STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on October 21, 2013 and completed on October 24, 2013, the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 281 SSD	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of manufacturer's instructions, and staff interview, the facility failed to follow professional standards of practice for 2 of 3 residents (Resident #32 and #33) observed receiving insulin. Failure to follow policy and manufacturer's recommendation for priming an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: Review of the facility policy titled "Administering Insulin Injections" occurred on 10/24/13. This policy, revised October 2011, stated, ". . . Procedure for Insulin Pens. . . 5. Apply safety needle and dial to 2 Units and prime by holding needle upright. . ." Review of the Humalog KwikPen manufacturer's instructions, revised 01/30/13, stated,"...	F 281	**F281** **How corrective action will be accomplished for those residents affected by the deficient practice:** The nurses working the unit on Oct. 21 evening shift were given re-instruction on priming insulin pens by the unit director. This unit was where Residents # 32 and 33 resided. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All diabetic residents who use insulin are at risk with this deficient practice. **What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:** Charge nurse orientation checklist was revised to include; Priming Insulin pens w/2 units and position needle upward. Nurses were in-serviced on November 6, on policy and procedure of insulin pen injections. **Monitoring we have put in place to ensure deficient practices will not recur;** A QA was completed with re-instruction given to nurses who continued the deficient practice. Follow-up QAs will be completed monthly x 2 then quarterly x 3. This monitoring will be monitored by the RN Unit Directors on each unit and the Director of Resident Services.	11-28-13

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

John Thompson | President/CEO | 11-13-13

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

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F 281	Continued From page 1 Priming your Humalog KwikPen: Prime before each injection. Priming ensures the Pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin. Step 5: Turn the Dose Knob to select 2 units. Step 6: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubble at the top. Step 7: Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. A stream of insulin should be seen from the needle. If you do not see a stream of insulin, repeat steps 5 to 7 . . ." - On 10/21/13 at 5:12 p.m., observation showed a licensed nurse (#15) prepared Resident #32's insulin injections. The nurse primed both the Humalog insulin KwikPen and the Lantus SoloSTAR pen with two units of insulin while pointing the pens downward. - On 10/21/13 at 5:30 p.m., observation showed a licensed nurse (#16) prepared Resident #33's insulin injection. The nurse primed the NovoLog FlexPen with two units of insulin while pointing the pen horizontally. Staff failed to hold, tap, and prime the pens in an upright position, therefore possibly giving an inaccurate dose of insulin. During an interview on 10/24/13 at 12:05 p.m., a nursing supervisor (#14) stated insulin pens should be primed in an upward position.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 18 sampled residents (Resident #11 and #25) with a diagnosis of constipation. Failure to implement appropriate and timely interventions to manage constipation may have resulted in Resident #11 and #25 receiving unnecessary suppositories. Findings include: Review of the facility policy titled "Bowel Management Protocol" occurred on 10/24/13. This policy, dated January 2013, stated, ". . . Procedure .. . 2. Notify nutritional services for bran or an equivalent nutritional stimulant for constipation. 3. Check BM [bowel movement] chart every shift and follow the resident's physician orders or standing orders for appropriate stool softener or laxative when constipated. Always start with the mildest for [sic] of intervention. a. PM [evening] nurse check BM book and give Milk of Magnesia or other laxative as ordered the 2nd day with no BM. b. Night nurse check for results and give suppository if indicated. . . . If you use pin [as needed]	F 309	F309 **How corrective action will be accomplished for those residents affected by the deficient practice;** Dietary added fiber orange juice, fiber basics and fruit fiber were to dinner and supper meal for Resident #11. However, resident continued to have poor intake and output and expired on 11-10-13 which was expected on her admission to the facility. Resident # 25 had fiber oatmeal changed from every other day to daily on 10-28-13. On 10-30-13 had prunes and peanut butter added on breakfast tray. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility may experience constipation at one time or another as well as many residents have a diagnosis of constipation who could be affected. **What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:** A BM Follow-up Documentation Record was developed for PM Nurses to initiate when a resident has had 2 days with no BM. This record will then be followed up with NOC Nurses and Day Nurses. This record will be given to the Unit Director and Nutritional Service to review and make changes as necessary and ensure follow-up. The Bowel Management protocol was reviewed at the Nurses meeting on November 6, 2013. A reminder was given to CNAs at their meeting on November 8, the importance of encouraging the fluids and fiber to the residents at meal time and accurate documentation of the resident's BM in Point of Care. The BM protocol was also reviewed with CNA staff.	

