North L ...partment of Health





| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 1004A | A. BUILDING _____ B. WING _____ | C 12/17/2009 |

| 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) COMPLETE DATE |
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| L3912 | 33-07-04.2-09,1b CODES AND STANDARDS<br><br>The guidelines for construction and equipment of hospital and medical facilities, 1992-93 edition, compiled by the American institute of architects committee on architecture for health with the exception of the section related to design temperatures;<br><br>This state licensing rule is not met as evidenced by:<br>Based on individual resident interview, resident group interview, observation, and direct light measurement, the facility failed to meet the standards for lighting as outlined in Chapter 8 (Nursing Facilities) of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1992-1993 edition, for 5 of 6 nursing units (West, South Central, North Central, Northeast, and Southeast) sampled. The guidelines in Chapter 8.12 (Electrical Standards), under section A4, state "Lighting shall be engineered to the specific application. Table 9 may be used as a guideline." Table 9, Illumination Values for Nursing Facilities, states the illuminance value for toilets and reading areas in resident rooms should be 30 footcandles.<br><br>Findings include:<br><br>During the group interview, conducted on 12/14/09 at 3:30 pm, when asked about lighting in the facility, Resident #31 stated she could read by the bed but not in the rest of the room. Resident #18 stated she did not like the indirect lighting in her room but doesn't think there is room for a lamp in her room. | L3912 | **L3912**<br><br>**How corrective action will be accomplished for those residents affected by the deficient practice:**<br>For residents # 18 and 31 the lighting will be changed to a fluorescent ceiling light in the bathroom and an additional table lamp will be offered to them for their room temporarily until more permanent light fixtures can be purchased for all residents' rooms. Resident #31 refused extra lamp stating "my room has enough light, I don't want any lamps." Resident #18 refused a table and floor lamp and will be offered a temporary ceiling light.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice;**<br>All residents have the potential to be affected by the darkness in the room and bathroom.<br><br>**What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:**<br>All residents' rooms and bathrooms in the facility will have additional | |

Division of Health Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 12-31-09

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| L3912 | Continued From page 1<br>During an interview on 12/14/09 at 4:35 p.m., Resident #18 stated "It is pretty dark in my room. Not very good lighting."<br><br>In an interview on 12/15/09 at 12:15 p.m., Resident #18 stated the lights are not good for anything and it is hard for her to see in her room and bathroom. At this time, Resident #18's room measured 6.1 footcandles by the toilet, 12.8 footcandles by the sink, and 11 footcandles in the reading area.<br><br>During the environmental tour on the morning of 12/15/09, light meter measurements obtained in the following resident areas identified the following measurements (recorded as footcandles):<br>Room 121: 7.6 toilet<br>Room 122: 4.3 toilet, 10 sink<br>Room 126: 3.92 toilet, 7.8 reading area<br>Room 82: 9.4 toilet 13.7 sink<br>Room 133: 6.1 toilet, 12.8 sink, 11 reading area<br><br>During a tour with two staff members (#9 and #10) on 12/16/09 at 8:10 a.m., light meter measurements (taken with the facility's light meter) in rooms 121 and 126 confirmed the values obtained the previous day. A staff member (#9) stated there was no need to measure other rooms as the two different machines had similar readings. A staff member (#10) agreed it was dark in the rooms/bathrooms.<br><br>On 12/16/09 at 1:00 p.m., additional light measurements obtained in resident bathrooms on each of the five units identified the following (recorded as footcandles):<br>Room 4: 5.2 toilet, 8.57 sink<br>Room 23: 11.1 toilet, 16.78 sink | L3912 | lights installed in the rooms to meet the required 30 foot-candles in toilets and reading areas.<br>**Monitoring we have put in place to ensure deficient practices will not recur;**<br>All rooms will be measured for required foot-candles after the installation is completed and documented. More lighting will be added upon resident request.<br>Social Services will ask resident on admission if the room has adequate lighting. Activity Dept. will also ask the question if lighting is adequate for reading or crafts on admission and quarterly with assessments and resident concerns with lighting be addressed as they arise. A CQI will be completed quarterly and monitored by the Director of Resident Services. | 4-16-10 |

