STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 07/13/15 and completed on 07/16/15, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		9/25/15

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

Electronically Signed | 08/05/2015

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and facility policy, the facility failed to immediately notify the resident's physician for 2 of 9 sampled residents (Resident #5 and #8) who were diagnosed with urinary tract infections (UTIs). Failure to promptly notify the physician of the resident's signs/symptoms of a urinary tract infection resulted in delayed treatment and may have contributed to Resident #8's hospitalization. Findings include: Review of the facility policy titled "Reporting and Initial Management of Suspected Infections" occurred on 07/16/15. This policy, revised June 2012, stated, ". . . the following occurrences will be reported . . . Symptoms of an active infection such as: . . . Casts or sediment in the urine . . . The charge nurse will take the following actions as soon as possible if an infection is suspected. . . . Notify the attending physician. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included incontinence and history of UTIs. The most recent Minimum Data Set (MDS), dated 05/17/15, identified severely impaired cognition, extensive assistance of one person for toileting, frequent urinary incontinence and occasional bowel incontinence.	F 157	1. Resident #5 experienced a UTI on 7-24-2015. The physician was notified and a culture order received on 7-24-15. A progress note was written. Care plan was updated. Resident #8 was assessed for signs & symptoms of a Urinary Tract Infection (UTI). Resident is free from infection as of 7-12-2015. Care plan updated. 2. All residents have the potential to be affected in this area. A list of resident with a history of reoccurring UTI¿s will be generated and each resident will be assessed for any s/s of a UTI or infection. 3. A mandatory nurses meeting was held on August 4 and 5, 2015 to review policy and procedures related ¿reporting and initial management of suspected infections and urogenital tract infections¿ with a focus on the need to notify physician, document in a timely manner, document a progress note at the time of onset, document if any cultures obtained, treatment initiated, and the outcome. 4. An audit will be developed to monitor residents with signs & symptoms of a suspected UTI and if the attending physician was notified in a timely manner.	

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F 157	Continued From page 2 The progress notes identified the following: * 06/19/15 at 4:56 p.m., "Resident has been displaying out of ordinary aggressive and anxious behaviors . . . Dipstick reading on urine . . . displayed positive . . . Fax for request for a UA [urine analysis]," and at 6:31 p.m., "Fax sent to Dr. [Doctor] [name] regarding positive dipstick of urine." * 06/26/15 at 6:16 p.m., "Fax re-sent [7 days after the original fax was sent] to Dr. [name] regarding urinary sx [symptoms] as no reply noted from fax sent on 06/19/15 regarding this." * 06/29/15 at 2:34 p.m., "Fax received [10 days after the original fax was sent] from Dr. [name] and UA/UC [urine culture] to be sent to lab," and at 5:18 p.m., ". . . urine sent to lab and will await physician recommendations." * 06/30/15 at 12:08 p.m., "U/A results returned from Dr. [name]. . . . They will culture and get back to us," at 1:41 p.m., "Call placed to [hospital] regarding resident symptoms and no results back yet from urine culture [6 days after the physician's order was received for a UC and 16 days after the physician was initially contacted regarding the resident's symptoms] and she will check on this and get back to me." and at 3:00 p.m., ". . . doctor would like to assess resident in the ER [emergency room] for possible admission . . ." Failure to immediately notify the physician of Resident #8's signs/symptoms of a urinary tract infection delayed her medical treatment and may have contributed to her hospitalization. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included urge/stress incontinence, urine	F 157	The audit will be completed 3 x¿s per week x 2 weeks, then 1 x per week x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The DNS, or designee, will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	

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F 157	Continued From page 3 retention, and history of recurrent UTIs. The most recent MDS, dated 06/21/15, identified intact cognition, extensive assistance of two or more people for toileting, frequent urinary/bowel incontinence. A progress note, dated 05/01/15 at 10:02 p.m., identified, "Reported by . . . CNA [certified nursing assistant] to nurse, that resident upon changing and mustard-colored discharge, that was explained as gooey and foul-smelling. . . ." A fax to Resident #5's physician, dated 05/22/15, stated, ". . . Patient has c/o [complained of] burning in peri area. Positive dipstick of leukocytes, protein, nitrates. . . . inner labia is red . . . inflammed [sic] . . . sensitive to touch. Some vaginal discharge noted from CNAs. . . ." The first signs/symptoms of infection were noted on 05/01/15, 22 days prior to staff notifying Resident #5's physician. Failure to immediately notify the physician of Resident #5's signs/symptoms of an infection delayed her medical treatment.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		8/14/15

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F 164	Continued From page 4 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident interviews, the facility failed to ensure personal privacy for 2 of 2 interviewable residents (Resident A and B) who expressed concerns regarding wandering residents. Failure to ensure privacy is an infringement on the residents' rights and may lead to a loss of dignity and/or social isolation. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 07/16/15. This policy, dated February 2013, stated, ". . . Ideas for maintaining a resident's dignity may include, but are not limited to: . . . Respecting resident's private space and property . . . not moving or inspecting	F 164	See also F250 1. Residents A and B were visited by Social Worker to discuss ensuring personal privacy. 2. All residents have the potential to be affected in this area. The social worker, administrator, and DNS, will randomly select 10-15 other interview able residents and each resident will be interviewed regarding privacy and if they have any concerns. 3. A mandatory nursing meeting was held on August 4 and 5, 2015 to review policy and procedures related to "resident dignity" with a focus on the need	

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F 164	Continued From page 5 resident's personal possessions without permission. . . ." - During an interview on 07/13/15 at 3:37 p.m., Resident A expressed concerns regarding his privacy. When asked why he keeps the door to his room closed, he described a wandering resident [Resident #11] who enters his room at all hours of the day or night. He stated, "I don't like others coming in here and snooping." - During an interview on 07/15/15 at 3:00 p.m. Resident B expressed concerns regarding her privacy. When asked why she keeps the door to her room closed, she described a wandering resident [Resident #11] who enters her room at all hours of the day or night. She stated, [Resident #11] goes through my stuff. I've had to wheel her out [Resident B ambulates with a walker]." Resident B then described an incident when she awoke one night to "hear someone in the bathroom." She stated, "She [Resident #11] was in there messing around." - Observation on 07/14/15 at 12:47 p.m. showed Resident #11 following an unidentified Certified Nursing Assistant (CNA) and Resident #18 down the hallway and into Resident #18 and #8's shared room. As the CNA followed Resident #18 towards the right side of the room, Resident #11 wheeled herself to the left. She immediately began inspecting and moving Resident #8's personal belongings lying on the dresser. When the CNA realized the surveyor was watching Resident #11, she stated, "[Resident #11], come over here please." Resident #11 then wheeled herself towards the center of the room. The CNA returned to Resident #18's side of the room and	F 164	to allow resident privacy and not to allow other residents to enter another resident's room to move or inspect personnel belongings without permission. The Social Worker will also discuss staff following care plan interventions regarding redirection of wandering residents and ensuring privacy of other residents. Staff educated on the facility behavior committee meetings which will concentrate on ways to give feedback on care plan interventions being effective and reviewing suggestions by staff. Education will also be done regarding the need to follow the care planned interventions for wandering residents. 4. An audit was developed to ensure dignity is met of all residents. The audit will be completed on random residents as well as residents A and B. The audit will be completed 3 x¿s per week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The Social Worker, Administrator, DNS, or designees, will be responsible for the completion of the resident interviews. The results of the audits will be reported to the QAPI committee for further recommendation.	

