting on the medication cart top with no one attending the cart.<br><br>During an interview on 07/13/16 at 5:25 p.m., an administrative nurse (#1) stated she expected medications to be administered to one resident at a time. | F 281 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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 | | 8/18/16 |

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| F 309 | Continued From page 23<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to adequately assess a fall for 1 of 3 closed resident records (Resident #17) reviewed. Failure to complete a thorough assessment following the fall, which resulted in bilateral pelvic fractures, prior to moving Resident #17, and implement actions based on that assessment may result in further bone damage and increased pain. Failure to inform the emergency room [ER] physician of Resident #17's fall and possible head injury may result in improper treatment and/or follow-up.<br><br>Findings include:<br><br>Review of the facility policy titled "Fall Management Program" occurred on 07/14/16. This policy, dated 06/04/15, stated, ". . . C. Post Fall Guidelines 1. . . . a. The nurse will assess and document on the resident post-fall including . . . ii. Inspection for bruises, swelling, and lacerations . . . iii. Level of consciousness iv. Presence of pain-determine if new pain or chronic pain exacerbation (if able) v. Presence of other injuries . . ."<br><br>Review of Resident #17's medical record occurred on July 13-14, 2016. Diagnoses included Alzheimer's disease and dementia. An addition to the diagnoses list on 02/28/16 included bilateral fractured pelvis.<br><br>Review of a quarterly Minimum Data Set (MDS), dated 11/29/15, identified short-term and long-term memory problems, and extensive | F 309 | N/A closed record review.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>An in-service education program for licensed nurses on the facility□s current policy for Fall Management (See exhibit Nsg 309-1) and Transfer of a Resident After a Fall (See exhibit Nsg 309-2) will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016. IDT reviews all falls weekly with a more in-depth review of events with injury on a regular basis to ensure appropriate assessment, actions, and communication occurred.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits of falls with injury and transfer to ER visits to ensure adequate communication of event is provided and documented weekly for four (4) weeks, twice a month for 3 months, monthly for 8 months (See exhibit Nsg 309-3)<br><br>Audit records 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 309 | Continued From page 24<br>assistance of two or more persons for transfers. A significant change MDS, dated 02/29/16, identified short-term and long-term memory problems, and extensive assistance of one person required for transfers.<br><br>Progress notes identified the following:<br>* 02/28/16 at 7:10 p.m.: "This nurse was summoned to the dinning [sic] room after supper because resident was having difficulty breathing and was shaking. Resident exhibited seizure like symptoms. Resident had repetitive jerking movemnets [sic], muscle stiffness, and a brief loss of consciousness. Resident seemed to regain her concisiousness [sic] this nurse attempted to to [sic] transport resident to her room to get access to her oxygen when fell off her wheel chair. Resident was given oxygen at 2 litres [sic] per minute [local] ambulance service was contacted and given resident condition. Resident family was contacted by phone and approved resident to be taken to ER [emergency room]. Resident was transported to [local hospital] by [local] ambulance service at 1815 [6:15 p.m.]. [Name of doctor] was contacted by phone and updated on the resident condition. Vital signs @ 1800 [at 6:00 p.m.]: BP [blood pressure] 128/75, P [pulse] 82, R [respirations] 19, T [temperature] 98.1."<br>The progress note did not identify the time of the fall, the specific assessment of the resident after the fall, what contributed to the fall and the method utilized to assist the resident off the floor.<br>* 02/28/16 at 9:59 p.m.: "Resident back from [local hospital transported by local ambulance] @ 2130 [at 9:30 p.m.] with diagnosis of L & R [left and right] pelvis fracture and with orders as follows: - Fentanyl patch 25 mcg [micrograms] | F 309 | Audits will begin August 1, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 309 | Continued From page 25<br>every 72 hours - Not to be up in wheel chair - Foley catheter to gravity if necessary"<br>* 02/28/16 at 10:07 p.m.: "Body assessment completed. Resident has bruises to the forehead and the left elbow. Resident whines/moans when turned to sides medicated with prn [as needed] tylenol 650 mg [milligrams]. Neurological indicators within normal limit. Lung sounds clear. Vital signs: BP 125/71, T 97.1, P 98, R 24, O2 [oxygen] sat [saturations] 93 on 2 LPM [liters per minute]."<br>* 02/29/16 at 6:35 p.m.: "Fall Follow Up: Bed bound as ordered. Neurological assessment findings: Resident's pupils do not respond to light, lt eye pupil size is 2, rt eye pupil size is 3. resident responds to verbal stimuli, however speech is non sensical, unable to [perform] bilateral upper and lower extremity strength test due to resident not responding to commands/instructions. Resident is repositioned q [every] 2 hours. Except for the eye assessment, (this writer is unclear of previously noted baseline- resident does not open eyes completely and attepmts [sic] to hold the eyelids closed during cares) the neurological assessment noted today is not different from previously noted baseline for resident. Non verbal pain scale total is 8, facial grimacing and moaning noted at rest during repositioning resident crys out in pain. Fentanyl 25 mcg patch is in place, and Tylenol suppository administered Q4 hours PRN, Resident has voided 2 x [two times] this shift- incontinent in brief, scant stool noted. Resident refused breakfast, however at [sic] lunch well. Facial abrasions noted to nose and forehead. No additional injury assessed. . . ."<br>The nurse failed to verify what the baseline neurological assessment was for Resident #17 to | F 309 | | |

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| F 309 | Continued From page 26<br>determine if any changes had occurred since the previous assessment.<br>* 02/29/16 at 9:59 p.m.: "Remained in bed on bedrest as ordered. Tylenol suppositories given q4 hrs. [hours] to help control pain. Moans and cries out when attempting to reposition and when attempting cares. . . ."<br>* 03/01/16 at 11:09 a.m.: "Order received to have hospice consult with dx [diagnosis] of end stage dementia and B) [bilateral] pelvis fx. [fracture]. Increase fentanyl patch to 50 mcg and change Q72 hours."<br>* 03/01/16 at 12:54 p.m.: ". . . No new injuries noted at this time. Resident in bed all shift d/t [due to] (B) pelvic fx's. Resident restless at times. Resident receives scheduled Fentanyl as ordered. . . . Resident received PRN Tylenol Suppository per MAR [medication administration record] for temperature [99.7], and was effective. Temperature is currently 98.1."<br>* 03/01/16 at 1:12 p.m.: "Resident to be admitted to Hospice services on 3-2-16 at 11am."<br>* 03/04/16 at 10:53 a.m.: "Falls committee review: fall on 2/28/16, fell forward out of WC [wheelchair], had seizure activity prior to fall, sent to ER, returned with Fx Lt & Rt pelvis. On bedrest, admit to Hospice Services 3/2/16, care and comfort measures."<br>The review failed to include a thorough investigation of the fall, determine contributing factors and develop and implement fall prevention strategies.<br>* 03/04/16 at 11:50 a.m.: ". . . Hospice notified of resident death."<br><br>Review of the "TRANSFER FORM" stated, "Resident had seizure after supper and then became unresponsive." Review of the | F 309 | | |