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| L3912 | Continued From page 2<br>Room 97: 6.25 toilet, 15.37 sink<br>Room 120: 5.03 toilet, 11.35 sink<br>Room 30: 7.4 toilet, 13.43 sink<br>Room 49: 6.2 toilet, 9.68 sink<br>Room 86: 5.68 toilet, 11.68 sink<br>Room 84B: 16.24 toilet, 17.78 sink<br>Room 75: 6.22 toilet, 12.6 sink<br>Room 67: 8.07 toilet, 11.7 sink | L3912 | | |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey and complaint survey, started on December 14, 2009 and completed on December 17, 2009, the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey. | F 000 | | |
| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<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.<br><br>This REQUIREMENT is not met as evidenced by:<br>1) Based on observation, record review, and staff interview, the facility failed to provide adequate supervision for 2 of 2 sampled residents (Resident #14 and #20) with falls and a history of attempts to self transfer and an accident free environment for 1 of 1 sampled resident (Resident #20) experiencing an injury while toileting. Failure to provide an accident free environment puts residents at risks of falls and/or injury.<br><br>Findings include:<br><br>- Record review for Resident #14 occurred on all days of survey. Medical diagnoses included: history of fall with left hip fracture, osteoporosis, | F 323 | **F323**<br><br>**How corrective action will be accomplished for those residents affected by the deficient practice;**<br>Resident #14 will remain on a toileting schedule. Staff will continue to toilet according to toileting plan and prn as requested by resident. Staff will continue to attempt to answer call lights in a 10 minute time frame as set up by Residents Council. Resident #20 will remain on the chair alarm in attempts to prevent a fall. All staff will be re-instructed to answer the chair/bed alarm when it is heard. The Acepticare was placed in a holder out of the resident's reach and taken off of the shelves that are directly above the toilet.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice;**<br>All residents who need assist to the toilet and are at risk for falls have the potential to be affected when the lights are not answered in a timely manner. All residents who are at risk for falls and have a chair alarm have the potential to be affected when the chair | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | CEO | 12-31-09 |

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 323 | Continued From page 1<br>edema, anxiety, and macular degeneration. The most recent Minimum Data Set (MDS), dated 10/13/09, identified short and long term memory problems, moderate impairment in daily decision making, usually able to make self understood, usually able to understand others, total assistance with toilet use and transfers with two staff, continent of bladder, and experienced a fall in the past 30 days.<br><br>The most recent "Bowel/Bladder assessment," stated, ". . . recommendations - scheduled toileting every 2-3 hours." The comprehensive care plan stated, ". . . toilet between 3-4 p.m. to prevent self toileting at that time."<br><br>The "Fall Progress Notes," dated 04/20/09, identified two falls in March and the following interventions in place: bed and chair alarm, toileting plan, encourage to be out in the lounge area, and toilet 3-4 p.m. to prevent self toileting at that time. The fall progress notes, dated 10/03/09, identified Resident #14 lost her balance and fell in her room, which resulted in a fracture. The record identified Resident #14 "did not call for assistance" and stated the resident's bed alarm "sounding."<br><br>Observation on 12/15/09 at 10:20 a.m. identified Resident #14 turned her call light on for assistance. Observation at 10:25 a.m. showed Resident #14 at the doorway of her room. The resident peeked out of her room and looked both ways down the hallway. Resident #14 then propelled herself back into her room, opened the bathroom door, and propelled into the bathroom. At 10:30 a.m., a CNA (#1) answered Resident #14's call light. Resident #14 commented to the CNA about having to "hold it" due to having to | F 323 | alarm is not answered and the resident may sustain a fall. All residents in the facility who use the toilet have the potential to be affected when the deodorizer can or anything else may fall off the shelf and strike them.<br><br>**What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:**<br>Mentor CNAs were in-serviced on December 22, 2009 on monitoring that lights be answered in less than 10 minutes and assist calls on the walkie-talkie be answered immediately. All staff will be in-serviced on January 20, 2010 at our mandatory in-service. Survey concerns were posted in report rooms and reviewed in report on Dec. 23, 2009 for staff review. MSLCC is creating 10 hour shifts for extra coverage on the units until 4:30 P.M. to cover for meal breaks and until short shift staff arrive. We are looking to put 8 staff in the 10 hour shift and currently have 4 in place to start January 4th. This should assist staff to get needed help to answer lights and transfer help when requested.<br>All cans of Ascepticare will be removed from the shelves and placed in a holder out of the residents reach.<br>All shelves used in residents' | |