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F 164	Continued From page 6 assisted her with cares. Resident #11 immediately returned to the left side of the room and began inspecting and moving Resident #8's personal belongings lying on the bed and dresser. Five minutes later, the CNA walked back into the room, realized the surveyor was still watching Resident #11, removed her from the room, and shut the door.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident interview, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 4 of 9 sampled residents (Resident #5, #8, #9, and B). Failure to knock on doors prior to entering residents' rooms does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 07/16/15. This policy, dated February 2013, stated, ". . . Ideas for maintaining a resident's dignity may include, but are not limited to: . . . Respecting resident's private space and property . . . knocking on doors and requesting permission to enter. . . ."	F 241	1. Residents #5, #8, #9 and #17 individual needs are being met as staff is knocking on resident¿s doors and waiting 5 seconds or for a resident response prior to entering a resident¿s room. 2. All residents have the potential to be affected in this area. The facility will conduct random audits throughout the facility monitoring for compliance in this area. 3. A mandatory all staff meeting will be held on August 11, 2015 to review policy and procedures related to "Resident Dignity" with a focus on the need for all staff to knock on resident doors and wait 5 seconds, or for a resident response, prior to entering a residents room.	8/14/15

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F 241	Continued From page 7 - During an interview on 07/15/15 at 3:00 p.m. Resident B expressed concerns regarding her privacy. She reported direct care staff "just knock and come in [her room]." Observation showed the following: * 07/13/15 at 3:37 p.m., two Certified Nursing Assistants (CNAs) (#5 and #6) knocked on the door as they entered Resident #9's room. Resident #9 stood next to the bed, bare from the waist down. As the two CNAs (#5 and #6) cued/assisted him to sit, a nurse (#7) knocked on the door and entered the room. * 07/13/15 at 4:50 p.m., two CNAs (#5 and #6) placed a bed pan under Resident #5, covered her with a blanket, and exited the room. At 5:08 p.m., the CNAs (#5 and #6) knocked on the door as they entered the room, stating, "Are you done?" * 07/13/15 at 5:00 p.m., two CNAs (#5 and #6) knocked on the door as they entered Resident #8's room. A third unidentified CNA then knocked on the door and entered Resident #8's room to ask them a question. Facility staff failed to request permission and/or wait for a response prior to entering Resident #5, #8, #9's rooms.	F 241	4. An audit will be developed to ensure resident dignity is being met with proper door knocking. The audit will monitor if door knocking is being done according to procedure by all staff. The audit will be completed on 5 random residents 3 x's per week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The DNS, or designee, will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		8/14/15

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F 250	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to develop and implement behavior interventions for 1 of 1 sampled resident (Resident # 11) observed wandering into a room occupied by two residents (Resident #8 and #18) and rummaging in a resident's belongings. Failure to develop and implement interventions for Resident #11's intrusive behaviors resulted in confrontations with other residents. Findings include: Review of the facility policy "Behavioral Causes and Interventions" occurred on 07/16/15. The policy, dated February 2013, stated, "Purpose: To aid in determining causes of behavior and appropriate interventions and strategies. Behavior Management Issues: 1. Cognitively impaired residents who wander with no rational purpose, and are oblivious to needs or safety . . . 2. . . . Moving about the facility aimlessly may indicate that cognitively impaired residents are frustrated, anxious, bored, hungry, or depressed. . . . Try to determine what's causing the behavior. Is the behavior related to the resident's physical or emotional health? . . . Is the behavior related to the environment? Is the environment too stimulating, such as too many people around or too much noise? . . . Is there a lack of structure or routine? . . . Is the behavior related to communication? . . ." - During an interview on 07/13/15 at 3:37 p.m.,	F 250	See also F 164 1. Resident #11 care plan updated to include behavioral interventions related to intrusive wandering. Social Worker is sending referral faxes to place Resident 11 in a more appropriate facility to better meet resident's needs. 2. All residents have the potential to be affected in this area. 3. A mandatory nurses meeting was held on August 4 and 5, 2015 with education given about the ¿behavior committee meetings¿ which will concentrate on ways to give feedback on care plan interventions as either being effective and reviewing suggestions by staff on new interventions to try. Education provided regarding the need to follow the care planned interventions and to document behaviors on wandering residents. All staff education was held on Aug 11th to review policy and procedure Behavioral Causes and Interventions and Behavior Committee Meeting with a focus on the need for all staff to become familiar with care plan interventions regarding wandering residents and to provide feedback to develop and implement individualized interventions for intrusive wandering residents. 4. An audit was developed to ensure individualized interventions are implemented for residents with intrusive	

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F 250	Continued From page 9 Resident A expressed concerns regarding his privacy. When asked why he keeps the door to his room closed, he described a wandering resident [Resident #11] who enters his room at all hours of the day or night. He stated, "I don't like others coming in here and snooping." - During an interview on 07/15/15 at 3:00 p.m. Resident B expressed concerns regarding her privacy. When asked why she keeps the door to her room closed, she described a wandering resident [Resident #11] who enters her room at all hours of the day or night. She stated, [Resident #11 goes through my stuff. I've had to wheel her out [Resident B ambulates with a walker]." Resident B then described an incident when she awoke one night to "hear someone in the bathroom." She stated, "She [Resident #11] was in there messing around." - Observation on 07/14/15 at 12:47 p.m. showed Resident #11 following an unidentified Certified Nursing Assistant (CNA) to Resident #8 and #18's shared room. As the CNA provided cares for Resident #18, Resident #11 immediately began moving Resident #8's personal belongings. The CNA stated, "[Resident #11], come over here please." Resident #11 then wheeled herself towards the center of the room. The CNA returned to assisting Resident #18 and Resident #11 immediately returned to the left side of the room and began moving Resident #8's personal belongings. Five minutes later, the CNA walked back into the room, removed Resident #11 from the room, and shut the door. - Resident #11's medical record, reviewed on July 15-16, 2015, identified diagnoses including	F 250	behaviors. The audit will be completed 3 x's a week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The social worker or designee will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee and Behavior committee for further recommendation.	

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Alzheimer's Disease, anxiety disorder, and depression. A quarterly Minimum Data Set (MDS), dated 04/05/15, identified the resident rarely made herself understood and rarely understood others, had short and long term memory problems, displayed inattention and disorganized thinking, physical behaviors on 1-3 days, and wandering daily during the seven day look back period.

Review of Resident #11's progress notes identified the following:
04/20/15 at 9:35 p.m.: " . . . Residents getting very upset with her going into their rooms and taking things without their permission. Cloths [sic], blankets, papers, anything that is lying loose and in reach of her hands. They are starting to close their door when they would rather keep them open if possible. . . ."
04/21/15 at 2:45 p.m.: "Resident . . . is going into other resident rooms and one female resident became very upset and pushed her out of her room . . . you can redirect her or help her, and she will repeat the same action a few minutes later."
04/23/15 at 4:50 p.m.: "CNA found resident trying to get around another resident who was blocking the hallway. Other resident was running into her feet with his wheelchair and she kept saying 'ouch my feet.'"
05/26/15 at 7:10 p.m.: . . .Continually propelling self up and down halls and into other resident's rooms. Staff constantly removing her from other resident's rooms rooms . . ."
05/27/15 at 9:42 a.m.: Redirected res. [resident] out of other res. rooms twice within one minute. Few minutes later a 3rd res. out to [sic] nurses station aggitated [sic] and reporting to staff that

