DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Division of Health Facilities

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FORM APPROVED
OMB NO. 0938-0391

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 _____	01/15/2015

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 01/12/15 and completed on 01/15/15, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000	F241 Dignity and Respect of Individuality 1. Resident #1, #2, and #10 individual needs for assistance with dining has been met by educating CNA staff on the	
F 241 SS=D	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, record review, review of facility policy, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity of 3 of 3 sampled residents (Resident #1, #2, and #10) dependent on staff for assistance with dining. Failure to ensure dignity in the dining room does not recognize the individuality of each resident or enhance their quality of life. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 01/15/15. This policy, revised February 2013, stated, ". . . Promoting resident . . . dignity in dining. (Examples include avoidance of . . . paper/plastic dishware . . . Respecting the resident's social status by . . . not excluding residents from conversations . . ." - Review of Resident #10's medical record occurred on January 14-15, 2015. Diagnoses	F 241	policy for promoting resident dignity in dining and resident assisted dining. Resident #1's care plan was revised on 01/27/2015 to address the use of plastic spoons at meal times. REsident #2 care plan was revised on 01/15/2015 to address resident's preference for a plastic spoon at meal times. Resident #10's care plan was updated to include interventions specific to mealtimes-see F309 plan of correction. 2. All residents have the potential to be affected in this area. All residents that need assistance in dining will be fed with dignity and proper feeding techniques. 3. All staff education will be provided on 2/17/2015 and will review policy and procedure on residnet dignity and feeding techniques. 4. An audit tool will be developed to monitor dining room dignity processes including	

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

J. Ahn — Administrator — 2/24/15

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 rs following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 241	Continued From page 1 included advanced Alzheimer's dementia. The quarterly Minimum Data Set (MDS), dated 12/20/14, identified severely impaired cognition, extensive assistance required for eating, and a mechanically altered diet. Observation showed the following: * On 01/13/15 at 8:30 a.m., Resident #10 sat at an assisted table in the dining room. The Certified Nursing Assistant (CNA) (#17) held a three ounce glass containing blenderized foods up to Resident #10's mouth until she drank the contents of the glass. Resident #10 swallowed repeatedly; drooling out of both sides of her mouth and coughing as she drank. On ten occasions, the CNA (#17) used the glass to scrape liquid [food] from the resident's face. She then refilled the glass and continued to feed her in the same manner. * On 01/13/15 at 12:30 p.m., Resident #10 sat at an assisted table in the dining room. The CNA (#18) held a three ounce glass containing blenderized foods up to Resident #10's mouth until she drank the contents of the glass. Resident #10 swallowed repeatedly; drooling out of both sides of her mouth. On five occasions, the CNA (#17) used the glass to scrape liquid [food] from the resident's face. She then refilled the glass and continued to feed her in the same manner. * On 01/14/15 at 8:44 a.m., Resident #10 sat at an assisted table in the dining room. The CNA (#19) conversed with other staff members as he held a three ounce glass containing blenderized foods up to her mouth until she drank the contents of the glass. Resident #10 swallowed repeatedly until the glass was emptied; showing residue above her upper lip, drooling out of both sides of her mouth, and sputtering/coughing as	F 241	use of plastic dishware, staff to resident conversations, mixing foods together and proper feeding techniques. If concerns are identified, education will be done. Audits will be completed by designated staff 3 meals per day x2 weeks, one of each meal 1x a week x2 weeks, one meal monthly x3 months, anbd 1 meal per quarter x3 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 241	Continued From page 2 she drank. On two occasions, the CNA (#19) used the glass to scrape liquid [food] from the resident's face. He then refilled the glass, and continued to feed her in the same manner. * On 01/14/15 at 12:25 p.m., Resident #10 sat at an assisted table in the dining room. The CNA (#19) conversed with other staff members as he held a three ounce glass containing blenderized foods up to her mouth until she drank the contents of the glass. Resident #10 swallowed repeatedly until the glass was emptied; showing residue above her upper lip, drooling out of both sides of her mouth, and sputtering/coughing as she drank. On four occasions, the CNA (#19) used the glass to scrape liquid [food] from the resident's face. He then refilled the glass and continued to feed her in the same manner. When asked what food items had been mixed in Resident #10's glass, the CNA (#19) responded, "This is chocolate cake and this is apple juice." He further identified the empty containers on her tray as having had "pork, potatoes, carrots, and water" in them. During interviews on 01/14/15 at 9:00 a.m. and 1:15 p.m., a managerial dietary staff member (#4) confirmed staff should not mix together food items, wipe saliva/food from residents' faces with their dishware, or converse with co-workers while feeding a resident. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included osteoarthrosis and pain. The significant change MDS, dated 11/14/14, identified moderately impaired cognition, limited assistance required for eating, and a mechanically altered diet.	F 241		