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| F 323 | Continued From page 2<br>wait for assistance. This CNA then called for further assistance and transferred the resident onto the toilet. After Resident #14 sat for several minutes on the toilet, she voided into the toilet; however, she stated the urge to have a bowel movement had "passed."<br><br>Observation on 12/16/09 at 3:45 p.m. identified Resident #14 turned her call light on. Observation at 4:05 p.m. identified Resident #14 in the hallway self propelling in her wheelchair. This resident stated, "I'm waiting for someone to take me to the bathroom." Observation showed a CNA (#2) entered Resident #14's room at 4:15 p.m. This CNA waited for assistance until 4:30 p.m., then the CNA (#2), with the assistance of a second CNA, transferred the resident onto the toilet.<br><br>During an interview on 12/17/09 at 8:00 a.m., an administrative nursing staff member (#3) stated facility staff placed Resident #14 on a toileting schedule due to her risk of falling and stated it is the responsibility of staff to follow the resident's toileting schedule and to answer call lights in a timely manner.<br><br>Failure to answer Resident #14's call light in a timely manner and failure to follow the toileting schedule placed Resident #14 at risk of falling due to attempts to self toilet.<br><br>- Record review for Resident #20 occurred on December 16-17, 2009. Medical diagnoses included: dementia, blindness, anxiety, and a history of falls. The most recent MDS, dated 10/11/09, identified problems with short and long term memory, moderately impaired with decision making, and required extensive assistance with transfers and toilet use. The "Falls Resident | F 323 | All cabinets in the soiled utility room containing chemicals will have a self latching device on the door when it is closed.<br><br>**Monitoring we have put into place to ensure practice does not recur:**<br><br>CQI on call lights will be completed monthly x 3, then quarterly. Response time when a CNA calls for assist will also be included on the CQI. A CQI will be completed on response time to bed/chair alarms that they are answered timely. A CQI will be completed quarterly on the cans of Ascepticare disinfectant that they are placed safely in the holder and out of the reach of the resident. A CQI will be completed on the chemicals stored in the soiled utility rooms monthly x 2 then quarterly. These CQIs will be monitored by the Director of Resident Services. | 1-21-10 |

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| F 323 | Continued From page 3 | F 323 | | |

Assessment Protocol Summary" (RAPS) stated, "compulsive - will get up without assistance."

Observation on 12/15/09 at 12:00 p.m. identified Resident #20 seated in the dining room, finished with his meal. Observation showed a chair alarm attached to his dining room chair. At 12:15 p.m., Resident #20 attempted to stand, and a licensed nurse (#5) stated, "Just a minute [Resident's name]. Wait until they come." Resident #20 then settled back into his chair. At 12:20 p.m., Resident #20 stated, "Come on!" and began to stand on his own. The resident's chair alarm sounded as he stood, and balanced himself by holding onto the dining room table. Observation showed staff members in the dining room assisting others, but no one in the dining room responded to Resident #20's chair alarm. A CNA (#6) walked past Resident #20 approximately one table away, but did not respond to the chair alarm. The CNA then looked in the direction of this surveyor, who pointed out Resident #20 attempting to self transfer from the table. This CNA then approached Resident #20 and assisted him out of the dining room using a gait belt.

Failure of facility staff to respond to Resident #20's chair alarm, when the resident attempted to self transfer, placed Resident #20 at risk of falling.

Review of a nurse's note for Resident #20, dated 12/02/09, stated, "11:50 a.m. Resident sitting on toilet in bathroom with CNA accompanying. Can of room deodorizer fell from shelf above toilet hitting resident on top of head. No bruising or redness. Denies headache."

Review of the incident report, dated 12/02/09,

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| F 323 | Continued From page 4<br>occurred on 12/17/09 at 9:40 a.m. The report stated, "Resident taken to the bathroom - while sitting on the toilet, room deodorize [sic] can fell from top shelf - (was placed on top of paper covering bedpan) hitting resident on top of head - no redness, bruise [sic] noted. Crani [cranial] checks initiated. . . . Causative Factors to Consider - Check if present: Other: Room deodorizer can placed on top of paper covering bedpan. . . . Type of injury: head injury. . . Attempts to prevent recurrence: DO NOT PLACE CAN in wrong place. . . . 12/03/09. Has been addressed at unit meetings et [and] CNA meetings that deodorant/sanitizer cans to be kept on top shelves in bathroom. Will continue to review with CNAs et instruct not to put cans on top of other things."<br><br>Observation in Resident #20's bathroom showed the following:<br><br>* On 12/16/09 at 3:50 p.m. identified a can of deodorizer labeled "Acepticare" sitting upright on a lower shelf.<br><br>* On 12/17/09 at 7:45 a.m. identified a can of deodorizer labeled "Acepticare" stored on its side on top of a blue basket of supplies. The can of deodorizer sat lengthwise on top of the supplies, which filled the basket and extended beyond the basket sides. This observed placement of the room deodorizer on top of other items is similar to the incident that occurred on 12/02/09, placing Resident #20 at risk of further injury.<br><br>During an interview on 12/17/09 at 8:00 a.m., an administrative staff member (#3) confirmed Resident #20 is impulsive, needs assistance with transfers, and stated she expects staff to answer | F 323 | | |