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| F 309 | Continued From page 27<br>"Notification of Transfer For Hospitalization, Therapeutic Leave & Bed Hold" stated, "Seizure like symptoms, difficulty breathing, unresponsive."<br>The transfer form lacked information regarding Resident #17's fall including that the resident had sustained an injury/bruise to the head.<br><br>The ER report did not indicate the physician had knowledge of a potential head injury.<br><br>During an interview on 07/14/16 at 1:27 p.m., an administrative nurse (#1) stated she interviewed the nurse who reported Resident #17 slumped forward in her wheelchair and he stated he was unable to stop her from falling. The administrative nurse (#1) stated she lacked information including how the resident landed on the floor, how staff transferred her off of the floor, and if the wheelchair had foot pedals on it at the time of the fall.<br><br>During an interview on 07/14/16 at 1:46 p.m., an administrative nurse (#1) stated the facility did not interview a second staff member who witnessed the fall.<br><br>The facility failed to ensure communication/follow-up following Resident #17's fall including the potential of a head injury to the transferring facility/ER. The facility failed to provide a thorough description of the extent of injury to ensure proper treatment occurred in the ER. | F 309 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a | F 314 | | 8/18/16 |

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| F 314 | Continued From page 28<br>resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to prevent the development/deterioration of pressure ulcers for 1 of 3 sampled residents (Resident #5) with a current pressure ulcer. Failure to consistently implement interventions, and provide timely and appropriate dressing changes may result in worsening pressure ulcers or the development of new ulcers.<br><br>Findings include:<br><br>Review of the facility policy titled "Pressure Ulcer/Wound Care Policy" occurred on 07/14/16. This policy, dated June 2015, stated, " . . . Residents having pressure ulcers will receive necessary treatment and services to promote healing and to prevent infection. . . . The resident's care plan will be reviewed and revised as needed based in assessment and treatment."<br><br>Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Type 2 Diabetes, arthritis and a pressure ulcer to the left buttock. The resident's Minimum Data Set, dated, | F 314 | Care plan updated for Resident # 5 to show individualized wound care on 7-28-2016 by wound nurse.<br><br>The facility has determined that anyone with a current pressure ulcer is at risk.<br><br>An in-service education program on the facilities current policy for Wound and Pressure Ulcer Policy which addresses specific orders will be obtained by MD and followed by professional nursing staff (See exhibit Nsg 314-1 revised)and Clean Dressing Change Procedure (See exhibit Nsg 314-2 revised) will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016. Education on repositioning residents will be passed through report and provided at nursing department meetings August 22-25, 2016. (See exhibit Nsg 314-4 revised). Care plans will include repositioning plans appropriate to individual needs.<br><br>The Director of Nursing Services (DNS), | |

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| F 314 | Continued From page 29<br>05/08/16 identified extensive assistance of one staff member for bed mobility, transfers and toileting. The current care plan stated, " . . . I have a pressure sore on my [lower] buttock that my nurses care for and are monitoring. . . ." The physicians orders stated, " . . . 04/22/16 - hydrogel gauze covered with boarder foam to [left] buttock daily and prn [as needed]."<br><br>Review of nursing progress notes identified the following measurements of Resident #5's left lower buttock pressure ulcer:<br>* 04/27/16 - 3 centimeters (cm) x 2.7 cm<br>* 05/12/16 - 3 cm x 2.8 cm<br>* 05/15/16 - 3 cm x 2.9 cm<br>* 06/11/16 - 4 cm x 3 cm<br>* 06/15/16 - 2.9 cm x 2.9 cm<br>* 06/19/16 - 1 cm x 1 cm<br><br>Observation on 07/11/16 at 3:02 p.m. showed a CNA (certified nursing assistant) (#8) provided perineal cares to Resident #5 after an incontinent bowel movement (BM). The CNA removed the dressing from the pressure ulcer as it contained BM. The pressure ulcer was approximately 1 cm x 1 cm in size. A licensed nurse (#7) applied a dressing to the pressure ulcer. This nurse stated she applied a mepilex dressing (a foam dressing). Staff failed to use the hydrogel gauze and cover with the boarder foam as ordered by the physician.<br><br>Observation on 07/12/16 at 7:45 a.m. showed Resident #5 in a wheelchair eating breakfast. Resident #5 remained in this wheelchair until approximately 12:30 p.m. when a CNA (#8) reported she toileted Resident #5 and assisted him to bed using the sit to stand lift. Staff failed to | F 314 | or designee, will complete random audits monitoring repositioning of residents necessary with pressure ulcers, care plans to reflect any necessary repositioning for resident with pressure ulcers,and wound and pressure ulcer care three times weekly for four (4) weeks, weekly for eight (8) weeks, every other week for three (3) months, monthly for 6 months (See exhibit Nsg 314-3 revised)<br><br>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin August 6, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 314 | Continued From page 30 | F 314 | | |

reposition Resident #5 for approximately five hours.

Observation on 07/12/16 at 4:27 p.m. showed a CNA (#10) provided perineal cares to Resident #5 after an incontinent BM. After providing perineal care, the CNA removed the dressing covering the pressure ulcer as it contained BM. The CNA (#10) notified the licensed nurse (#7) to apply a new dressing. The licensed nurse informed the CNA (#10) she was busy and not able to replace the pressure ulcer dressing. The CNA used the sit to stand lift and assisted Resident #5 into the wheelchair. At 5:38 p.m. staff wheeled Resident #5 into the dinning room with no dressing on the pressure ulcer.

During an interview on 07/13/16 at 11:01 p.m. a licensed nurse (#7) informed the surveyor on 07/12/16 after supper, the on-coming nurse applied the dressing to Resident #5's pressure ulcer. The medical record lacked documentation of the dressing change. The licensed nurse (#7) confirmed on 07/11/16 she applied a mepilex dressing and not a hydrogel gauze covered with boarder foam as ordered.

Observation on 07/13/16 at 7:45 a.m. showed Resident #5 in a wheelchair eating breakfast. Resident #5 remained in this wheelchair until 12:39 p.m. when an unidentified CNA reported she toileted the resident and assisted the resident into bed. Staff failed to reposition Resident #5 for approximately five hours.

During an interview on 07/14/16 at 09:10 a.m. an administrative nurse (#1) stated she expected staff to reposition Resident #5 every two hours

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| F 314 | Continued From page 31<br>when in the wheelchair, to apply dressings as ordered and replace the pressure ulcer dressing immediately when notified. | F 314 | | |
| F 315 SS=E | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure 6 of 8 sampled residents (Resident #1, #3, #6, #7, #10, and #11) on a scheduled toileting program received appropriate care to restore as much normal bladder function as possible. Failure to assist residents to toilet as scheduled may result in increased episodes of urinary incontinence.<br><br>Findings include:<br><br>- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and history of urinary tract infection (UTI). The current care plan stated, ". . . I remain able to go to the bathroom with assistance and have occasional urinary incontinence and bowel incontinence. Please | F 315 | On 7-29-16 a Memo was distributed to all Neighborhoods with Subject title: Bowel and Bladder Toileting Schedules. (See Exhibit Nsg 315-1). Residents #1, #3, #6, #10 and #11 will be reevaluated for appropriate toileting programs by implementing a new toileting trial starting on 8/1/16. Resident #7 is non-weight bearing and not appropriate for toileting schedule. The care plan has been updated for resident #7. On 8-4-16 Nurse Manager will review results of toileting trial and determine the appropriate toileting program for these residents.<br><br>The facility has determined that all residents that have been identified as incontinent according to Section H of the | 8/18/16 |