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F 241	Continued From page 3 Observation on 01/13/15 at 8:30 a.m. showed Resident #2 at an assisted table in the dining room feeding herself with a plastic, disposable spoon. - Observation during breakfast and the noon meal on 01/13/15 showed staff assisted Resident #1 to eat her meals with a plastic, disposable spoon. During an interview on 01/14/15 at 2:40 p.m., a managerial staff member (#4) confirmed plastic, disposable utensils should not be used with meals.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure proper positioning for 1 of 1 sampled resident (Resident #6) observed sitting in a wheelchair leaning at a 30-45 degree angle to the right side. Failure to provide appropriate trunk support had the potential to cause Resident #6 discomfort/pain, difficulty when performing activities of daily living (ADLs), and at risk of	F 246	F 246 Reasonable Accommodation of Needs/Preferences 1. Resident #6's individual needs have been met by the LPTA evaluating wheelchair positioning devices on 01/22/2015. Care plan revised on 01/22/2015 to include cues to re-position self and offes of devices and bolsters. 2. All residents who have wheelchairs have a potential to be affected. A list of residents that require a wheelchair for locomotion will be generated. The LPTA will review each resident and any new interventions will be added to the residents care plans for repositioning devices to provide appropriate trunk support to attempt to prevent	

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F 246	Continued From page 4 aspiration during meals. Findings include: Review of the facility policy titled "Wheelchair Positioning" occurred on 01/15/15. This policy, issued June 2012, stated, ". . . Correct Wheelchair Positioning . . . Hips are centered between the armrests and buttocks against the backrest . . . Resident in upright positioning and weight bearing equally at hips. (Does not lean to one side.) . . . Your therapists can assist with adaptive equipment and wheelchair selection if you have difficulty correctly positioning the resident. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, osteoarthrosis, spondylosis, and history of multiple compression fractures. The quarterly Minimum Data Set (MDS), dated 11/29/14, identified moderately impaired cognition and extensive assistance required for transfers and mobility. The current care plan addressing Resident #6's individualized mobility needs identified, ". . . Interventions: Resident uses high-back wheelchair with ROHO air cushion for pressure relief . . ." Observation showed the following: * On 01/13/15 at 8:02 a.m. and 10:25 a.m. and 01/14/15 at 8:30 a.m. and 1:50 p.m., Resident #6 sat in her wheelchair, leaning at a 30 degree angle to her right side. * On 01/13/15 at 8:22 a.m., 9:30 a.m., 10:25 a.m., and 3:14 p.m., Resident #6 sat in her wheelchair, leaning at a 45 degree angle to her right side.	F 246	aspiration at meals. 3. Education on wheelchair positioning will be provided to all staff on 02/17/2015. The LPTA will discuss the importance of identifying residents that may need assistive devices or cueing for proper positioning, discuss the risks involved with poor positioning including discomfort/pain, difficulty performing ADL's and risk of aspiration during meals. 4. An audit tool will be developed and completed by designated staff. Audits will be completed 3-5 times per week x4 weeks, then 1 time per week x4 weeks, then 1 time per month x2 months, then quarterly x3 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 246	Continued From page 5 * On 01/13/15 at 8:40 a.m. and 12:38 p.m., Resident #6 sat in her wheelchair, leaning at a 30 degree angle to her right side and eating her meals in her room. Observations made during survey showed staff failed to ensure Resident #6 maintained an upright position. During an interview on 01/14/15 at 8:40 a.m., a health information staff member (#15) indicated Resident #6 was assessed by physical therapy in 2010 following a femoral fracture. She (#15) confirmed Resident #6 had not been re-assessed since that time. During an interview on 01/15/15 at 9:25 a.m., a physical therapy staff member (#16) indicated although they had trialed different wheelchairs, they had not attempted positioning devices [such as a wedge or pillow] to assist Resident #6 in maintaining an upright position. She (#16) confirmed even though Resident #6 "does not like change," staff should ensure she is positioned as close to midline as possible.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 248	F 248-Activities Meet Interests/ Needs of each REsident 1. Resident #2, #6 and #11 were reassessed for current interests and abilities and care plan was revised. 2. All residents have the potential to be affected by this deficiency. A Population analysis will be completed by 02/16.2015 to establish a base line of all resident's activity	