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| F 323 | Continued From page 5 | F 323 | | |

chair alarms in a timely manner. She further stated cans of deodorizer should be stored on the top shelf, out of reach of residents, and agreed the incorrect placement of the can represents an accident hazard to Resident #20.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/14/08

2) Based on observation, staff interview, and review of product information labels, the facility failed to ensure an environment free of hazardous chemicals in 3 of 6 soiled utility rooms (North Central, Northeast, and South Central). Failure to ensure the secured storage of hazardous chemicals places vulnerable residents (e.g. wandering, confused) at risk for exposure to these chemicals.

Findings include:

During random observations of the unlocked soiled utility rooms on 12/15/09 at 9:10 a.m., observation revealed the following chemicals in unlocked cabinets:
* North Central soiled utility room: eight jugs of Penner Patient Care Whirlpool Disinfectant Cleaner, one spray bottle and one bottle with a pump of Ecolab Neutral Disinfectant Cleaner, and one aerosol can of Triple S Foam Disinfectant Cleaner and Deodorizer.
* Northeast soiled utility room: three pump bottles of Ecolab Neutral Disinfectant Cleaner, one aerosol can of Triple S Foam Disinfectant Cleaner and Deodorizer, one spray bottle and one jug of Triple S Enz-Odor II.
* South Central soiled utility room: one spray bottle and one pump bottle of Ecolab Neutral

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| F 323 | Continued From page 6<br>Disinfectant Cleaner, one aerosol can of Asepticare Disinfectant Virucide, one aerosol can of Triple S Foam Disinfectant Cleaner and Deodorizer, one spray bottle and one jug of Triple S Enz-Odor II.<br>Observations indicated signs posted on cabinet doors in the Northeast and South Central soiled utility rooms. The signs stated the cabinets should be kept locked at all times. During the environmental tour at 10:00 a.m. with a staff member (#8), the cabinet in the North Central soiled utility room remained unlocked.<br><br>Review of product information labels indicated:<br>* Penner Patient Care Whirlpool Disinfectant Cleaner: ". . . Keep out of reach of children. . ."<br>* Ecolab Neutral Disinfectant Cleaner: ". . . DANGER, Keep out of reach of children. . ."<br>* Triple S Foam Disinfectant Cleaner: ". . . Keep out of reach of children. . . Harmful if swallowed, absorbed through skin, or inhaled. . ."<br>* Triple S Enz-Odor II: ". . . Keep out of reach of children. . . Avoid contact with skin, eyes, and clothing. . ."<br>* Asepticare Disinfectant Virucide: ". . . Keep out of reach of children. . . Avoid contact with eyes. . . Avoid food contact. . ."<br><br>During interview on 12/15/09 at 10:30 a.m., an administrative staff member (#8) stated she expected staff to lock chemicals in the cabinets in the soiled utility rooms at all times.<br><br>Failure to maintain an environment that is as free as possible from hazards over which the facility has control, such as assuring the safe storage of toxic chemicals, has the potential to place vulnerable residents in the Northeast, North Central, and South Central Units at risk for harm. | F 323 | | |

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| F 327 SS=D | 483.25(j) HYDRATION<br><br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide sufficient fluid intake to maintain proper hydration for 3 of 3 sampled residents (Resident #13, #14, and #19) identified by the facility with insufficient fluid intake and observed not offered fluids during cares.<br><br>Findings include:<br><br>- Record review for Resident #14 occurred on all days of survey. Medical diagnosis included: constipation, hypertension, edema, anemia, and renal failure. The most recent Minimum Data Set (MDS), dated 10/13/09, identified short and long term memory problems, moderate impairment in daily decision making, usually able to make self understood, usually able to understand others, limited assistance with eating, and insufficient fluid intake.<br><br>The current comprehensive care plan stated, "offer adequate fluids daily." and listed staff responsible as "ALL." The most recent "Hydration Assessment," dated 10/13/09, identified Resident #14's daily fluid needs of "1259-1500 cc. [cubic centimeters]" The assessment identified 684 ccs consumed at meals and an additional 816 ccs needed to achieve Resident #14's daily fluid needs.<br><br>Observation of meals on 12/14/09 and 12/15/09 | F 327 | F327<br><br>**What corrective action will be accomplished for those residents affected by the deficient practice;**<br>Residents #13, 14 and 19 will be put on an Intake and Output x 7 days.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice;**<br>All residents who need assist to eat or drink or have insufficient fluid intake as evidenced by the MDS have the potential to be affected.<br><br>**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**<br>Mentor CNAs were in-serviced on December 22, 2009. All staff will be in-serviced on January 20, 2010 at the mandatory in-service. Reminders will be given during monthly unit meetings and CNA meetings.<br><br>**Monitoring we have put into place to ensure practice does not recur;**<br>CQIs will be completed weekly x 1 month.<br>Monthly x 3 months then quarterly and will be monitored by the Director of Resident Services. | 1/21/10 |