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| | 355053 | A. BUILDING _____ B. WING _____ | 07/14/2016 |

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| KNIFE RIVER CARE CENTER | 118 22ND ST NE BEULAH, ND 58523 |

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| F 315 | Continued From page 32<br>follow my toileting schedule . . ."<br><br>The facility completed a seven-day toileting assessment on 03/03/16 and care planned Resident #6's toileting schedule as "2 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., and 11 p.m."<br><br>Observation on 07/12/16 showed staff toileted Resident #6 at 12:09 p.m., but did not document the voiding until 2:34 p.m. The staff failed to toilet Resident #6 at 2 p.m. and 4 p.m.<br><br>When asked about Resident #6's toileting schedule during an interview on 07/12/16 at 12:20 p.m., a certified nurse aide (CNA) (#13) stated, "We don't wake her when asleep [to toilet] as she wanders all night then, we wait until we hear her bed alarm go off and then assist her to the toilet. I check on her about every hour and ask if she has to go to the bathroom, and she usually says yes and does go well."<br><br>Review of Resident #6's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during one to three of the scheduled toileting times every day, and the resident was incontinent on seven occasions.<br><br>- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia. The current care plan stated, ". . . I require extensive assistance of staff with my ADL's [activities of daily living] including . . . toileting . . . I am frequently incontinent of both bladder and bowel . . . I do have a toileting schedule to help me maintain my continence. . . ." | F 315 | MDS have the potential to be affected.<br><br>Review and updates to the Bladder Assessment Policy (See Exhibit Nsg 315-2), Bowel Assessment Policy (See Exhibit Nsg 315-3) Toileting Programs procedure (See Exhibit Nsg 315-4) were completed. All residents on a toileting schedule will be reviewed for any needed changes. Communication to staff regarding residents on a toileting schedule will be reviewed at shift report and be included on the CNA daily information worksheets. An in-service education program for nursing service staff on these policies/procedures will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits for accuracy of toileting schedules and care plans reflecting the resident current status/needs. Audits will be completed weekly for four (4) weeks, twice a month for 5 months, monthly for 6 months (See exhibit Nsg 315-5)<br>Audit records will be reviewed at the quarterly QAPI committee meetings until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin August 3, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 315 | Continued From page 33 | F 315 | | |

The facility completed a seven-day toileting assessment on 04/30/14, and care planned Resident #7's toileting schedule as "2 a.m., 8 a.m., 12 p.m., 4 p.m., 7 p.m., and 10 p.m."

Observation on 07/12/16 showed staff failed to toilet Resident #7 at 12 p.m. At 4:50 p.m. the resident refused the CNA's (#14) offer to toilet. The CNA checked the resident's brief and it was dry.

Review of Resident #7's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during three to five of the scheduled toileting times every day, and the resident was incontinent on 26 occasions.

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia. The current care plan stated, ". . . I do have occasional incontinence of both urine and bowel . . . I am on an individualized toileting schedule to help keep me dryer. Please toilet me per my toileting schedule. . . ."

The facility completed a seven-day toileting assessment on 09/25/15, and care planned Resident #10's toileting schedule as "3 a.m. and 5 p.m." in addition to the routine every two hours toileting.

Review of Resident #10's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during one or both of the scheduled toileting times every day, and the resident was incontinent on five occasions.

- Review of Resident #11's medical record

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| F 315 | Continued From page 34 | F 315 | | |

occurred on July 13-14, 2016. Diagnoses included edema. Medications included Lasix (diuretic) 80 milligrams twice daily. The current care plan stated, ". . . I need staff assistance of one with my ADL's including . . . toileting . . . I have an individualized toileting schedule to manage my urinary incontinence. Please toilet me per my schedule. . . ."

The facility care planned Resident #11's toileting schedule as "12 a.m., 6 a.m., 10 a.m., 1 p.m., 3 p.m., 5 p.m., and 9 p.m."

Review of Resident #11's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during three to five of the scheduled toileting times every day, and the resident was incontinent on seven occasions.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The current care plan stated, ". . . I am frequently incontinent of bowel and bladder and wear a brief at all times. I do have continent episodes on the toilet also. I am on an individualized toileting program . . ."

The facility completed a toileting assessment on 06/13/14 and care planned Resident #1's toileting schedule as "2 a.m., 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 6 p.m., 8 p.m., and 9 p.m."

Review of Resident #1's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during five to eight of the ten scheduled toileting times every day, and the resident was incontinent of urine on 30 occasions

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| F 315 | Continued From page 35<br>and incontinent of bowel on 12 occasions.<br><br>- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The current care plan stated, ". . . I have frequent bladder urge incontinence and have occasional incontinence of bowel. I wear a brief for protection. . . . I am on an individualized toileting program. . . ."<br><br>The facility completed a toileting assessment on 04/18/16 and care planned Resident #3's toileting schedule as "12 a.m., 5 a.m., 9 a.m., 2 p.m., 6 p.m., and 9 p.m."<br><br>Review of Resident #3's Bowel and Bladder flowsheet for July 01-13, 2016 showed staff failed to offer toileting during three to five of the six scheduled toileting times every day, and the resident was incontinent of urine on 15 occasions and incontinent of bowel on one occasion. | F 315 | | |
| F 318 SS=E | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure 5 of 7 sampled residents | F 318 | Education was provided to RT staff regarding appropriate therapy services | 8/18/16 |

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| F 318 | Continued From page 36<br>(Resident #3, #4, #5, #9, and #12) on a restorative therapy (RT) program received restorative nursing services. Failure to provide restorative therapy services as recommended did not provide the residents the opportunity to maintain their range of motion (ROM), balance, strength, and mobility.<br><br>Findings include:<br><br>- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included osteoarthritis.<br><br>The current physician's orders stated, "Restorative Therapy As Evaluated." The care plan stated, ". . . I have restorative therapy and/or restorative nursing programs to improve and/or maintain my strength, activity tolerance, mobility and functionality of ADL's. . . ."<br><br>A restorative therapy quarterly screen, dated 04/07/16 stated, "Res. [resident] participates in RT ROM [range of motion] & NA [nursing assistant] dining program 6-7 days/week for a minimum of 15 min/day [minutes per day] to maintain/increase activity tolerance and mobility to assist with ADLs [activities of daily living] and gait and to maintain/improve oral intake . . ."<br><br>A restorative therapy quarterly screen, dated 07/01/16, stated, "Resident participates in RT ROM 6-7 days/wk [week] for a minimum of 15 min./day to maintain activity tolerance to assist with ADLs, mobility and gait. Resident continues to benefit from active participation in this program." | F 318 | and documentation resident for each resident in a restorative program on 8/1/16. All residents in a restorative program will be reassessed. Restorative Programs reviewed and updated for residents # 3, 4, 5, 9, and 12. Quarterly Screen note updated in Electronic Health Record.<br><br>The facility has determined that all residents who participate in a restorative program have the potential to be affected.<br><br>Documentation education will be provided to the Restorative Therapy Coordinator. Regular review by RN and therapy to assure appropriate assessment and progress of goals are met.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits to monitor quarterly notes, appropriate goals, and frequency of treatment weekly for four (4) weeks, monthly for eleven (11) months (See exhibit Nsg 318-1)<br><br>Audits will begin August 10, 2016.<br><br>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 318 | Continued From page 37 | F 318 | | |

Review of the April 2016 through July 2016 RT documentation showed staff failed to consistently provide range of motion six to seven times a week as directed.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included arthritis.