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F 309	Continued From page 3 medication 3 or more times in a 2 week period, notify the physician for a scheduled stool softener or laxative. If the resident is on a scheduled stool softener/laxative and it is ineffective, notify the physician for a change in the scheduled med [medication]. . . ." - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included unspecified constipation. Resident #11's current care plan identified "MSLCC [Missouri Slope Lutheran Care Center] bowel movement plan in place." Current medications included Zoloft (an antidepressant) and Risperdal (an antipsychotic), both of which may cause constipation, and Senns S [a laxative/stool softener] twice per day. A fax to the physician, dated 09/27/13, identified facility staff requested an increase in Resident #11's laxative. The physician responded on 09/30/13 with an increase in Senna S to twice per day. PRN orders included Bisacodyl (a laxative) suppositories, docusate sodium (a stool softener) capsules, and milk of magnesia (a laxative) suspension. Nurses' notes stated the following: *09/13/13 at 6:07 a.m.: ". . . Bisacodyl - Resident on third day with no recorded BM. . . ." Staff failed to attempt milk of magnesia prior to administering a suppository. *09/20/13 at 3:48 p.m.: ". . . Milk of Magnesia per [nurse] day three no BM . . ." *09/21/13 at 6:21 a.m.: ". . . Bisacodyl - Resident on 5th day with no recorded BM.. . "Certified Nursing Assistant (CNA) charting showed Resident #11 had a BM on 09/16/13 and not again until 09/21/13; however, staff failed to attempt an intervention until 09/20/13 (day 4	F 309	**Monitoring we have put into place to ensure practice does not recur:** The BM Follow-up Documentation Record was initiated on November 8, 2013 and a QA will be completed from results on November 13, 2013. Follow-up QAs will be completed monthly x 2 then quarterly x3. This information will be monitored by the Unit Directors, Nutritional Services and Director of Resident Services.	11-28-13

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F 309	Continued From page 4 without a BM). *09/25/13 at 6:36 a.m.: ". . . Bisacodyl - Resident on 4th day with no recorded BM. . . ." *09/25/13 at 1:22 p.m.: ". . . Milk of Magnesia constipation . . ." Staff failed to attempt milk of magnesia prior to the suppository and also failed to provide an intervention until day four without a BM. *09/26/13 at 6:52 a.m.: ". . . Resident on 5th day with just one small recorded BM [on 09/25/13]. No suppository given as resident has AM (morning) bath. . . ." *09/27/13 at 6:06 a.m.: ". . . Bisacodyl - Resident on sixth day with just one recorded BM. . . ." *09/30/13 at 2:29 p.m.: ". . . Order received from [physician name] to increase the Senna S [a laxative/stool softener] 1 tab [tablet] po [by mouth] daily to bid [twice a day]. . . ." *09/30/13 at 2:34 p.m.: ". . . Bisacodyl. 3rd day without BM . . ." Staff failed to attempt milk of magnesia prior to administering a suppository and failed to attempt interventions on day 2 without a BM. *10/03/13 at 6:57 a.m.: ". . . Resident on third day with no recorded BM. No suppository given as resident has AM bath. . . ." *10/03/13 at 9:45 p.m.: ". . . Resident on day 3 without bm, refused mom [milk of magnesia] . . ." *10/04/13 at 6:48 a.m.: ". . . Bisacodyl 1 suppos [suppository] given [rectally] for constipation as 4th day w/o [without] BM . . ." Staff failed to attempt interventions on day 2 without a BM. *10/11/13 at 6:09 a.m.: ". . . Bisacodyl [administered] . . ." Staff failed to attempt interventions on day 2 without a BM and failed to attempt milk of magnesia prior to administering a suppository. *10/14/13 at 6:10 a.m.: ". . . Bisacodyl given for constipation as 3rd day w/o BM . . ." Staff failed to	F 309		