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F 250	Continued From page 11 [Resident #11] came in her room and dumped her milkshake on the floor. The res. stated, 'I'm done with this!' . . ." 05/30/15 at 5:40 p.m.: "Nurse wintnessed [sic] res. from [room number (#)] pushing [Resident #11] way from [room #] while [Resident #11] resisted trying to push back against other resident by using her feet against the floor. Nurse interviened [sic]. Res. From [room #] stated that [Resident #11] propelled herself in to her room and came after her in a threatening matter [sic] hitting and scratching at her Res. states 'She scaired [sic] me and I was looking for something to through [sic] at her.' when resident from across hall [room #] came to help. This nurse propelled [Resident #11] in w/c [wheel chair] away from the situation to nurses station. At this time another female resident from [room #] states has 'chased her out' of her room 2 times today and was called a 'bitch' and 'wasn't very happy' with her as well. This nurse has redirected [Resident #11] out of other residents rooms multiple times today as well, but res. goes from one room to another all day. 06/14/15 at 1:03 p.m.: ". . . During lunch resident would go to other tables and disturb other residents. . . ." 06/14/15 at 1:06 p.m.: "resident very agitated/anxious at this time; is wandering into other resident rooms and when redirected, hollers out and becomes more agitated . . ." 06/17/15 at 12:00 p.m.: "Patient is [sic] another patient's room . . . Patient would not come with person writing out of room. . . ." 06/26/15 at 12:26 p.m.: "Resident has been restless all morning . . . going into other resident rooms . . . sometimes strikes out with her arm during cares or verbal redirection."	F 250		

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	355093	A. BUILDING _____ B. WING _____	07/16/2015

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F 250	Continued From page 12 07/07/15 at 4:58 p.m.: "Resident has been restless all day . . . continuously enters other residents' room et [and] disrobes self in some as well. She is not easily redirected. . . ." 07/07/15 at 6:39 p.m.: Resident was found in another residents bed. . . . Staff redirected her." 07/15/15 at 4:09 p.m.: ". . . Writer has also been attempting to provide resident with items to fidget with or rummage in due to constant wandering. Resident has very short attention span and has been unable to engage in activity 1:1 [one to one] with writer. Resident is now holding her personal monkey and appears content but continues to wander around the facility." 07/15/15 9:38 p.m.: "Resident restless and continually 'on the go' in her w/c. Propels self in halls and requires frequent redirection from staff to remove from other residents rooms (unwelcome). Resident usually resistant to redirection. . . . Resident was taken for 'walks,' given snacks, activities offered, fluids offered, and fluids offered [sic]. At times is effective. . . " The Resident #4's current care plan identified a problem, initiated on 01/22/15: "The resident has a behavior symptom R/T [related to] Dementia E/B [evidenced by] wandering continuously in her wheelchair around the facility, H/O [history of] grabbing at others." Interventions stated, "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed Provide opportunity for positive interaction, attention with eye contact offer hand. BEHAVIOR #1 wander: redirect as able/needed. BEHAVIOR #2: disrobing: attempt to dress in layers. BEHAVIOR #3: resistive to cares: redirect/reapproach." The	F 250		

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F 250	Continued From page 13 care plan lacked specific individualized interventions staff should implement to address Resident #11's intrusive wandering into other resident's rooms and confrontations with other residents related to the wandering. During an interview on the morning of 07/16/15, a social services staff member (#2) stated staff have attempted placing a barrier to prevent Resident #11 from entering other resident's rooms, but she was able to remove the barrier. Staff's failure to develop and implement individualized interventions for Resident #11's intrusive wandering resulted in other residents expressing anger towards Resident #11, attempting to remove her from their rooms, and blocking the hallway. These responses may result in an injury for Resident #11 or other residents attempting to remove her from their rooms.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/15/2015	F 309	1. Resident #12 physician was contacted for a new swallowing evaluation. The swallowing study was	8/14/15

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F 309	Continued From page 14 Based on observation, record review, review of facility policy and procedure, and review of professional literature, the facility failed to ensure 1 of 4 sampled residents (Resident #12) observed being fed received the care and services necessary to attain the highest degree of safety possible while being fed in his room. Failure to ensure a resident with a known risk of dysphagia was alert and positioned properly prior to providing food/liquid resulted in the resident aspirating. Findings include: Review of the facility policy titled "Dysphagia" occurred on 07/16/15. This policy, dated September 2012, stated, ". . . Dysphagia - Any problem in . . . swallowing . . . beverages . . . conditions that indicate the resident is at risk for dysphagia include: . . . Alzheimer's disease . . . nursing staff will observe for signs and symptoms of dysphagia when interacting with residents or when observing the meal service. Signs and symptoms of dysphagia are as follows: . . . coughing or choking when ingesting . . . liquid . . . drooling, difficulty initiating a swallow . . . poor lip closure, poor control of head and/or body position . . . excessive time required to complete a meal . . ." Review of Resident #12's medical record occurred on July 15-16, 2015. Diagnoses included advanced Alzheimer's dementia. The quarterly Minimum Data Set (MDS), dated 06/21/15, identified severely impaired cognitive skills, no symptoms of a swallow disorder, mechanical diet, and extensive assistance of one person required for eating.	F 309	done on 8-4-15 with no new changes. She had teeth extracted on July 8 2015 and the care plan was updated. 2. Residents that have dysphasia have the potential to be affected in this area. 3. A mandatory nurses meeting was held on August 4 and 5, 2015 to review policy and procedures titled ¿Dysphagia¿ with a focus on the need for staff to ensure the resident is alert and awake and positioned close to 90 degrees as possible, control the size of the bolus, and recognized signs and symptoms of lung aspiration. A list of residents with the diagnosis of dysphasia with mechanically altered meals was generated and each resident will be assessed and documentation will be completed in a progress note. Staff will note any signs and symptoms of aspiration, alertness during meals, positioning, diet order and liquid consistency according to physician¿s orders. 4. An audit was developed to monitor residents with a dysphasia diagnosis and mechanically altered meals and fluids checking to ensure the resident is alert and awake prior to assisting with meals, if the wheelchair is positioned close to 90 degrees as possible, the staff control of the size of the bolus, and recognized signs and symptoms of a food or fluid aspiration. If swallowing concerns are identified the nurse will be informed and	

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F 309	Continued From page 15 The current care plan stated, ". . . Focus: . . . nutritional problem . . . Interventions: . . . Diet: regular-warm liquified [sic] diet . . ." The kardex further stated, ". . . EATING: Resident requires total assistance to eat. Allow resident the time needed to complete the meal. . . ." A progress noted, dated 06/15/15, stated, ". . . A swallow eval. [evaluation] was completed on 02/10/15 which indicated a liquid diet was still appropriate for her. She requires total assist from staff. Staff is to allow adequate time to complete meals. . . ." Observation showed the following: * 07/14/15 at 12:30 p.m., a certified nursing assistant (CNA) (#12) fed Resident #12 in the dining room. Resident #12 sat in her wheelchair with the back support reclined at a 40 degree angle (placing Resident #12 at an increased risk of premature loss of food/liquid over the back of her tongue), her head turned to the right side (directing the bolus to the right side of her oral cavity), and her eyes closed. The CNA (#12) held a glass containing thin liquids to Resident #12's mouth (allowing the liquids to pour into her mouth) even though Resident #12 was unresponsive. Resident #12 began drooling from the right side of her mouth (an indication Resident #12 did not swallow her secretions) and coughed on three occasions (an indication Resident #12 did not swallow her secretion and secretions had entered her airway). The CNA (#12) continued to feed Resident #12 even though she was unresponsive and demonstrating signs/symptoms of dysphagia/aspiration. * 07/15/15 at 8:40 a.m., an unidentified staff	F 309	the resident¿s physician will be contacted according to facility procedure. The audit will be completed 3 x's per week x 2 weeks, then weekly x 2 weeks, then monthly x2 months, then quarterly x3 quarters. The DNS or designee will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	