The current care plan stated, ". . . I have restorative therapy and/or restorative nursing programs to improve and/or maintain my strength, activity tolerance, mobility and functionality of ADL's. . . ."

A restorative therapy quarterly screen, dated 05/10/16 stated, "Res. participates in RT ROM 6-7 days/wk for a minimum of 15 min/day to maintain/improve activity tolerance and joint mobility to assist with ADLs and transfers. Res. continues to benefit from participation in this program."

A restorative therapy quarterly screen, dated 07/08/16 stated, "Resident participates in RT ROM 6-7 days/wk for a minimum of 15 min./day to maintain/improve activity tolerance to assist with ADLs and transfers. Res. continues to benefit from this active participation in this program."

Review of the April 2016 through June 2016 RT documentation showed staff failed to consistently provide range of motion six to seven times a week as directed.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses

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| F 318 | Continued From page 38<br>included multiple sclerosis and paraplegia.<br><br>The current care plan stated, ". . . Restorative Therapy provides range of motion and exercises to my upper extremities and ankles 5-7 days per week as I allow."<br><br>A restorative therapy quarterly screen, dated 01/14/16 stated, "Res. participates in RT ROM 6-7 days/week for a minimum of 15 min/day to increase/maintain joint mobility to assist with transfers and ADLs. Client continues to benefit from actively participating in this program."<br><br>Review of the May 2016 through June 2016 RT documentation showed staff failed to consistently provide range of motion six to seven times a week as directed.<br>- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included osteoarthritis, weakness, and a sprained ankle.<br><br>The current care plan stated, ". . . I have restorative therapy and/or restorative nursing programs to improve and/or maintain my strength, activity tolerance, mobility and functionality of ADL's. . . ."<br><br>A restorative therapy quarterly screen, dated 06/23/16 stated, "Res. participates in RT ROM 6-7 days/wk for a minimum of 15 min/day to maintain/improve mobility and strength to assist with ADL's and transfers. Res. continues to benefit from active participation in this program."<br><br>Review of the April 2016 through June 2016 RT documentation showed staff failed to consistently | F 318 | | |

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| F 318 | Continued From page 39<br>provide range of motion six to seven times a week as directed.<br><br>- Review of Resident #12's medical record occurred July 13-14, 2016. Diagnoses included osteoarthritis, weakness, and a sprained ankle.<br><br>The current care plan stated, ". . . I have restorative therapy and/or restorative nursing programs to improve and/or maintain my strength, activity tolerance, mobility and functionality of ADL's. . . ."<br><br>A restorative therapy quarterly screen, dated 06/30/16 stated, "Resident participates in RT ROM 6-7 days/week for a minimum of 15 min/day to maintain/improve mobility and strength with ADL's, transfers, mobility and level of independence. Res. continues to benefit from active participation in this program."<br><br>Review of the April 2016 through June 2016 RT documentation showed staff failed to consistently provide range of motion six to seven times a week as directed.<br><br>During an interview on the morning of 07/14/16, an administrative nurse (#1) reported RT services should be provided as recommended. | F 318 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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. | F 323 | | 8/18/16 |

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| F 323 | Continued From page 40<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 01, 2015.<br><br>ASSISTIVE DEVICES AND SUPERVISION<br><br>1. Based on observation, record review, and staff interview, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for 1 of 5 sampled residents (Resident #9) observed requiring supervision during transfers. Failure to use a gait belt with transfers placed Resident #9 at risk for sustaining a fall or injury.<br><br>Findings include:<br><br>Review of Resident #9's medical record occurred on all days of survey. Diagnoses included osteoarthritis, weakness, history of cellulitis of right lower limb, and history of sprained right ankle. The quarterly Minimum Data Set (MDS), dated 06/27/16, identified the resident required extensive assistance of one person with bed mobility, dressing, and bathing and limited assistance of one person with transfers, toilet use, and personal hygiene.<br><br>Review of Resident #9's current care plan stated, ". . . I need limited assist with . . . transfers. . . . I need staff assistance with toileting. . . . My left hip was replaced years ago and the appliance has loosened. . . . Since this has happened, I can no longer ambulate independently with my FWW | F 323 | 1.Memo on gait belt usage with Resident #9 per care plan was passed in report on 7/28/16<br><br>The facility has determined that all residents have the potential to be affected.<br><br>An in-service education program on the facility□s current policy for Ambulating/Transferring a Resident with a Gait Belt (See exhibit Nsg 323-1) will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits monitoring appropriate gait belt usage daily for two (2) weeks, three times weekly for four (4) weeks, weekly for six (6) weeks, every other week for three (3) months, monthly for 5 months (See exhibit Nsg 323-2_)<br><br>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin August 1, 2016.<br><br>Corrective action completion date: August | |

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| F 323 | Continued From page 41<br>[front wheel walker]. I use a power wheelchair for my mobility. For my transfers, I need staff assistance of one with a gait belt. My Dr. [doctor] does not want me to transfer on my own any longer. . . . I am at risk for falls, in fact I recently had a bad fall off the toilet in my room [sic] and bruised my face and sprained my ankle. . . ."<br><br>Review of Resident #9's nursing progress notes showed seven falls during self transfers occurred between August 2015 to June 2016. These incidents occurred in the resident's room and bathroom.<br><br>Review of the physician note, dated 02/23/16, stated, ". . . Resident probably should not be out of bed or chair without assist to maximize safety. . . ."<br><br>Observation on 07/11/16 at 4:37 p.m., showed a certified nursing assistant (CNA) (#17) assisted Resident #9, utilizing a pivot stand transfer, from her electric wheelchair to the recliner without utilizing a gait belt.<br><br>Observation on 07/13/16 at 11:27 a.m. showed a CNA (#19) in the bathroom with Resident #9, who was seated on the toilet. During perineal cares, the CNA (#19) asked the resident to stand. Observation showed the resident grabbed onto the wheelchair arm rests, which were in front of her and stood up independently. The CNA (#19) failed to assist with the transfer and failed to utilize a gait belt. The CNA (#19) then assisted the resident, with a pivot stand transfer, from the toilet to the electric wheelchair and again, the CNA (#19) failed to utilize a gait belt. The CNA (#19) transferred the resident from the electric | F 323 | 18, 2016.<br><br>2.Temperatures were checked in all areas. Water temperatures in the boiler room were checked and Maintenance found that the mixer valve was stuck. Maintenance then bypassed and replaced the mixer. When water temperatures were rechecked the water temperatures were normal. Maintenance rechecked a half hour later and water temperatures were within normal range.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>Maintenance will complete Boiler room water temperature checks daily and weekly resident rooms water temperature checks. On July 13, 2016, education provided to Maintenance Aides in regards to checking and documenting water temperatures. Other staff will be educated on the Safe Water Temperatures Policy on August 17, 2016 at the General Staff meeting.<br><br>Maintenance will follow Safe Water Temperatures Policy and other staff members will also be informed of the policy. (See exhibit Mnt 323-1). Water temperatures will be documented on the Water Temperatures Checks form (see exhibit Mnt 323-2).<br><br>Audits will begin July 13, 2016. | |