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F 248	Continued From page 6 to provide an ongoing program of meaningful activities designed to meet the interests and the physical, mental, and psychosocial well-being for 3 of 7 sampled residents (Resident #2, #6, and #11) dependent on staff for activities. Failure to provide activities that met the residents' individual needs and interests, including one-to-one activities, limited the residents ability to reach their highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility's policy titled "Activity Program" occurred on 01/15/15. This policy, revised June 2012, stated, ". . . The center will provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. . . . Because leisure/recreation are important components of daily life and an integral part of holistic care, therapeutic approaches to activities and programs will be implemented and offered to each resident." - Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included pain and macular degeneration. The significant change Minimum Data Set (MDS), dated 11/14/14, identified moderately impaired cognition and limited-to-total assistance required for activities of daily living (ADLs). The MDS identified animals/pets, doing her favorite activities, and participating in religious services as very important to her, and keeping up with the news and going outside to get fresh air as somewhat important to her.	F 248	participation levels. 3. All staff was educated on 02/17/2015 on the procedure titled, "Activity PRogram" with a focus on the need to educate staff on importance of meaningful activities for the residents including physical, mental and psychococial needs with specific activities of interest and frequency staff need to provide group and 1:1 visits. Activity department will meet by 02/18/2015 to review findings of the activities of interest assessments, population analysis findings, documentation of acceptance and refusals, need to keep resident activity care plans up to date and to run the activity participation reports in PCC every month and as needed. 4. An audit tool will be developed and completed by the Actvity Director or designee, to monitor resident activity involvement in group and/or 1:1 programs, care plan information including therapeutic approaches and ensuring staff are docu=menting activity participation and generate the PCC activity participation report every month and with the resident quarterly care conference. This audit will be completed 3-5 times per	

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F 248	Continued From page 7 The current care plan addressing Resident #2's individualized activity needs identified, ". . . Focus: The resident is dependent on staff for activities, cognitive stimulation, social interaction R/T [related to] reduced hearing and vision . . . enjoys spending time with others. . . . Interventions: Offer and provide 1 to 1 bedside/in-room activities as tolerated by resident if unable to engage in out of room activities. Resident enjoys visiting and being read to due to poor vision . . . Resident's preferred activities are visiting, cats, music, spiritual programs, and spending time with others . . . Provide adaptive equipment large print reading items . . . Introduce resident to residents with similar background, interests and encourage/facilitate interaction . . . Encourage ongoing family involvement. Invite resident's family to attend special events . . . Offer pet visits enjoys cats . . ." An activity progress note, dated 11/20/14, stated, ". . . Resident [#2] is dependent on staff for activity participation. Resident requires assistive devices due to hearing loss and visual impairments. Printed materials need to be read to her at times due to visual loss. Resident has limited participation in center activities. Recent hip surgery and increased pain present. Resident prefers in-room activities as well as center activities of spiritual programs, visiting with others, special events music and meals. Resident has good family contact and involvement. Staff will continue to provide necessary materials as needed for activity participation. . . ." Observations throughout the four day survey failed to show activity staff interacted with Resident #2 in or outside of her room.	F 248	week for 4 weeks, then 1-2 times per month for 3 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 248	Continued From page 8 Resident #2's "Activities - Follow Up Question Report" showed staff offered activities (including 1:1, beauty shop, exercise, family, mail, religion, staff) to Resident #2 on ten of 30 days in November, 14 of 31 days in December, and seven of 14 days in January. - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included dementia with behavioral disturbance and anxiety. The quarterly MDS, dated 11/29/14, identified moderately impaired cognition and supervision-to-extensive assistance required for activities of daily living (ADLs). The annual MDS, dated 04/12/14, identified favorite activities as very important to her, and reading books, newspapers, and magazines, listening to music, keeping up with the news, going outside to get fresh air, and participating in religious services as somewhat important to her. The current care plan addressing Resident #6's individualized activity needs identified, ". . . Focus: The resident is dependent on staff for activities, cognitive stimulation, social interaction R/T personal choices and poor hearing E/B [evidenced by] shows little interest in leisure activity or spending time with others, prefers to be in room. . . . Interventions: Provide 1 to 1 in-room visits and activities if unable to engage in out of room activities. Resident enjoys watching TV. . . . Offer to turn on TV in room when resident chooses not to participate in organized activities: prefers family or spiritual type programs. . . ." An activity progress note, dated 10/20/14, stated, ". . . Resident [#6] is dependent on staff for activity participation. Resident has much limited involvement in out of room activities. Has little	F 248		