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F 309	Continued From page 16 member fed Resident #12 in the dining room. Resident #12 sat in her wheelchair with the back support reclined at a 70 degree angle, her head turned to the right side, and her eyes closed. The unidentified staff member rubbed Resident #12's arm stating, "[Resident #12], drink. Can you open your eyes?" She then held a glass containing thin liquids to Resident #12's mouth (allowing the liquids to pour into her mouth) even though Resident #12 was unresponsive. When the CNA realized the surveyor was watching Resident #12, she adjusted Resident #12's head closer to midline. The unidentified staff member again rubbed Resident #12's arm and stated, "[Resident #12], wake up." She held the glass containing thin liquids to Resident #12's mouth (allowing the liquids to pour into her mouth) even though Resident #12 remained unresponsive. Resident #12 began drooling heavily from the right side of her mouth onto her chin and clothing protector. The unidentified staff member stated, "[Resident #12], wake up. Have a drink. Here's a drink [Resident #12]. [Resident #12] take a drink." The unidentified staff member continued to feed Resident #12 even though she was unresponsive and demonstrating signs/symptoms of dysphagia. The facility failed to: * ensure Resident #12 was awake/alert prior to feeding her, * position Resident #12 as close to 90 degrees as possible prior to feeding her, * control the size of the bolus [sip], * recognize Resident #12's signs/symptoms of dysphagia and/or aspiration (poor lip closure, drooling, difficulty initiating a swallow, coughing, excessive time required to complete a meal).	F 309		

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F 309	Continued From page 17 Failure to implement the above interventions place Resident #12 at increased risk of/resulted in her aspirating during meals.	F 309		
F 314 SS=G	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 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 professional reference, review of facility policy, and staff interviews, the facility failed to provide the necessary treatment and services to prevent the development and promote the healing of pressure ulcers for 2 of 3 sampled resident (Resident #4 and #9) identified with pressure ulcers. Failure to provide timely and appropriate skin assessment and/or dietary interventions resulted in the development of Resident #4 and #9's facility-acquired heel pressure ulcers and in Resident #9 experiencing pain/discomfort. Findings include: Review of the facility policy titled "Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements" occurred on 07/16/15. This policy, revised September 2012,	F 314	1. Resident # 4¿s pressure ulcer is still present and showing signs of healing. Staff continues to provide physician order treatment, daily skin inspections, weekly measurements, and monitoring for wound healing. If wound doesn¿t show signs of healing within 14 days the primary care physician will be notified and any new treatments will be implemented according to orders. Dietary Manager implemented fortified foods. Care plan updated. Resident # 9¿s pressure ulcer on left heel is healed as of 7-19-2015. Care plan updated. Dietary informed for pressure ulcer on 6-12-2015. 2. All residents have the potential to be affected in this area.	8/14/15

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F 314	Continued From page 18 stated, ". . . A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. . . . If a pressure ulcer is identified . . . The registered nurse should record the type of wound and the degree of tissue damage . . . the location of the area, the measurements and the ulcer/wound characteristics. . . . Dietary automatically will be notified when the Wound Data Collection [form] is signed and locked. . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included history of multiple cerebrovascular accidents (CVAs) with hemiplegia, weakness, and history of an unstageable pressure ulcer to his left heel. The most recent Minimum Data Set (MDS), dated 06/29/15, identified intact cognition, limited-to-extensive assistance for most activities of daily living (ADLs), one or more unhealed pressure ulcers, one unstageable pressure ulcer due to slough [light colored tissue] and/or eschar [brown/black necrotic tissue], longest length from head to toe: 7.0 centimeters (cm), widest width side-to-side perpendicular to length: 5.9 cm, and receiving skin treatments including: pressure reducing device for chair/bed and ulcer care. Resident #9's "Braden Scale for Predicting Pressure Sore Risk," dated 07/11/15, revealed a score of 16; indicating he was at risk. The current physician orders identified the following: * 05/28/15, Blister to left outer heel: 1. Telfa/ABD	F 314	3. A mandatory nurses meeting was held on August 4 and 5, 2015 to review policy and procedures related to Skin Assessment, pressure ulcer prevention and documentation requirements with a focus on the need to ensure individualized care plan interventions for residents with heel pressure ulcers. All residents with heel pressure ulcers need to have heel booties on while in bed, the nurse needs to notify dietary immediately on all skin concerns and pressure ulcers, and need to follow physician orders and care plan interventions to float heel and keep pressure off the affected area. 4. An audit was developed to monitor and document the initial requirements according to policy and procedure including if a wound data collection UDA was completed, if a weekly Wound RN assessment is completed, if dietary was notified, dietary interventions were implemented, and care plans updated. The audit will be completed 3 x¿s per week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The DNS or designee will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	

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[absorbant dressing]/kerlix dressing applied. 2. Multipodus boot on, two time a day.
* 06/30/15, 1 cup of protein jello daily.

Resident #9's current care plan stated, ". . . Focus The resident has unstageable pressure ulcer to left heel. . . . Interventions . . . Assist to turn/reposition at least every 2 hours. Reposition with 1 person. Avoid positioning resident on left heel, float heel with pillows placed under left calf. Assess/record/monitor wound healing weekly. Report improvements and declines to the health care provider. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care [all initiated 05/26/15]. Provide supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing [initiated 07/08/15]. Provide pressure relieving/reducing device on bed: multipodus boot to left foot, pressure relief mattress and float left heel [initiated 05/26/15/revised 07/09/15]."

The progress notes and wound data collection forms identified the following:
* 05/16/15 at 3:41 p.m., "WEEKLY SKIN EVALUATION sat [Saturday] Legs are in excellent condition. No new skin issues at this time."
* 05/26/15 at 4:00 p.m., ". . . C/O [complained of] having Lt [left] heel pain. Res. . . . nurse to check and noted clear fluid leaking from large blister to heel. Reported same to Unit Supervisor."
* At 4:15 p.m., ". . . Nurse reports to me that resident has a blister to the left outer heel and when I measured, noted that measurements are 6.2 x 9 cm. in size; area is draining clear liquid and skin is wrinkled and wet looking; surrounding

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tissue is red and underneath the blister area is noted that skin is red. Dr. [name] notified . . ."
* At 4:31 p.m., ". . . initial data collection . . . Left heel . . . Appears to have been a blister that opened up as moist and wrinkled up against base of wound. Red/purple in color with white center . . . length 6.2 cm . . . width 9 cm . . . Skin adheres over the base of the wound, red/purple, wrinkled and moist. . . . Pain when measuring wound, pressure relieving boot placed to left lower leg. . . . Adaptic, ABD and gauze were placed to protect the heel and multipodus boot for pressure relief. Will see medical provider tomorrow morning for further evaluation. . . ." The record lacked evidence the Dietary department was automatically notified of Resident #9's wound as per facility policy.
* At 6:02 p.m., "Resident has blister area to side of left heel that measures appr. [approximately] 6.2 x 9 cm. in size and is draining clear liquid. Dr. [name] notified and gauze dressing applied. . . ."
* 05/27/15 at 11:30 a.m., "Patient returned to facility . . . 1. Friction blister to left heel. . . . New orders. 1. apply nonstick dsg [dressing] to left heel until healted [sic] BID [twice daily]. If opens, apply bacitracin also. 2. Avoid and [sic] friction to heel protect in bed."

On 05/27/15, the facility contact the State survey and certification agency and reported Resident #9's left heel blister as an injury of unknown origin.