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| F 323 | Continued From page 42<br>wheelchair to her manual wheelchair and failed to utilize a gait belt.<br><br>During an interview on 07/14/16 at 2:42 p.m., an administrative nurse (#1) stated she expected staff to use a gait belt during transfers requiring an assist of one person.<br><br>The staff failed to provide the required assistance during Resident #9's ADL's including utilizing a gait belt during transfers to ensure the resident's safety.<br><br>WATER TEMPERATURES<br><br>2. Based on observation, review of facility policy, and staff interview, the facility failed to ensure acceptable temperatures for hot water on 3 of 3 units (Whispering Winds, Harvest Lane, and Shady Lane) and a resident gathering area (Fellowship room). Failure to maintain acceptable temperatures may result in residents and/or staff receiving burns.<br><br>Findings include:<br><br>Review of the facility policy "Boiler Policy and Procedures" occurred on 07/14/16. This policy stated, "All gauges will need to be checked on a daily basis . . . The maintenance Supervisor will be responsible . . . to keep track of and make sure they are running good."<br><br>On 07/13/16 at 11:35 a.m. a surveyor washed his hands at the sink in the male fellowship bathroom and noted the water felt hot. | F 323 | Completion date August 18, 2016.<br><br>3. Maintenance checked the Housekeeping Room door to make sure it was latching properly. Chemicals in the unlocked public bathrooms were removed immediately. Both were completed on July 14, 2016 and staff was educated on July 28, 2016 and July 29, 2016.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>Notices were placed in Staff areas to make staff aware that chemicals were not to be placed in unlocked areas that were assessable to the residents. Housekeeping Staff was educated to watch these areas so that no chemicals were placed in unlocked areas and that if found they would be removed immediately and then they would go to staff in that area and remind them that chemicals were not allowed in unlocked areas because of the danger to residents. Staff will also monitor the Housekeeping Room door to make sure it is locking properly.<br><br>Housekeeping Supervisor will complete audits bi-weekly for three (3)weeks, weekly for four (4) weeks, bi-monthly for 3 months, monthly for six (6) months.(See exhibit Hsk323-1)<br><br>Audit records will be reviewed by the Risk Management/Quality Assurance | |

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| F 323 | Continued From page 43<br>Observation of water temperatures on Harvest Lane, Whispering Winds, Shady Lane, and Fellowship area occurred on - 07/13/16 from 11:40 a.m. to 12:38 p.m. and showed the following temperatures:<br>Fellowship room: 121.6 F (degrees Fahrenheit)<br>Men's bathroom by Fellowship room: 122.3 F<br>Women's bathroom by Fellowship room: 122.5 F<br>Whispering Winds:<br>* North East dining area: 120.7 F<br>* Room 100: 120.1 F<br>* Room 108: 122.2 F<br>Harvest Lane:<br>* Room 206 : 119.2 F<br>* Room 251: 121.1 F<br>* Room 255 : 119.3 F<br>* Room 261: 122.7 F<br>* Room 263: 123.4 F<br>* Room 264: 119.3 F<br>Shady Lane:<br>* Room 306: 121.6 F<br>* Room 365: 122.1 F<br><br>During an interview on 07/13/16 at 12:45 p.m., the survey team notified an administrative nurse (#1) of the water temperatures in the sinks. The nurse stated the water should not be that hot in sinks, and immediately notified maintenance.<br><br>During an interview on 07/13/16 at 12:50 p.m., a maintenance supervisor (#4) stated a mixer valve was stuck on the boiler causing the high temperatures. He stated staff check the boiler and hot water heater temperatures everyday, with the goal to keep the temperature under 110 degrees. At 12:59 p.m., the maintenance supervisor stated the temperature at the mixer valve is now 111 F, and was 118 F when first | F 323 | Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin July 28, 2016.<br><br>Corrective action completion date: August 15, 2016. | |

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| F 323 | Continued From page 44 | F 323 | | |

notified of this problem.

During an interview on 07/13/16 at 2:00 p.m., a maintenance supervisor (#4) stated the facility sink water temperatures were now between 106.5 and 113 F.

HAZARDOUS CHEMICALS

3. Based on observation, review of Material Safety Data Sheets, policy review, work orders, and staff interview, the facility failed to ensure an environment free of accident hazards on 2 of 3 units (Shady Lane and Harvest Lane). Failure to store chemicals securely placed cognitively impaired residents residing on the units at risk of an injury.

Findings include:

Review of the facility policy, "Storage of Chemicals - Housekeeping" occurred on 07/14/16. This policy, revised on 03/12/13, stated, ". . . The door to the Housekeeping Rooms must be closed and locked when not in use. . ."

Review of Material Safety Data Sheets on 07/18/2016 identified the following:
* Triple S - New Concept - Ultra Concentrated Extraction Cleaner, dated 05/22/2015, "Ingestion can cause death . . . harmful if swallowed."
* Triple S - Carpet Rinse Plus Rinse and Neutralizer, dated 06/15/2015, "Ingestion can cause . . . possible death."
* Triple S - Pleascent Clean, dated 11/29/2011, "Ingestion: May be harmful . . . Get medical attention."

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| F 323 | Continued From page 45<br>* Lysol Professional Disinfectant, dated 05/17/2012, "Ingestion may result in ethanol poisoning . . . hazardous to humans."<br>* Avert Sporicidal Disinfectant Cleaner - Diversey, dated 05/27/2015, "Ingestion: Causes burns, serious damage to mouth, throat, and stomach."<br>* Professional Resolve - Stain Remover, dated 07/08/2010, "Keep out of reach of children."<br>* Schultz - Insect Spray Houseplant & Garden, dated 10/21/2004, "Harmful if swallowed."<br>* Rug Doctor - Pet Stain Remover, dated 02/28/2014, "May be harmful if swallowed."<br><br>Review of the facility work order report, dated 4/28/16,stated, "The door to the main housekeeping room on Shady Lane is hitting the wall when it closes. . . Will need to order a new door . . ."<br><br>A tour of the environment occurred on the morning of 07/14/16 at 8:35 a.m. with a maintenance supervisor (#4). Observation showed the following:<br><br>1) Chemicals in an unlocked housekeeping room on Shady Lane:<br>* Triple S - New Concept - Ultra Concentrated Extraction Cleaner: two bottles<br>* Triple S - Carpet Rinse Plus Rinse & Neutralizer: two bottles<br>* Triple S - Pleascent Clean: twenty one bottles<br>* Lysol Professional Disinfectant: three cans<br>* Avert Sporicidal Disinfectant Cleaner - Diversey: two bottles<br>* Professional Resolve - Stain Remover: three bottles<br>* Schultz - Insect Spray Houseplant & Garden: | F 323 | | |

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| F 323 | Continued From page 46<br>one bottle<br>* Rug Doctor - Pet Stain Remover: one bottle<br><br>2) Chemicals in an unlocked public bathroom in both Shady Lane and Harvest Lane:<br>*Lysol Professional Disinfectant<br>*Fecal Odor Eliminator Code 4T bottle, stated, "Keep children away . . . do not swallow . . ."<br><br>During an interview on 07/14/16, a maintenance supervisor (#4) stated the housekeeping door should be locked. During the environmental tour, an environmental department supervisor (#3) and a maintenance supervisor (#4) stated they would not expect Lysol and Fecal Odor Eliminator to be accessible to residents in bathrooms. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #11) on continuous flow oxygen received the proper | F 328 | On 7/28/16 care plan updated for Resident #11, communication through shift report, and email that resident is to use a concentrator for oxygen supply | 8/18/16 |