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interest in leisure activities or visiting. Staff will offer to turn on TV and will attempt to provided 1 to 1s with resident in order to increase social participation and provide cognitive stimulation this is done as resident desires as she enjoys being in her room independently. Staff will continue to encourage involvement and provide 1 to 1s in order to maintain cognitive stimulation and increase social participation. Resident will continue to communicate her needs and wants with staff. . . ."

Observation on 01/13/15 at 9:30 a.m. showed Resident #6 sitting in her darkened room, leaning to the right side in her wheelchair. An activity staff member (#13) entered the room and repositioned her so she faced her television set. Resident #6 then began actively watching the show already in progress. At 9:40 a.m., when asked how often activity staff visit with Resident #6, the activity staff member (#13) stated, "We go in and visit with her many times during the day." The observation at 9:30 a.m. was the only interaction observed between Resident #6 and activity staff in or outside of her room throughout the four day survey.

Resident #6's "Activities - Follow Up Question Report" showed staff offered activities (including 1:1, beauty shop, mail, party, religion, staff, TV) to Resident #6 on nine of 30 days in November, 13 of 31 days in December, and three of 14 days in January.

- Review of Resident #11's medical record occurred on January 14-15, 2015. Medical diagnoses included dementia, anxiety, and depression. The quarterly MDS, dated 12/15/14, identified severely impaired cognition and

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limited-to-total assistance required for ADLs. The annual MDS, dated 09/14/14, identified being around animals/pets as very important to Resident #11, and her favorite activities and snacks as somewhat important to her.

The current care plan addressing Resident #11's individualized activity needs identified, ". . . Focus: The resident is dependent on staff for activities, cognitive stimulation, social interaction R/T Cognitive deficits E/B Short attention span, periods of crying for no apparent reason difficult to console, . . . does not do well with change . . . Interventions: Provide 1 to 1 small group activities if unable to attend center programs, may enjoy being read to, sensory activity, w/c rides, TV hx [history] of enjoying animal or family type programming, music, and sitting outside on nice days. . . . Residents preferred activities are: music, parties or special events, will attend these and other activities with her friend when present, needs encouragement and reassurance to stay, does not like large group activity. . . . Encourage ongoing family involvement. . . . Offer pet visits has a history of enjoying dogs but likes to hold the center cat . . ."

An activity progress note, dated 12/24/14, stated, ". . . Resident [#11]dependent on staff for social and cognitive activities. Resident participates in sensory stimulation activities. Resident has difficulty communicating due to cognitive deficits. Resident labile at times for an unidentified reason. Resident difficult to gauge enjoyment in activities. Staff provided 1 to 1 assistance during tasks. . . ."

Observations throughout the four day survey failed to show activity staff interacted with

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F 248	Continued From page 11 Resident #11 in or outside of her room. Resident #11's "Activities - Follow Up Question Report" showed staff offered activities (including 1:1, bible, exercise, family, group, mail, music, party, pet, reading, sensory, and staff) to Resident #11 on 15 of 30 days in November, 17 of 31 days in December, and seven of 14 days in January. During an interview on 01/13/15 at 9:40 a.m., when asked how often activity staff visit with dependent residents, the activity staff member (#13) stated, "It varies depending upon how busy we are." When asked the length of a typical 1:1 visit, she (#13) stated, "five-to-ten minutes." During an interview on 01/14/15 at 1:00 p.m., when asked for an explanation of staff charting, a managerial activity staff member (#14) explained "TV" is checked when staff "turn on the television and/or turn the channel" for the resident, "Mail" is checked when staff "deliver the mail and/or read to [a resident] if he/she is unable" to, "Family" is checked when staff see "family have come [to the facility]." When asked the length of a typical 1:1 visit, she (#14) stated, "We usually try for 15 minutes." Record review and observations made during survey showed staff failed to provide meaningful and individualized activities specific to Resident #2, #6, and #11's physical and/or cognitive abilities.	F 248		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	F280-Right to Participate Planning Care - Revise CP 1. Care Plan for resident #2	