The progress notes and wound data collection forms identified the following:
* 05/28/15 at 4:16 p.m., ". . . pain scale of 3/10. Multi-podus boot helps to decrease pain. . . ."
* 05/29/15 at 2:16 p.m., ". . . the resident voice[d]

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F 314	Continued From page 21 complaints of pain related to the wound. . . ." * [Exact date and time not identified], ". . . resident has ambulation boot to assist with pressure relief during ambulation which is currently broken. Therapy working to get this working again for resident. . . ." * 06/22/15 at 3:29 p.m., ". . . Resident requires increased assistance at times with mobilization due to pain in heel." * 06/24/15 at 9:52 a.m., ". . . Due to pressure ulcer [Resident #9] was started on Fortified foods on 06/02/15 for added protein in meals. . . ." * At 3:38 p.m., "Dean is triggering for nutrition risk due to pressure ulcer. . . . Dietary started fortified foods on 06/12/15. . . . he would benefit from high protein nutritious snacks . . . Also recommended trying protein jello . . ." This was the first indication Dietary staff had been notified of Resident #9's wound (17 days after facility staff first discovered his wound). During an interview on 07/15/15 at 2:15 p.m., a managerial dietary staff member (#15) stated, "I found out [about Resident #9's ulcer] on 06/12/15. I always care plan fortified foods the same day I'm told of the ulcer." The progress notes and wound data collection forms identified the following: * 06/29/15 at 1:53 p.m., ". . . Residents Multipoodus [sic] boot is at PT [Physical Therapy] as is broken. Note redness/bruising to arch of bottom of foot, resident states is sore, appears to be from walking on boot. Telfa applied to heel . . . Wrapped with Kelix [sic] . . . Resident wearing loose fitting slipper at this time, until boot returns from PT." * 06/30/15 at 2:35 p.m., ". . . left heel . . . Length	F 314		

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F 314	Continued From page 22 7 cm . . . Width 5.9 cm . . . PAtient has c/o pain when he walks . . ." * At 2:42 p.m., ". . . wound assessment . . . Patient has c/o pain with ambulation." * At 4:26 p.m., "Due to condition of resident's walking boot, a new walking boot was ordered and has been given to resident to use during ambulation due to heel ulcer." The order for protein jello was written 06/30/15 (34 days after facility staff first discovered his wound). * 07/01/15 at 2:35 p.m., ". . . Left heel . . . 3/10 on pain scale. . . ." * [Exact date and time not identified], ". . . Resident continues to ambulate when he feels able due to pain in heel. Resident does have new walking boot to use. provides support to heel and relieves pressure during ambulation. . . ." * 07/02/15 at 3:53 p.m., ". . . Left heel . . . Resident says that it hurts when he applies pressure to it. . . ." * 07/13/15 at 3:15 p.m., ". . . left heel . . . Length 6.8 cm . . . Width 5.5 cm . . . Wound has mostly resolved, outline of old scab present. Skin firm, no c/o pain, blanchable to touch. Will continue to monitor for 1 week to ensure proper wound healing. . . ." Observation on 07/13/15 at 3:47 p.m. showed a managerial nurse (#14) providing Resident #9's cares. As she attended to Resident #9, she described his left heel ulcer as "blanchable with firm new skin. The outline of the blister is still there, 6.8 x 9.5 cm. [Resident #9] does not have any pain." The facility failed to identify Resident #9's ulcer prior to it being a 6.2 x 9 cm draining blister,	F 314		

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failed to notify the Dietary department at the time they first discovered his wound (17 days delayed), and failed to initiate fortified foods per physician's order (34 days delayed).

- Resident #4's medical record, reviewed on all days of survey, identified diagnoses including dementia and osteoarthrosis. A Significant Change in Status Minimum Data Set (MDS), dated 05/03/15, identified the resident with severe cognitive impairment, required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, and had no current pressure ulcers. A Braden Scale for Predicting Pressure Sore Risk, dated 04/30/15, identified a score of 15 indicating a mild risk for pressure ulcers. Recommended interventions included "Protect Heels."

The resident's current care plan identified a problem: "The resident has potential for pressure ulcer development R/T [related to] incontinence, mobility deficits, dementia. Braden=15. 06/01/15: Superficial skin lesion to right outer 5th toe . . ." Interventions included: "Assist to turn/reposition at least every 2 hours . . . Provide pressure relieving mattress on bed . . . Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc [etcetera], noted during bath or daily care." The care plan lacked interventions to "protect" the resident's heels, such as floating the heels when in bed.

During an interview on 07/15/15 at 10:15 a.m., a managerial nurse (#14) reported nursing staff used to check the resident's skin during their bath. Currently, the "night nurse checks the

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resident's skin prior to bed, with medication pass, or with night cares."

A Skin Observation sheet, dated 07/14/15 at 2:07 a.m., stated, "Skin check was completed - no skin conditions observed. . . . Currently applying corn pad to 5th toe and between 3-4th toe on right foot. Applying antibiotics ointment to those areas."

Observation on 07/14/15 at 1:55 p.m. showed Resident #4 lying on her bed with her heels resting directly on the mattress. The surveyor asked the Certified Nursing Assistant (CNA) (#8) to remove the sock from Resident #4's foot in order to observe her toes. Observation showed foot drop of the right foot and revealed the corn pads in place on the 5th toe and between the 3rd and 4th toes. Observation also showed a reddened area approximately five centimeters (cm.) in diameter on the resident's right heel with a dark red center approximately 0.5 cm. in diameter. Following the observation, the surveyor informed the charge nurse (#9) of the reddened heel.

A nursing progress note, dated 07/14/15 at 3:17 p.m., stated, "In to see patient heels for concerns of reddness [sic]. Right heel is soft to center, blanchable [color lightens when touched]. No open areas noted. Heels to be floated while in bed, care plan updated. . . ."

A second observation of Resident #4's right heel occurred with a licensed nurse (#9) and an administrative nurse (#1) on 07/14/15 at 4:15 p.m. at the surveyor's request. Observation showed the heel remained reddened. The nurse

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(#9) palpated the resident's heel and stated it felt "soft." Observation showed the red area blanched at the outer edge when touched by the nurse. The nurse stated Resident #4 does not usually wear shoes, but wears slipper socks provided by the family. The nurse failed to measure the area at that time.

Observation on 07/15/15 at 7:45 a.m. showed Resident #4 seated in her wheelchair wearing shoes on both feet.

Observation on 07/15/15 at 11:12 a.m. showed Resident #4 in bed with her right foot resting directly on a pillow. A licensed nurse (#9) measured the reddened area on the resident's right heel at the surveyor's request. Observation of the heel revealed a red outer edge lightening to pink towards the center with a dark red center. The nurse measured the reddened/pink area as 4.5 by 6 cm. and the dark red center as 0.5 by 0.5 cm.

Observation on 07/15/15 at 4:45 p.m. with an administrative nurse (#1) showed the resident seated in her wheelchair and wearing shoes. The nurse (#1) immediately removed the shoe from the right foot and asked a licensed nurse (#9) to put slippers on the resident.

A Wound Data Collection sheet, dated 07/16/15 at 12:22 a.m., stated, "Heels floated on pillows. Slipper socks. No shoes. Will continue to monitor skin integrity. . . . Denies pain. Encouraged resident to keep feet floating on pillow. Explained this would relieve pressure. Red area blanches well."