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F 309	Continued From page 5 attempt interventions on day 2 without a BM and failed to attempt milk of magnesia prior to administering a suppository. *10/17/13 at 6:43 a.m.: ". . . Bisacodyl is on 3rd day w/o BM. Laxative held as res. [resident] has early morning bath. . . ." Record review identified no interventions attempted on 10/17/13. *10/18/13 at 6:04 a.m.: ". . . Bisacodyl given [rectally] as 4th day w/o BM . . ." Staff failed to attempt interventions on day 2 without a BM and failed to attempt milk of magnesia prior to administering a suppository. *10/21/13 at 6:53 a.m.: ". . . Resident is on third day with no recorded BM, no suppository given as resident has early AM bath. . . ." Record review identified no interventions attempted on 10/21/13. *10/22/13 at 6:12 a.m.: ". . . Bisacodyl [administered] . . ." Staff failed to attempt interventions on day 2 without a BM and failed to attempt milk of magnesia prior to administering a suppository. *10/23/13 at 10:17 a.m.: ". . . Note increased constipation, has had Dulcolax suppos [7 times] so far in Oct. Fax to [physician name] with med list to inform. . . ." The medication administration record (MAR) for October 2013 identified Resident #11 received Bisacodyl suppositories six times and milk of magnesia once. Although Resident #11 used prn laxatives 3 or more times in a two week period following the increase in Senna S on 09/30/13, staff failed to contact the physician until 10/23/13. Observation of breakfast meals on October 22-24, 2013 identified Resident #11 received four ounces of "fiber orange juice;" however, the resident failed to consume the juice at the three breakfast meals observed. Dietary progress	F 309		

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F 309	Continued From page 6 notes and assessments failed to identify other individualized interventions to help manage Resident #11's constipation. During an interview on the morning of 10/24/13, a supervisory nurse (#10) stated she was unsure if the dietary department was aware of Resident #11's constipation and stated staff should attempt oral laxatives before administering a suppository. - Review of Resident #25's medical record occurred October 23-24, 2013. Diagnoses included constipation. An annual Minimum Data Set (MDS), dated 10/07/13, identified Resident #25 experienced constipation. The current care plan identified MSLCC bowel movement plan in place. Resident #25's physician ordered the following medications for constipation: * 09/04/13 Senna S increased from one twice a day to one every morning and two every evening. * 06/11/11 Milk of Magnesia 30 milliliters (ml) daily prn. * 05/25/13 Bisacodyl 10 mg suppository, rectally, daily prn. * 08/21/13 Tap water enema daily prn. Review of the PRN MAR identified the following: * August 2013: nursing staff administered Bisacodyl suppositories on four of five occasions without offering Milk of Magnesia the day before as per policy. * September 2013: nursing staff administered Bisacodyl suppositories on two of two occasions without offering Milk of Magnesia. * October 2013: nursing staff administered Bisacodyl suppositories on four of four occasions without offering Milk of Magnesia.	F 309		

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F 309	Continued From page 7 During an interview on 10/24/13 at 8:30 a.m. an administrative nurse (#1) identified the facility bowel movement plan as - the second day a resident does not have a bowel movement, the evening nurse gives Milk of Magnesia; on the third day the resident does not have a bowel movement, the night nurse gives a suppository unless it is a bath day and then the suppository is given after the bath. If that doesn't work then the resident would receive an enema. The staff member added if a pm constipation medication is given three or more times in a two-week period, staff are to notify the doctor; and if the resident is on an opioid medication, a medication for stools is always started. Resident #25 received four Bisacodyl suppositories in a two week period, (October 9-22, 2013) without staff contacting the physician regarding the increased suppository use. During an interview on 10/24/13 at 9:40 a.m. an administrative nurse (#5) identified Resident #25 frequently refused the Milk of Magnesia. The record failed to show the resident refused Milk of Magnesia for the months of August, September, and October 2013.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident 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	F 314	**F314** **What corrective action will be accomplished for those residents affected by the deficient practice;** Resident # 12 was seen by Jennifer Bryan, Wound Care FNP, on October 29, 2013. Please see Consultation report. Nursing continues to monitor area on foot and follow orders written by Jennifer Bryan.	