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| F 328 | Continued From page 47<br>treatment and care. Failure to ensure a continuous supply of oxygen may result in respiratory distress and increased anxiety.<br><br>Findings include:<br><br>Review of Resident #11's medical record occurred on July 13-14, 2016. Diagnoses included chronic obstructive pulmonary disease (COPD) and anxiety disorder. A physician order, dated 08/17/15, stated, "Continuous oxygen 4 LPM [liters per minute] via nasal cannula," and dated 06/13/16, "Titrate O2 [oxygen] to maintain sats [saturation] > [greater than] 90%." The resident's record showed her oxygen saturation levels consistently between 90 to 100% for the months of June and July 2016.<br><br>Resident #11's current care plan stated, ". . . I am on continuous oxygen and do become short of breath with exertion. . . ." The quarterly Minimum Data Set (MDS), dated 06/18/16, indicated the resident had intact cognition and required extensive assistance with locomotion.<br><br>On 07/12/16 at 9:35 a.m., observation showed Resident #11 in her room with continuous oxygen on at 4 LPM via the portable oxygen unit on the back of the wheelchair. At 9:50 a.m., the resident stated, "I think I'm out of oxygen, I'm getting very short of breath." The resident stated staff assisted her to her room after breakfast, but didn't change her (connect the oxygen tubing) to the concentrator in the room. This surveyor summoned a certified nurse aide (CNA) (#15) to check Resident #11's portable oxygen unit, and determined it was empty. The CNA connected the resident's oxygen tubing to the oxygen | F 328 | unless being transported through hallways, in the bathing room, or out to an appointment to maintain adequate oxygen supply. Portable tanks will be utilized for all other times.<br><br>All residents receiving higher doses of oxygen have the potential to be affected by this practice.<br><br>An in-service education program for all nursing staff on the facility□s current policy for Oxygen Concentrator Procedure (See exhibit Nsg 328-1) and Liquid Oxygen Filling and Use Procedure (See exhibit Nsg 328-2), and Certified Medication Aide Tour of Duty ( See exhibit Nsg 328-4)which demonstrates checking and filling portable oxygen tanks, will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits of adequate supply of oxygen available continuously weekly for four (4) weeks, twice a month for 3 months, monthly for 8 months (See exhibit Nsg 328-3)<br><br>Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin August 3, 2016. | |

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| F 328 | Continued From page 48<br>concentrator and took the portable oxygen unit out of the room to refill.<br><br>On 07/12/16 at 4:30 p.m., observation showed Resident #11 in the hallway by the lounge, with oxygen on at 4 LPM via the portable oxygen unit on her wheelchair. The resident stated, "The tank [portable oxygen unit] ran out again this afternoon." The resident stated her oxygen runs out quickly because of using 4 LPM, and by the time staff refill the unit she gets short of breath.<br><br>During an interview on 07/14/16 at 1:00 p.m., an administrative nurse (#1) stated staff should connect the resident's oxygen to the concentrator while in her room. | F 328 | Corrective action completion date: August 18, 2016. | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically | F 329 | | 8/18/16 |

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| F 329 | Continued From page 49<br>contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of facility policy, the facility failed to ensure adequate indications for use for 1 of 6 sampled residents (Resident #3) receiving as needed (prn) antianxiety medication. Failure to ensure adequate indications before using an antianxiety medication (Clonazepam) placed Resident #3 at risk of receiving an unnecessary medication and experiencing adverse reactions.<br><br>Findings include:<br><br>Review of the facility policy titled "Medication Administration - General Guidelines" occurred on 07/14/16. This policy, revised April 2014, stated, ". . . C. Documentation . . . 2) When PRN medications are administered, the following documentation is provided . . . b) Complaints or symptoms for which the medication was given. . . ."<br><br>Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety.<br><br>The physician's orders identified Clonazepam 0.25 milligrams daily as needed for agitation.<br><br>Review of the May 2016 through July 2016 | F 329 | Education on PRN documentation was passed in report and sent via email to all licensed nurses and certified medication aides on 7/27/16. Resident #3 medication order for clonazepam indicates to give medication for agitation.<br><br>The facility has determined that all residents receiving PRN medications have the potential to be affected.<br><br>An in-service education program for licensed nurses and certified medication aides on the facility□s current policy for Medication Administration□General Guidelines (See exhibit Nsg 329-1) will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits of PRN medication use to ensure adequate indications for use of the medication is documented weekly for four (4) weeks, twice a month for 3 months, monthly for 6 months (See exhibit Nsg 329-2) | |

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| F 329 | Continued From page 50<br>medication administration records and progress notes identified Resident #3 received prn Clonazepam the following times:<br>* May 2016: 11/13 doses administered without indication for use<br>* June 2016: 8/9 doses administered without indication for use<br>* July 2016: 5/5 doses administered without indication for use<br><br>The facility failed to ensure adequate indications for the use of antianxiety medication which placed Resident #3 at risk of receiving unnecessary medications. | F 329 | Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin August 1, 2016.<br><br>Corrective action completion date: August 18, 2016. | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to ensure 1 of 14 sampled residents (Resident #9) remained free of a significant medication error. Failure to administer antibiotics as ordered has the potential to result in a negative outcome:<br><br>Findings include:<br><br>Review of the policy titled "MEDICATION ADMINISTRATION - GENERAL GUIDELINES" occurred on 07/14/16. This policy, revised April 2014, stated, ". . . B. Administration. . . . . 2) Medications are administered in accordance with written orders of the attending physician. . . . C. | F 333 | Resident #9 received medication as a new order received from physician and medication was administered. Medication error reviewed with relevant nursing staff. Policy education provided to all nurses and CMAs related to immediate follow up when medication is not available by calling pharmacy and by calling the physician if medication is not administered as ordered.<br><br>All residents receiving medications have the potential to be affected by this practice. | 8/18/16 |