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F 314	Continued From page 26 During an interview on 07/15/14 at 2:20 p.m. a dietary manager (#15) stated staff had not informed her of Resident #4's reddened heel and stated she would implement fortified foods immediately. The facility's failure to identify the reddened area on Resident #4's right heel during the daily skin assessments, measure the area at the time of identification, and promptly implement interventions such as not wearing shoes and ensuring the heels remained floated, placed Resident #4 at risk of the reddened area progressing to a stage 2 pressure ulcer.	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and facility policy, the facility failed to provide services to treat urinary tract infections (UTIs) for 2 of 9 sampled residents (Resident #5 and #8) with a history of UTIs. Failure to provide prompt treatment of UTIs resulted in Resident #5 & #8 delayed treatment, and #8's hospitalization for pyelonephritis [a type	F 315	1. Resident #5 experienced a UTI on 7-24-2015. A progress note was written. Care plan was updated. Resident #8 was assessed for signs & symptoms (s/s)of a Urinary Tract Infection (UTI). Resident is free from infection as of 7-12-2015. Care plan updated.	8/14/15

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F 315	Continued From page 27 of infection of the urinary tract that usually begins in the bladder/urethra and moves up into the kidneys] with dehydration and shock. Findings include: Review of the facility policy titled "Urogenital Tract Infections" occurred on 07/16/15. This policy, revised June 2012, stated, ". . . Signs/Symptoms: Suprapubic pain, Urethral burning, Urgency, Frequency, Dysuria [pain/discomfort associated with urination], Fever . . . Confusion, Change in behavior . . ." Review of the facility policy titled "Reporting and Initial Management of Suspected Infections" occurred on 07/16/15. This policy, revised June 2012, stated, ". . . The charge nurse will take the following actions as soon as possible if an infection is suspected. . . . Notify the attending physician. . . . Document the time of onset, any cultures obtained, any treatment initiated and the outcome in the nurse's notes. . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included incontinence and history of UTIs. The most recent Minimum Data Set (MDS), dated 05/17/15, identified severely impaired cognition, extensive assistance of one person for toileting, frequent urinary incontinence and occasional bowel incontinence. The current care plan stated, ". . . Focus: . . . frequent bladder incontinence . . . Interventions: . . . Monitor/document for s/s [signs/symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color,	F 315	2. All residents have the potential to be affected in this area. A list of resident with a history of reoccurring UTI's will be generated and each resident will be assessed for any s/s of a UTI or infection. 3. A mandatory nurses meeting was held on August 4 and 5, 2015 to review policy and procedures related "reporting and initial management of suspected infections and urogenital tract infections" with a focus on the need to notify physician, document in a timely manner, document a progress note at the time of onset, document if any cultures obtained, treatment initiated, and the outcome. 4. An audit will be developed to monitor residents with signs & symptoms of a suspected UTI and if the attending physician was notified in a timely manner. The audit will be completed 3 x's per week x 2 weeks, then 1 x per week x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The DNS, or designee, will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	

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increased pulse, increased temp [temperature] urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. . . ."

The progress notes identified the following:
* 06/15/15 at 7:05 p.m., "Resident very restless; will not eat, has been toileted and reassured/redirected several times; is exit seeking . . . resident got out of her wheelchair and walked unassisted in hallway with very unsteady gait . . ."
* 06/18/15 at 4:40 p.m., "Resident has been restless . . . kicked at CNA [certified nursing assistant] . . . reassured several times . . ."
* 06/19/15 at 4:56 p.m., "Resident has been displaying out of ordinary aggressive and anxious behavoirs [sic] in the previous shifts leading the unit supervisor to request a dipstick on urine for s/s [signs/symptoms] of infection. Dipstick reading on urine at 5:00 p.m. on 06/19/15 displayed positive leul [leukocytes], pos [positive] nitrates and +1 of blood. Urine was moderately dark yellow (straw to brownish) in color, oderous [sic], and cloudy. Will continue to monitor. Fax for request for a UA [urine analysis]."
* At 6:31 p.m., "Fax sent to Dr. [Doctor] [name] regarding positive dipstick of urine."
* 06/26/15 at 6:16 p.m., "Fax re-sent [7 days after the original fax was sent] to Dr. [name] regarding urinary sx [symptoms] as no reply noted from fax sent on 06/19/15 regarding this."
* 06/29/15 at 2:34 p.m., "Fax received [10 days after the original fax was sent] from Dr. [name] and UA/UC [urine culture] to be sent to lab regarding altered mental status and in reply to my fax sent on 06/26/15."
* At 4:26 p.m., "UA obtained. Urine dip positive

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for Leu [leukocytes], Nit [nitrates], blood, UA sent to hospital lab . . ."
* At 5:18 p.m., "Lab report received regarding urine sent to lab and will await physician recommendations."
* 06/30/15 at 12:08 p.m., "U/A results returned from Dr. [name]. Orders for Macrobid [antibiotic] 100 mg [milligrams] BID [twice daily] x [times] 7 days. They will culture and get back to us."
* 07/03/15 at 3:00 p.m., "Resident is currently on a/b [antibiotic] therapy for UTI, urine is amber colored with no foul smell. Resident c/o of shaking and chills, T [temperature] 98.9, she is currently resting in bed. Fluids have been encouraged."
* 07/04/15 at 5:49 a.m., "Resident has temp [temperature] of 99.6, received scheduled Tylenol as ordered. When asked how she is feeling stated, 'I am not feeling very well.' . . . Resident stated how thirsty she was et [and] received . . . water . . . et . . . orange juice."
*07/05/15 at 12:01 p.m., "For the past couple of days, resident has been complaining of feeling cold; noted to have a low-grade temp but skin warm/dry; had a small emesis after breakfast today and is resting in bed at this time and CNAs reported that she was slightly clammy; resident is currently on macrobid for UTI."
* At 1:41 p.m., "Call placed to [hospital] regarding resident symptoms and no results back yet from urine culture [6 days after the physician's order was received for a UC and 16 days after the physician was initially contacted regarding the resident's symptoms] and she will check on this and get back to me."
* At 3:00 p.m., "Resident vomited after breakfast today and has been resting in bed most of the day and having poor intake due to sleepy - Low

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grade temp and respirations more labored; skin warm/clammy . . . doctor would like to assess resident in the ER [emergency room] for possible admission and will be sent per ambulance. . . ."
* At 5:39 p.m., "[Hospital] notifies us that resident will be kept there at the present time possibly overnight for further evaluation and treatment of UTI . . ."

The hospital report, dated 07/05/15, stated, ". . . ASSESSMENT: Pyelonephritis with dehydration and shock. . . ."

Failure of the facility to 1) notify the physician in a timely manner of Resident #8's signs/symptoms of infection and 2) obtain the culture results in an effort to determine if Resident #8 had been placed on the correct antibiotic, resulted in her experiencing unnecessary discomfort, fatigue, restlessness, poor appetite, increased confusion, fever, and resulted in her hospitalization for pyelonephritis, dehydration, and shock.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included urge/stress incontinence, urine retention, and history of recurrent UTIs. The most recent MDS, dated 06/21/15, identified intact cognition, extensive assistance of two or more people for toileting, frequent urinary/bowel incontinence.

The current care plan stated, ". . . Focus: . . . h/o [history of] UTIs . . . recurrent UTIs . . . Interventions: . . . Monitor/document for s/s UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp urinary frequency, foul smelling

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urine, fever, chills, altered mental status, change in behavior, change in eating patterns. . . ."

A progress note, dated 05/01/15 at 10:02 p.m., identified, "Reported by . . . CNA to nurse, that resident upon changing and [sic] mustard-colored discharge, that was explained as gooey and foul-smelling. . . ."

A fax to Resident #5's physician, dated 05/22/15, stated, ". . . Patient has c/o [complains of] burning in peri area. Positive dipstick of leukocytes, protein, nitrates. Also inner labia is red, looks to be inflammed [sic] and sensitive to touch. Some vaginal discharge noted from CNAs. . . ." Nursing staff failed to document the above information in the resident's progress notes. Also, the first signs/symptoms of infection were noted on 05/01/15, 22 days prior to staff notifying Resident #5's physician.