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F314	Continued From page 8 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident with a facility-identified pressure sore (Resident #16) received the necessary monitoring and treatment to promote healing. Failure to determine potential causative factors and document monitoring of Resident #16's left foot pressure sore limited the facility's ability to track and trend healing, implement appropriate preventive measures, and determine the effectiveness of interventions. Findings include: Review of the facility's policy and procedure, "Maintenance of Skin Integrity and Prevention and Treatment of Pressure Areas," occurred on 10/24/13. This document, revised September 2013, stated "Policy:. . . All preventative measures will be taken to maintain skin integrity and to prevent and treat pressure ulcers. Routine Preventative Measures for Residents: . . . 4. Inspect skin for redness during dressing and undressing. CNA [certified nursing assistant] should inspect skin with cares/bath and report concerns to the charge nurse. . . . 13. Complete a Pressure Ulcer/Wound Assessment flow sheet daily, on residents with actual occurrence/ulcer. Monitor, evaluate, readjust and document interventions and outcomes. . . ." Review of Resident #16's medical record	F314	**How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility are at risk for skin breakdown and may need nurse assessment and monitoring. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Nurses were in-serviced on protocol for monitoring arterial and pressure ulcers on November 6, 2013. CNAs were in-serviced on November 8, 2013 on the importance of reporting skin breakdown to nurses. **Monitoring we have put into place to ensure practice does not recur;** A QA was completed on November 13, 2013 to review that nurses are monitoring and documenting wound and ulcers on the Pressure Ulcer/Wound Assessment Flow Sheet. A QA will be completed monthly x 2 then quarterly x 3. These QAs will be monitored by Unit Directors and Director of Resident Services.	11-28-13

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F 314	Continued From page 9	F 314		

occurred on October 21-24, 2013. The facility admitted the resident in March 2010. Current diagnoses included diabetes, peripheral vascular disease, and rheumatoid arthritis. The resident's quarterly nursing assessment, dated 10/13/13, identified "faint/absent pulses" in the lower extremities. Resident #16's quarterly Minimum Data Set (MDS), dated 07/18/13, identified the resident was moderately cognitively impaired and had no pressure ulcers. The medical record identified a history of healed pressure ulcers on the resident's buttocks in February 2013.

Resident 16's Pressure Ulcer Care Area Assessment (CAA), dated 11/01/12, identified facility staff would monitor the resident's skin during cares. The resident's current care plan, dated 10/17/13, stated "Focus, [Resident #16] has a pressure ulcer. Site: left outer foot. Unavoidable. . . . History of Ulcers. . . . Interventions . . . Document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements daily. . . . If resident refuses treatment, confer with Care Plan Team . . . Document alternative methods. . . . [Resident #16] refuses foam boots. . . ."

Resident #16's podiatrist treatment note, dated 10/07/13 at 9:30 a.m., stated "Physical Exam . . . Pulses are absent to digital palpation. . . . She has approximately 1 cm [centimeter] dry gangrenous area at the left 5th metatarsal head. There is no dressing on this. . . . Assessment: 1. Dry gangrenous ulcer left 5th metatarsal. . . . 3. . . . PVD [peripheral vascular disease] . . . Plan: . . . I believe as long as we can keep pressure away from this, it should not progress. I would suggest she wear her Pedors [extra depth] shoes during the day for environmental protection and warmth

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F 314	Continued From page 10	F 314		

and bunny boots at night. She states she will refuse to do this. See what nursing staff can do to offload this. . . ."

Resident #16's physician's orders, dated 10/13/13 at 11:26 p.m., stated "Monitor darkened area to left foot until resolved."