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| F 333 | Continued From page 51<br>Documentation. . . . 3) If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. [example given] the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), it is noted on the MAR [medication administration record] and an explanatory note is entered in the area of the record provided for this documentation. . . ."<br><br>Review of Resident #9's medical record occurred on all days of survey. Diagnoses included cellulitis and hematoma of the right lower limb. The nursing review and progress report, dated 01/05/16, stated, ". . . large hematoma that formed to the back of her R [right] lower leg . . . This happened at the end of October and the leg did result with an infection that was treated during November with a course of two antibiotics. The leg has recently acted up on her again on 12/22, forming some blistered areas and [name of physician] did another course of antibiotics . . ." The medical record identified the cellulitis and hematoma of right lower limb healed on 04/02/16.<br><br>Physician's orders, dated 11/17/15, showed the physician ordered a refill of Doxycycline 100 milligram (mg) BID (twice a day) for one week to be started on 11/20/15. This order was a continuation of a previous Doxycycline 100 mg BID order with a stop date of 11/19/15.<br><br>Review of the November 2015 MAR identified staff failed to administer Doxycycline for three consecutive days (November 20, 21, and 22), totaling six missed doses. | F 333 | An in-service education program for all licensed nurses and certified medication aides on the facility□s current policy for Medication Administration-General Guidelines which ensures that medications are available. In the event that they are not, immediate notification to pharmacy will be done(See exhibit Nsg 333-1 Revised). Education will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random medication pass audits which includes ensuring all medication is available during medication pass and comparing the MAR to medication cards weekly for four (4) weeks, twice a month for 3 months, monthly for 6 months (See exhibit Nsg 333-2 Revised)<br><br>Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.<br><br>Audits will begin August 6, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 333 | Continued From page 52<br>During an interview on 07/14/16 at 2:42 p.m., an administrative nurse (#1) confirmed the staff failed to administer Resident #9's antibiotic medication as ordered. | F 333 | | |
| F 363 SS=E | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/01/15.<br><br>Based on observation, review of facility menus, review of facility policy, 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.<br><br>Findings include:<br><br>Review of the facility policy titled "Portion Control" occurred on 07/14/16. This policy, dated 04/12/15, stated, ". . . 3. . . . Portions that are too small result in the individual not receiving the nutrients needed. . . ." | F 363 | Portion sizes of all foods on the facility menus have been re-evaluated by the Registered Dietician and the Dietary Manager to assure accuracy and adequacy of planned meals. Foods are being served using proper serving scoop sizes for the accurate delivery of portion sizes in all 3 dining rooms.<br><br>The new portion sizes are served to resident(s) # 10 scoop for ground fish and sausage, # 8 scoop for mashed potatoes and pureed knoephla.<br><br>The Facility has determined that all residents have the potential to be affected.<br><br>On July 27, 2016, the Dietary Manager in-serviced the dietary staff on the facility guidelines for portion sizes. | 8/18/16 |

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| | 355053 | A. BUILDING _____ B. WING _____ | 07/14/2016 |

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

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| F 363 | Continued From page 53<br><br>- Observation of tray line occurred in the Whispering Winds dining room on 07/12/16 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:<br>* Mashed potatoes served with a 1/3 cup scoop. The menu identified 1/2 cup.<br><br>- Observation of tray line occurred in the Shady Lane dining room on 07/12/16 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menu and the actual amount served to residents:<br>* Ground fish served with a 2 ounce (oz) scoop. The menu identified 3 oz.<br>* Ground sausage served with a 2 oz scoop. The menu identified 3 oz.<br><br>- Observation of tray line occurred in the Harvest Lane dining room on 07/12/16 during the noon meal. Observation showed the following inconsistencies between portion sizes listed on the facility's menu and the actual amount served to residents:<br>* Ground fish served with a 1/3 cup scoop. The menu identified 1/2 cup.<br>* Ground sausage served with a 1/3 cup scoop. The menu identified 1/2 cup.<br>* Pureed Knoephla served with a 1/4 cup scoop. The menu identified 1/2 cup.<br>* Mashed potatoes served with a 1/4 cup scoop. The menu identified 1/2 cup.<br><br>During an interview on 07/14/16 at 8:10 a.m., a dietary supervisory (#18) stated staff should | F 363 | The Dietary Manager or designee will conduct Menu and Nutritional Adequacy Daily audits for four (4) days . Weekly audits for four (4) weeks starting . Monthly audits for four (4) months<br><br>Audits will begin July 27, 2016.<br><br>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.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 363 | Continued From page 54<br>follow portion sizes listed on the menus. | F 363 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 431 | | 8/18/16 |

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| F 431 | Continued From page 55<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to properly secure and store medications in 3 of 3 units (Shady Lane, Harvest Lane, and Whispering Winds). Failure to discard expired medications increases the risk of residents receiving medication with reduced efficacy. Failure to ensure medications both regular and controlled are stored securely may result in unauthorized access to medications.<br><br>Findings include:<br><br>Review of the facility policy titled "Medication System Procedure" occurred on 07/13/16. This policy, revised 07/12/16, stated, ". . . narcotics will be double locked in medication room cupboard, in the locked medication room. . . . The Certified Medication Aide is responsible for: . . . I. Medications set-up for dispensing must remain in nurse/CMA possession or line of sight. . . . 11. All blister cards are labeled with the resident name, [prescription] number, name of medications, dosage, lot number, and expiration date. . . . 13. When administering medication . . . d. Check expiration dates prior to use. . . ."<br><br>Review of the facility policy titled "MEDICATION ADMINISTRATION - GENERAL GUIDELINES" occurred on 07/14/16. This policy, revised April 2014, stated, ". . . 12) During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. . . . No medications are kept on top of the cart. . . ." | F 431 | All narcotic storage areas were double locked on 7/12/16 by DON. An educational memo was passed in report and emailed to all licensed nurses and certified medication aides regarding double locking narcotics, checking and properly disposing of expired medications, and reminded not to leave medications unattended.<br><br>All expired medications, dressings, and vacutainer tubes were properly disposed of by 7/26/16.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>An in-service education program on the facility□s current policy for Controlled Drugs, Medication System Procedure, and Pharmaceutical Services (See exhibits Nsg 431-1) will be conducted by the Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>A licensed nurse or certified medication aide will sign off every shift with the narcotic count verifying that the narcotic cabinets are locked (ensuring narcotics to be double locked). (See exhibit Nsg 431-2) A licensed nurse or certified medication aide will do a weekly check for any expired medications, dressings, and vacutainer tubes in the medication rooms | |

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| F 431 | Continued From page 56<br>- Observation on 07/11/16 at 4:35 p.m., showed a medication cart outside a resident's room with no staff present or within eyesight. The top of the cart contained one Jantoven (anticoagulant) 5 mg (milligram) tablet medication card, one Jantoven 2.5 mg tablet medication card, and a medication cup containing one red capsule and one white capsule.<br><br>- Observation on 07/12/16 at 11:26 a.m. showed unlocked narcotics in Harvest Lane medication room. The unlocked medication box contained ten Oxycodone (narcotic drug) 5 mg tablets and fifteen Oxycodone 10 mg ER (extended release) tablets.<br><br>- Observation on 07/12/16 at 2:36 p.m.of the medication cart located in Shady Lane showed one bottle of Vitamin B-6 expired August 2015, one bottle of Vitamin B-6 with no expiration date, and one bottle of non aspirin pain relief/reducer expired February 2013.<br><br>- Observation on 07/13/16 at 2:15 p.m. in Whispering Winds medication room showed three tubes of Glutose #15 (low blood sugar medication) with an expiration date of August 2015.<br><br>- Observation on 07/13/16 at 4:29 p.m., showed a medication cart outside a resident's room with no staff present or within eyesight. The top of the cart contained two gabapentin (medication for nerve pain) medication cards.<br><br>During an interview on 07/14/16 at 3:00 p.m. an administrative nurse (#1) stated she expected the facility nurses to double lock narcotics, lock | F 431 | and medication carts. (See exhibit Nsg 431-3). The Director of Nursing Services (DNS), or designee, will complete random audits for expired medications, to ensure narcotics are double locked, and that medications are not left unattended weekly for four (4) weeks, twice a month for 3 months, monthly for 6 months (See exhibit Nsg 431-3)<br><br>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin July 12, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 431 | Continued From page 57<br>medications in a medication cart, and dispose of expired medications. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of | F 441 | | 8/18/16 |