The progress notes identified the following:
* 05/22/15 at 1:43 p.m., "u/a [urine analysis] sent to lab at this time per orders."
* At 1:44 p.m., "Fax received from Dr. [name]. 1. Clotrimazole 1% topical vaginal cream. Apply Externally to peri-area BID x 7 days. 2. Send U/A Re: Dysuria [pain or discomfort during urination]."
* At 4:25 p.m., "[Resident #5] . . . states she has been . . . tired . . . poor appetite . . . trouble concentrating . . ."
(Review of past physician's orders identified an order for one 400-80 mg Bactrim tablet two times a day for UTI starting 05/22/15.)
* 05/30/15 at 2:27 p.m., "Resident completed Bactrim for UTI 05/29/15, resident has no further symptoms of UTI."

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F 315	Continued From page 32 Failure of the facility to 1) document Resident #5's complaints of burning and staff observations of her red, inflamed, and sensitive labia, 2) document the completion and/or results of Resident #5's positive urine dipstick, and 3) notify the physician in a timely manner of Resident #5's signs/symptoms of infection resulted in her experiencing unnecessary discomfort, fatigue, poor appetite, and trouble concentrating.	F 315		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/15/2015 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistive devices and supervision necessary to prevent accidents for 1 of 6 sampled residents (Resident #1) requiring staff assistance with transfers. Failure to utilize a gait belt when assisting Resident #1 and ensure the environment remained free of accident hazards may have contributed to a fall with a nasal septum fracture and contusion of the right thumb. Findings include:	F 323	1. Resident #1 is being transferred with one staff member and a gait belt and staff member was educated on 4/21/2015. 2. All residents that need assistance with transfers or ambulation have the potential to be affected in this area. 3. A mandatory nurses meeting was held on August 4 and 5, 2015 to review the procedure titled Gait Belt with a focus on the need to use a Gait Belt when a resident is transferred or ambulating. Staff educated to NOT use the residents¿ arms, pants/slacks belt as a gait belt.	8/14/15

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F 323	Continued From page 33 Review of the facility policy titled "Gait (Transfer) Belt" occurred on 07/16/15. This policy, dated 10/2013, stated, "Purpose: * To safely transfer or ambulate resident * To aid resident in maintaining balance * To avoid injury to both resident and staff member Procedure: . . . 2. Place belt around resident's waist . . . 3. Belt also can be applied while resident is sitting or lying in bed. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of falls, and malaise and fatigue. An annual Minimum Data Set (MDS) dated 05/10/15, identified extensive assist of one staff member for bed mobility and transfers. The care plan stated, "Focus . . . The resident has an ADL [activity of daily living] self care performance deficit RT [related to] mobility deficits both visual and hearing deficits and cognitive defisitis [sic], EB [evidenced by] unstable gait, forgets to use the walker properly. . . . Interventions: AMBULATION: Resident requires assist of 1 to ambulate cues for placement of FWW [front wheeled walker] . . . TRANSFERS: Resident requires 1 staff participation with transfers. . . ." Observation during the survey showed Resident #1 transferred and ambulated using a gait belt and assist of one staff member. A "Mobilization Support Data Collection Tool," dated 02/08/14, identified Resident #1 ambulated with limited assistance of one staff member using a gait belt and assistive device.	F 323	4. An audit will be developed to monitor gait belt usage. The audit will be completed 3 x's per week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The DNS, or designee, will be responsible for the completion of the audits. The results of the audits will be reported to the QAPI committee for further recommendation.	

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	355093	A. BUILDING _____ B. WING _____	07/16/2015

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A "Slipped or Fell" report date, 04/21/2015 at 11:45 p.m., stated, " . . . CNA [certified nursing assistant] assisting Resident out of bed, CNA turned to turn off bed alarm, Resident tripped on call-light cord and fell. Resident bleeding from nose. Bruising noted to bridge of nose. On Resident's right thumb joint blood pooling beneath skin. Resident states 'I dont know what happened.' Resident admits to some pain to nose. Denies pain elsewhere. . . . Predisposing Environmental Factors: Equipment/assistive devices. . . tubing/cords . . . Furniture . . . Predisposing Situation Factors: Alarm sounded . . . Using walker . . ." Gait belt/transfer belt was not marked in the predisposing situation factors.

During an interview on the afternoon of 07/14/15 a supervisory nurse (#1) stated she would talk with staff on duty during Resident #1's fall and inquire if a gait belt was in use during the transfer. An undated, handwritten statement received on 07/15/15, stated, "To whom it may concern, When [Resident #7] fell on April 21st, a gaitbelt was placed around her waist to assist her off the floor. CNAs were educated to ask Resident to wait for gaitbelt to be applied before getting up from bed. . . ." This statement was signed by the nurse and CNA on duty on April 21, 2015.

An Emergency Room Report dated 04/22/2015, stated, " . . . Female who fell forward onto the floor when she tripped on a cord on the floor. She landed with her right hand on her face. She has blood [sic] nose and some swelling and bruising under the eyes. . . . Assessment: 1. Fracture of the bony nasal septum status post fall. 2. Black eyes and swelling around the nose 3. Contusion

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F 323	Continued From page 35 right thumb. . . ." During an interview on 07/16/15 at 08:45 a.m. with two supervisory staff members (#1 and #13) both stated staff are expected to use a gait belt when assisting Resident #1.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional standards, and staff interview, the facility failed to assure 1 of 1 sampled resident (Resident #7) receiving insulin remained free of significant medication error. Failure to administer Resident #7's insulin for three consecutive days has the potential to result in a negative outcome. Findings include: The facility policy titled "Physician/Practitioner Orders" dated, July 2015, stated, ". . . Maintaining Physician Orders . . . 5. eMAR [electronic medication administration record] . . . Once the order is entered into the PCC [point click care], depending on order category, the order will populate the appropriate electronic documentation location within the application: eMAR . . ." Nursing 2015 Drug Handbook,"35th edition, Wolters Kluwer, Philadelphia, page 764 stated, ".	F 333	1. Resident #7 is receiving insulin according to physician orders. 2. All residents have the potential to be affected in this area. 3. A mandatory nurses meeting will be held on August 4 and 5, 2015 to review procedure titled, "Physician/Practitioner Orders¿ and the¿ Nurse change checklist¿ with a focus on the need to check for any orders pending confirmation by the license nurse every shift, and if so, confirm the orders. 4. An audit will be developed to monitor if all physician orders are confirmed at the end of every shift. The audit will be completed daily x 2 weeks, then weekly x 2 weeks, then monthly x 2 months, then quarterly x 3 quarters. The HIM, or designee, will be responsible for the completion of the audits. The results of	8/14/15

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F 333	Continued From page 36 . . Lantus . . . To manage type 2 diabetes in patients who need basal (long-acting) insulin to control hyperglycemia Adults: Individualized dosage, and give subcutaneously once daily at the same time each day . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included type 2 diabetes and altered mental status. Current medications included glipizide (oral diabetic medication) and Lantus (long-acting) insulin 10 units subcutaneously once a day. Review the Resident #7's physicians orders for Lantus insulin identified the following medication changes: * 06/11/2015 15 units once a day * 06/19/2019 decreased to 12 units once a day * 07/06/2015 decreased to 10 units once a day Review of Resident #7's June 2015 eMAR identified staff failed to administer Lantus insulin 12 units on three occasions. (June 19, 20, and 21) Review of Resident #7's medication error report, dated 06/22/2015, stated, ". . . Staff member noticed that resident had not received her 12U [units] Lantus insulin for 3 nights in a row. . . . The order had been changed per the DR. and when putting on the MAR the order had not been confirmed so the order did not come up for the night nurse to give. . . ." Review of Resident #7's blood sugars from 06/20/2015 to 06/22/2015 identified 222 as the highest blood sugar obtained by staff.	F 333	the audits will be reported to the QAPI committee for further recommendation.	