| 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 _____ | C 12/17/2009 |

| 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 327 | Continued From page 8 | F 327 | | |

identified Resident #14 ate independently. Resident #14's meal tray contained the following fluids: a cup of coffee, an eight ounce glass of water, an eight ounce glass of milk, and for breakfast meals, an additional glass containing juice. The resident took sips of her fluids, but left approximately two-thirds of her fluids on her tray following the meals.

Observation of cares, on 12/14/09 and 12/15/09, identified a glass of water in Resident #14's room. Facility staff failed to offer or encourage fluids to Resident #14 with any cares completed.

Observation, on 12/15/09 at 1:30 p.m., showed a licensed nurse (#7) performed a rectal check on Resident #14. This nurse stated this resident had not had a bowel movement in four days and the rectal check showed a small amount of formed stool in the rectum. This nurse called the physician and obtained an order for a stool softener twice a day and a one time order for Magnesium Citrate.

Failure to offer adequate fluids daily to Resident #14 during cares and failure to ensure adequate fluids are consumed during meals may have contributed to Resident #14's problems with constipation.

- Record review for Resident #13 occurred on all days of survey. Medical diagnosis included: Alzheimer's disease, dementia, anxiety, and history of urinary tract infections. The most recent MDS, dated 10/13/09, identified short and long term memory problems, moderately impaired decision making, supervision with eating, and insufficient fluid intake.

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| F 327 | Continued From page 9<br>The current comprehensive care plan stated, "offer adequate fluids daily." The most recent "Hydration Assessment," dated 10/06/09, identified Resident #13's daily fluid needs of "1136-1500 ccs." The assessment identified additional fluids consumed at meals as "744 ccs" and additional fluids needed to meet daily needs as "756 ccs."<br><br>Observation of meals on 12/14/09 and 12/15/09 showed Resident #13 seated at an assisted dining table with staff. Observation showed the following fluids available on Resident #13's tray: a cup of coffee, an eight once glass of juice, an eight ounce glass of water, an eight ounce glass of milk and, in addition to these fluids, a can of pop available at lunch. Observation showed the resident consumed approximately a third of these fluids.<br><br>Observations of cares, on 12/15/09 and 12/16/09, identified a glass of water in Resident #13's room. Facility staff failed to offer or encourage fluids with any cares provided.<br><br>- Record review for Resident #19 occurred on December 16-17, 2009. Medical diagnosis included: Mild mental retardation, dementia, anxiety, hypertension, and diabetes. The most recent MDS, dated 11/08/09, identified short and long term memory problems, moderately impaired with daily decision making, independent with eating, and insufficient fluid intake.<br><br>A current physician/nursing order stated, "Encourage fluids." The current comprehensive care plan stated, "Failure to consume almost all fluids . . . potential for fluid volume deficit . . . offer adequate fluids daily." The nursing assessment, | F 327 | | |

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| F 327 | Continued From page 10<br>dated 08/05/09, stated, "Resident refuses fluids frequently. Unable to force fluids. . ."<br><br>The current "Hydration Assessment," dated 11/10/09, identified Resident #19's daily fluid needs as "1953 ccs." The assessment identified fluid intake at meals as "513 ccs" and additional fluids needed to achieve daily fluid needs as "1440 ccs."<br><br>Observation of cares, on 12/16/09, identified a glass of water in Resident #19's room. Facility staff failed to offer or encourage fluids with cares provided.<br><br>During an interview on 12/17/09 at 8:00 a.m., an administrative staff member (#3) stated the expectation is for staff to offer fluids with cares and, even though a resident has a history of refusing fluids, staff are still expected to offer fluids. | F 327 | | |
| F9999 | FINAL OBSERVATIONS<br><br>The complaint investigated in conjunction with the standard Medicare/Medicaid survey was unsubstantiated. | F9999 | | |