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| F 441 | Continued From page 58<br>infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 8 sampled residents (Resident #2, #4, and #5) observed during perineal care/dressing change. Failure to follow infection control practices related to proper glove use/hand hygiene during perineal care and wound dressing changes has the potential to spread infection to other residents, staff, and visitors.<br><br>Findings include:<br><br>Review of the facility policy titled, "Employee Handwashing Procedure" occurred on 07/14/16. This policy, dated, June 2013, stated, " . . . When to Wash Hands . . . After contact with any body fluids . . ."<br><br>Review of the facility policy titled "Clean Dressing Change" occurred on 07/14/16. This policy, dated, September 2003, stated, " . . . 8. Gently remove dressing from the wound site. . . . 9. Observe old dressing for drainage . . . 10. Remove gloves . . . Hand hygiene. Apply clean gloves. 11. Cleanse wound site with cleansing agent . . . 13. Place clean dressing over wound site . . . 15. Remove gloves . . . 16. Hand hygiene . . ."<br><br>Observation on 07/11/16 at 4:05 p.m. showed a certified nursing assistant (CNA) (#8) donned 2 | F 441 | Staff caring for Residents #2, #4, and #5 were educated via report and a memo on 7/29/16 on appropriate hand washing / hand hygiene and glove use.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>All nursing personnel will be in-serviced on the facility'□s policy/procedure for hand washing / hand sanitizing and glove use and Licensed nurses will be in-serviced on clean dressing changes August 10, 2016 and August 11, 2016.<br><br>The Director of Nursing Services (DNS), or designee, will complete random audits monitoring for appropriate use of gloves and hand hygiene between glove use during resident cares and with dressing changes. Resident care audits will be done daily for two (2) weeks, three times weekly for four (4) weeks, weekly for six (6) weeks every other week for three (3) months for 5 months. Dressing change glove use and hand sanitizing will be done 3 times weekly for 4 weeks, weekly for 8 weeks, every other week for 3 months, and monthly for 6 months. (See exhibit Nsg 441-1 Revised) | |

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| F 441 | Continued From page 59<br>pair of gloves (double gloved) to assist Resident #5 with a large loose incontinent bowel movement (BM). The CNA (#8) stated "I double glove in case of a mess and I need to change gloves quickly and my hands get so sweaty it's hard to get gloves on." The CNA (#8) assisted Resident #5 from the bed into the bathroom using the sit to stand lift. In the bathroom, the CNA pulled down the resident's pants and removed the brief. The CNA (#8) performed perineal care, removed the first pair of gloves and positioned the resident onto the toilet. The CNA then adjusted the resident's foley catheter bag, removed his shoes and pants and removed the second pair of gloves. The CNA stated her hands were sweaty, wiped them with a paper towel, doubled gloved and continued to assist the resident.<br><br>- Observation on 07/11/16 at 4:46 p.m. showed two CNAs (#13 and #16) provide incontinence cares to Resident #2. The CNA (#16) donned 2 pair of gloves (double gloved), provided perianal cares, applied lantiseptic cream to Resident #2's buttocks and removed the first pair of gloves. The CNA (#16) performed front perineal cares and removed the second pair of gloves. The CNA (#16) doubled gloved to provide care and failed to remove her gloves and perform hand hygiene before applying lantispetic cream.<br><br>- Observation on 07/12/16 at 9:40 a.m. showed Resident #4 in bed on her side. A licensed nurse (#7) donned gloves and removed the dressing from the resident's boil on the right gluteal. The dressing contained dark drainage. The licensed nurse removed her gloves, donned gloves, cleansed the wound with water, applied a clean | F 441 | This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin August 1, 2016.<br><br>Corrective action completion date: August 18, 2016. | |

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| F 441 | Continued From page 60<br>dressing and removed her gloves. The nurse (#7) then donned gloves, cleansed the pressure ulcer on the right gluteal fold, applied a dressing, removed her gloves and performed hand hygiene. The nurse (#7) failed to perform hand hygiene after removing the dressing from the boil and before cleansing the pressure ulcer.<br><br>During an interview on 07/14/16 at 9:10 a.m. an administrative nurse (#1) stated she expects staff to not double glove and to perform hand hygiene during and after each dressing change. | F 441 | | |
| F 502 SS=C | 483.75(j)(1) ADMINISTRATION<br><br>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, professional reference review, and staff interview, the facility failed to ensure laboratory supplies stored in 3 of 3 medication rooms (Whispering Winds, Harvest Lane, and Shady Lane) had not expired. Use of expired Vacutainers (a blood specimen collection tube) and Hemoccults (fecal blood test) may result in inaccurate lab test results.<br><br>Findings include:<br><br>The Hemoccult SENSA product instructions, dated June 2015, stated, ". . . Storage and Stability . . . The Hemoccult SENSA Slides and Developer will remain stable until the expiration dates. . ." | F 502 | An educational memo was passed in report and emailed to all licensed nurses and certified medication aides regarding checking and properly disposing of lab supplies.<br><br>All expired lab supplies were properly disposed of by 7/26/16.<br><br>The facility has determined that all residents have the potential to be affected.<br><br>A log to monitor lab supplies for expiration was established. (See exhibits Nsg 502-1) Education will be conducted by the | 8/18/16 |

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| F 502 | Continued From page 61<br><br>The BD Vacutainer Evacuated Blood Collection System reference material, revised September 2012, stated, ". . . Storage . . . Do not use tubes after their expiration date. Tubes expire on the last day of the month and year indicated. . . . "<br><br>During observation on 07/12/16 from 11:05 a.m. to 2:50 p.m., of the three medication rooms showed:<br>* Shady Lane medication room:<br>- five BD Vacutainer Tan tubes Ref (Reference #) 367820 expired February 2016<br>- three BD Vacutainer Green tubes Ref 367960 expired April 2016<br>- five Hemoccult SENSA specimen cards expired April 2016<br>- one Hemoccult SENSA Developer (developing solution for Hemoccult SENSA specimen card) 15 mL (milliliters) expired June 2016<br>- sixteen BD Vacutainer Serum Red tubes Ref 367815 expired June 2016<br>- eight BD Vacutainer Lavender tubes Ref 367841 expired June 2016<br>* Whispering Winds medication room:<br>- ten Hemoccult SENSA specimen cards expired April 2016<br>- eight BD Vacutainer Lavender tubes Ref 367841 expired June 2016<br>* Harvest Lane medication room:<br>- four BD Vacutainer Serum Red tubes Ref 367815 expired June 2016<br><br>During an interview on 07/12/2016 at 2:50 p.m., a staff nurse (#7) stated expired lab supplies should be removed from use. | F 502 | Director of Nursing Services or designee on August 10, 2016 and August 11, 2016.<br><br>A licensed nurse or certified medication aide will do a weekly check for any expired medications, dressings, or vacutainer tubes in the medication rooms and medication carts. (See exhibit Nsg 502-1). The Director of Nursing Services (DNS), or designee, will complete random audits for expired medications weekly for four (4) weeks, twice a month for 3 months, monthly for 6 months (See exhibit Nsg 502-2).<br><br>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.<br><br>Audits will begin the week of August 8, 2016.<br><br>Corrective action completion date: August 18, 2016. | |