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F 333	Continued From page 37 During an interview on 07/16/15 at 08:45 a.m. a supervisory staff member (#1) confirmed staff failed to administer Resident #7's insulin on June 19, 20 and 21.	F 333		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		8/14/15

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F 441	Continued From page 38 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: INFECTION CONTROL PRACTICES: 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 3 of 9 sampled residents (Resident #3, #4, and #6) observed when assisted with cares and/or eating. Failure to follow established infection control practices may result in the spread of infection within the facility. Findings include: - Review of the facility policy and procedure "Hand Hygiene and Handwashing" occurred on 07/16/15. The policy, revised November 2014, stated, "Purpose: To ensure appropriate hand hygiene technique . . . Hand Hygiene Product Selection . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: . . . *After having contact with body fluids, wounds or broken skin . . . *After removing gloves. NOTE: Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above. . . ." Observation on 07/14/15 at 10:00 a.m. showed two Certified Nursing Assistants (CNAs) (#8 and #12) assisted Resident #3 to bed. Observation	F 441	1. Resident #3 is receiving nourishment after proper hand hygiene according to procedure. Resident #4 is receiving ready to eat foods without bare hands. Resident #6's Foley catheter bag is not touching the floor, and used linen is not on the floor. 2. All residents that require assistance with cares and meals have the potential to be affected in these areas. All residents have the potential to be affected by linen on the floor. All residents with Foley catheters have the potential to be affected in this area. All residents that receive a tub bath have the potential to be affected in this area. 3. A mandatory nursing meeting will be held on August 4th and August 5th, 2015 to review policies and procedures related to "Hand Hygiene & Hand washing", "Food Handling", "Standard precautions", "Bathing", and "Catheterization" focusing on the following areas: A) Always perform hand hygiene after	

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F 441	Continued From page 39 showed the resident incontinent of bowel. The CNA (#8) donned gloves and provided perineal care, using multiple wipes to cleanse the perineal area of stool. The CNA then removed her gloves, and without performing hand hygiene, placed a clean brief, covered the resident with blankets, picked up a glass of supplement and offered the resident a drink. The resident refused. The CNA then washed her hands. During an interview on 07/16/15 at 9:30 a.m. an administrative nurse (#7) stated she expects staff to wash their hands after glove removal when providing perineal cares. - Observation on 07/14/15 at 7:56 a.m. showed two CNA's (#10 and #11) assisted Resident #6 with morning cares. The CNA (#11) cleansed the resident's face and threw the washcloth on the carpeted floor. After doing perineal care, the CNA (#11) threw the washcloth on the floor. The CNA (#11) placed Resident #6's foley catheter bag on the floor, set the graduate cylinder on the floor, picked up the foley catheter bag, emptied it into the graduate, and placed the foley bag back onto the floor. During an interview on 07/16/15 at 10:00 a.m. a supervisory staff member (#7) confirmed staff should not place a foley catheter bag on the floor and she expected staff to place dirty washcloths into a laundry basket, not on the floor. - Review of the facility policy and procedure "Food Handling" occurred on 07/16/15. The procedure, dated February 2013, stated, "Purpose: To limit contamination of food served to a highly susceptible population. Policy: Food	F 441	glove removal. If hands are visibly soiled, use soap and water. If hands are not visibly soiled, use alcohol based rub B) Nothing belongs on the floor except your feet. (Example- linens, catheter bags, pillows, etc.) The floor is a dirty place. C) Any ready to eat items cannot be touched by bare hands. (use napkin or silverware) D) Proper contact time for sanitizing tub with disinfectant is 10 minutes. * System change: Tub cleaning instructions are now posted in the bathing areas. * System change: a timer was purchased for each bathing room to ensure the allotted time of 10 minutes was allowed per manufacturer's recommendations. 4. Audits will be developed to monitor if all steps are followed according to policy and procedure for hand hygiene, after removing gloves, ready to eat food handling, no Foley catheters or linen touching the floor, and tub cleaning is done according to posted instructions. Audit will be completed 3 times per week for 2 weeks, then 1 time per week for 2 weeks, then monthly for 2 months, then quarterly for 3 quarters. Findings will be reported to QAPI committee for further recommendations.	

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will be handled in a manner that minimized the risk of contamination. Procedure: 1. Ready-to-eat foods will not be touched with bare hands. Proper utensils such as tissue, spatula, tongs, single-use gloves, etc. [etcetera], will be used for food handling. . . ."

Observation on 07/14/15 at 8:30 a.m. showed a licensed nurse (#1) seated at a dining table with Resident #4 on her left and Resident #6 on her right. The nurse (#1) picked up Resident #4's toast with her bare hands and held it for the resident to eat. She then turned to Resident #6, adjusted his glasses, and without performing hand hygiene, picked up Resident #4's toast again and fed it to her.

During an interview, on 07/16/15 at 9:30 a.m. an administrative nurse (#7) confirmed staff should avoid bare hand contact with ready-to-eat food when feeding residents.

CLEANING OF BATHTUBS

2. Based on observation, review of facility policy, review of daily maintenance instructions, and staff interview, the facility failed to follow accepted infection control practices for 2 of 2 resident bathtubs (north-south unit and east-west unit). Failure to follow accepted infection control practices when disinfecting bathtubs has the potential to spread infection within the facility.

Findings include:

Review of the facility policy "Bathing" occurred on 07/16/15. This policy, stated, ". . . PROCEDURE FOR CLEANING TUB AND SHOWER STALL . . .

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F 441	Continued From page 41 2. Spray walls of tub and shower stall with disinfectant and brush across surfaces. Allow disinfectant to remain on surfaces for at least 10 minutes or according to manufacturer's recommendations. . . ." Review of the "Cascade Contour Bathing Systems with Aqua-Aire Safe Operations and Daily Maintenance Instructions" occurred on 07/14/15. This manual stated, " . . . System Cleaning (After Every Bath) . . . 7. Let disinfectant stay on surface for 10 minutes. . . ." Observation on 07/14/15 at 1:30 p.m. showed a certified nursing assistant (CNA) (#3) in the east-west bathing area. The CNA explained between residents she cleans the bathtub by using the disinfecting jets and pointed to a jet button. She then used a brush to scrub the walls of the bathtub and used the bathtub spray nozzle to rinse the tub. When asked how long she leaves the disinfectant on the bathtub the CNA (#3) replied, "I rinse it right off. Observation on 07/14/15 at 2:55 p.m. showed CNA (#4) in the north-south bathing area. The CNA explained between residents she cleaned the bathtub by using the disinfecting jets, scrubs the bathtub with a brush and rinsed off the disinfectant. When asked how long she leaves the disinfectant on the CNA (#4) replied "10 to 15 seconds." Observation on 07/14/15 at 3:04 p.m. showed a CNA (#3) in the east-west bathing area. The CNA explained she had just finished a bath and started cleaning the bathtub. The CNA (#3) used the disinfecting jet button and scrubbed the	F 441		

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F 441	Continued From page 42 sides of the bathtub and the shower chair with the disinfectant solution. At 3:10 p.m. the CNA rinsed the sides of the bathtub with the bathtub spray nozzle. At 3:13 the CNA (#3) rinsed the bathtub a second time and the shower chair. The CNA agreed rinsing the bathtub at 3:10 p.m. did not allow the disinfectant 10 minutes of contact time. During an interview on 07/14/15 at 2:30 p.m. a supervisory nurse (#7) confirmed staff should leave the disinfectant on for 10 minutes per the daily maintenance instructions.	F 441		