Resident #16's Nursing Progress Notes stated the following:
*10/07/13 at 10:51 a.m. - "Seen by [podiatrist], new order keep pressure off left 5th met [metatarsal], if it opens need to see, lambswool between right 2 and 3 toe, lotion daily . . . updated [physician's] nurse of this."
*10/13/13 at 6:46 p.m. - "Resident has been spending more time in bed . . . A message was left for restorative therapy to possibly get her a pair of blue or foam boots to wear in bed."
*10/17/13 at 8:58 a.m. - "Has dark brown scab on (L) [left] outer foot, nurses have been monitoring since 10/13/13. Will consider pressure related, unstageable due to scab present. [Resident #16] has air mattress in place. Refuses foam boots of any kind. Agrees to try foot cradle, notified supplies. Charge nurse will complete pressure ulcer flow sheet."
*10/17/13 at 10:31 a.m. - "RN [Registered nurse] measured the left outer aspect of left foot at 2 cm round scab. Toes on this foot are also discolored and cool to touch when compared to the right foot. Charted on the PU [Pressure Ulcer] flow sheet, and will pass in report. . . . RN called son and updated son . . ."

Resident #16's Pressure Ulcer Flow Sheet identified the staff began monitoring of the left outer foot area on 10/13/13. Facility staff began measuring and documenting the left foot ulcer on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

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F 314	Continued From page 11 10/17/13 as follows: *10/17/13 - length - 2 cm; width - 2 cm; depth - "?"; wound bed - eschar *10/18/13 - length - 0.7 cm; width - 0.7 cm; depth - "?"; wound bed - eschar; progress - worsened *10/19/13 - same as 10/18/13 *10/20/13 through 10/24/13 - length - 0.7 cm; width - 0.8 cm; depth - "?"; wound bed - none; progress - no change. During interview, on 10/21/13 at 4:20 p.m., Resident #16 reported the left foot area began after she "bumped" her left foot. Observation on 10/22/13 at 9:55 a.m. with a licensed nursing staff member (#12), showed a dried area on the lateral aspect of the fifth metatarsal-phalangeal joint. The licensed nurse measured the area and reported the area "0.7 cm" long and "0.7 cm" wide. Observation on October 21-23, 2013 showed Resident #16 wearing socks and slippers on both feet and seated in her recliner with her feet elevated or in her power wheelchair with her feet on the foot rests. During interview, on 10/24/13 at 10:20 a.m., a supervisory nursing staff member (#13) reported the following regarding Resident #16's left foot pressure ulcer: - the facility does not have documentation identifying the ulcer before the podiatrist's visit on 10/07/13. - the facility did not receive the podiatrist's dictated report until 10/21/13 as identified by the fax notation on the report. - the facility staff member who received the verbal instructions from the podiatrist on 10/07/13 was a	F 314		

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	355059	A. BUILDING _____ B. WING _____	10124/2013

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F 314	Continued From page 12 "new nurse" and should have initiated the daily monitoring documentation form at that time. - the reduction in size from 2 cm on 10/17/13 to 0.7 cm on 10/18/13 is attributed to a reduction in the resident's edema. The facility staff failed to identify Resident #16's left fifth toe ulcer prior to the podiatrist's visit on 10/07/13, failed to attempt interventions until 10/07/13, and failed to document appearance and size until 10/17/13. These failures may have delayed healing Resident #16's pressure ulcer and limited the facility's ability to determine the effectiveness of the treatment program.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer's recommendations, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 7 sampled residents (Resident #11) observed during a gait belt transfer and 1 of 4 sampled residents (Resident #15) observed during a sit-to-stand lift transfer. Failure to ensure staff use gait belts and mechanical lifts appropriately placed residents at	F 323	**F323** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 15 was evaluated by O.T. in Aegis Therapy on Nov. 6 for appropriateness of Pal lift and was changed to Hoyer Lift due to safety concerns. See Therapy note. Resident #11 condition was deteriorating and expired on 11-10-13. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who are transferred with a pal lift or with the use of a gait belt may be at risk for injury due to this deficient practice.	

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F 323	Continued From page 13 risk for falls and injuries. Findings include: Review of the manufacturer's guideline "Seat Strap Instructions occurred on 10/24/13. The instructions, dated 12/09, stated ". . .1. While the resident is seated, center the seat strap under the person's legs. . . .3. Bring the seat strap beneath the knees leaving about 10 inches of slack hanging . . . 5. Lift the resident just clear of the wheel chair, at this point there should still be a little slack in the seat strap to allow you to pull it back. If not, lower resident and adjust the strap with more slack. Caution: Observe the resident's feet as you lift. If feet begin to lift off the platform, stop lifting and lower the person to a comfortable height." - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included osteoarthritis, dementia, and a history of stroke. The current Minimum Data Set (MDS), dated 09/14/13, identified extensive assist of two people for transfers. Observation on 10/22/13 at 9:27 a.m. showed two certified nursing assistants (CNAs) (#6 and #8) assisted Resident #11 to stand from her wheelchair and ambulate to the bathroom using a gait belt. Resident #11 ambulated with an unsteady gait, and observation showed the gait belt was loose around the resident's waist. A CNA (#6) then gathered the excess in her hand to make the gait belt tighter. Observation on 10/22/13 at 1:09 p.m. showed two CNAs (#7 and #8) assisted Resident #11 to stand from her wheelchair and ambulate to the	F 323	**What measures will be put into place or systemic changes made to ensure the deficient practice rill not recur;** Nurses were in-serviced on November 6 at their nurses meeting on safe use of gait belts and safety strap on pal lift. CNAs were in-serviced on November 8 at their staff meeting on safe use of gait belt and safety strap on pal lift. Proper placement of gait belts and safety strap was added to the CNA Orientation Checklist for mentors to cover during training. A picture of proper placement of seat strap will be displayed on Pal Lifts for staff to refer to. **Monitoring we have put in place to ensure practice does not recur;** QA completed by nursing on proper placement of safety strap on pal lift and gait belts for Nov. 13. Follow-up QAs will be completed monthly x 2, then quarterly x 3. Monitoring will be done by CNA mentors, Unit Directors and Director of Resident Services.	11-28-13

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F 323	Continued From page 14	F 323		

bathroom using a gait belt. Resident #11 ambulated with an unsteady gait, and observation showed the gait belt was loose around her waist, sliding up her back and across her chest.

Observation on 10/23/13 at 9:44 a.m. showed two CNAs (#8 and #9) assisted Resident #11 to stand from her wheelchair and ambulate to the bathroom using a gait belt. The resident's gait was unsteady, and observation showed the gait was loose around her waist, sliding up her back and across her chest.

- Review of Resident #15's medical record occurred October 21-24, 2013. A quarterly MDS, dated 08/02/13, identified Resident #15 required extensive assistance of two or more persons for transfer and toilet use; and had functional limitation of range of motions on both upper and lower extremities. The "Daily Care Card (Care Plan)", dated 08/28/2013, identified Resident #15 transferred with assist of two and a pal lift (standing mechanical lift).

Observation of care on 10/22/13 at 3:00 p.m. showed two CNAs (#2 and #3) transferred Resident #15 with a standing mechanical lift using a seat strap. In assisting the resident into the stand lift, the CNAs (#2 and #3) placed the strap under the resident thighs, just behind his knees, and engaged the lift to raise the resident to a standing position. The CNAs (#2 and #3) failed to reposition the seat strap after lifting the resident, which caused the resident's feet to lose contact with the footplate. The CNAs (#2 and #3) transferred Resident #15 from his bed to the bathroom, located across the room, with the resident sitting swing-like on the seat strap. In the bathroom, with the seat strap holding the

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F 323	Continued From page 15 resident's thighs tightly together, the CNAs (#2 and #3) pulled down the resident's pants. The resident expressed discomfort as staff pulled the brief from between his legs. The CNAs (#2 and #3) identified concerns with the positioning of Resident #15's feet on the footplate and called a nurse to the room. The nurse (#4) and the CNAs (#2 and #3) transferred the resident from the toilet to his wheelchair. As the CNAs (#2 and #3) raised the resident to stand both the CNAs (#2 and #3) and the nurse (#4) failed to move the strap back from the resident's knees. The strap again held the resident's thighs tightly together. As the CNAs (#2 and #3) and the nurse (#4) attempted to redress Resident #15, staff had to force the brief between the resident's thighs. Again the resident expressed discomfort and staff could not pull up his pants. During the transfer from the bathroom to the wheelchair, Resident #15's feet where not in contact with the foot plate and he sat swing-like on the seat strap until lowered onto his wheelchair. During an interview, on 10/24/13 at 8:40 a.m., an administrative nurse (#5) identified the staff should have more training on the use of the seat strap.	F 323		