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F 280	Continued From page 12 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/26/14 AND 09/26/13 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 5 of 13 sampled residents (Resident #2, #8, #10, #11, and #13). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive	F 280	was updated to reflect use of plastic silverware per resident's request. Care Plan for resident #8 was updated to include bilateral body pillows while in bed to maximize resident's safety. Care Plan for resident #10 was updated to include the need to use the soaker pad when turning/repositioning her to prevent further bruising. Care plan for resident #11 was updated to include that guardina will provide coffee at meals per his request and in his presence. Care plan for resident #13 was updated to include resident's interest and assistance to watch TV church services. 2. All residents have the potential to be affected by this deficiency. 3. An all staff will be held on 02/17/2015 to educate the staff on the procedure titled, "Care Plans" with a focus on the need to ensure timely revisions to care plans are made and communicated to the staff. 4. An audit tool will be developed to monitor the care plans when a change in a resident's condition or health status such as assistive devices	

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F 280	Continued From page 13 Care Plan and Care Conferences" occurred on 01/15/15. This policy, revised June 2014, stated, "... The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. . . . the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life. . . Designated staff member will . . . Implement a system for . . . updating care plans at the center. The care plans will be reviewed by each interdisciplinary team member before care conference. . . . Care plans are to be reviewed with each MDS [Minimum Data Set] completed. . . ." - Observation on 01/13/15 at 8:30 a.m. showed Resident #2 seated at an assisted table in the dining room feeding herself with a plastic, disposable spoon. During interviews on 01/14/15 at 9:00 a.m. and 1:15 p.m., a managerial dietary staff member (#4) stated she "just found [sic] about the spoons," dietary/nursing staff have been giving plastic [lighter] silverware to Resident #2, per her request/preference. Resident #2's current care plan failed to reflect her request for plastic [lighter] silverware. - Observations during the initial tour on the afternoon of 01/12/15 and on 01/13/15 at 3:40 p.m. showed Resident #8 in bed with bilateral body pillows. Resident #8's current care plan failed to identify the bilateral body pillows.	F 280	for safety, turning and reposi-tioning needs, assistance with hot coffee, and resident's preference in watching TV, to ensure the staff is uddating care plans timely. The audit will be completed by the DNS or designee. The audit will be completed 3-5 times weekly for two weeks, then one time per week for two weeks, then monthly for 2 months, and quarterly for 3 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued comliance. 5. 02/19/2015	

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F 280	Continued From page 14 - Review of Resident #10's progress notes identified the following: * On 09/19/14, ". . . Also 2 finger bruises to R [right] hip from turning resident 1.5 cm [centimeter] x 1.5 and 1 cm x 1 cm. . . . Staff informed to use soaker pad when turning." * On 10/10/14, ". . . Resident has one yellow bruise on left thigh by knee measuring 1 cm x 1.2 cm and one yellow bruise on right upper thigh measuring 1 cm x 1 cm both appear to be from fingers. . . ." During an interview on 01/14/15 at 5:00 p.m., a managerial nursing staff member (#1) confirmed staff were educated to use a soaker pad to turn/reposition Resident #10. Resident #10's current care plan failed to reflect the need to use a soaker pad when turning/repositioning her to prevent further bruising. - Review of Resident #11's progress note, dated 07/15/14, identified, "[Physician] sent faxed [sic] back noting that she is aware of coffee spill on resident on 07/03/14." The progress notes failed to identify Resident #11 had spilled coffee on herself. An incident report dated 07/03/14, stated, "Resident was given coffee . . . by an outside person . . . and spilled it on [her] outer lt [left] leg. No redness on [sic] no s/s [signs/symptoms] of pain. . . . Cool washcloth applied to area. . . ." During an interview on 01/14/15 at 5:00 p.m., a managerial nursing staff member (#1) stated, "A visitor used a cup with no lid [on 07/03/14], and was educated after the spill. [Resident #11's]	F 280		

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F 280	Continued From page 15 guardian said no to more coffee. [Resident #11] is being fed by staff now." Resident #11's current care plan failed to identify her guardian's request that she no longer be given coffee. - Review of Resident #13's progress note, dated 07/29/14 at 10:00 a.m., stated, ". . . Wife and son in to discuss concerns they are having . . . It is expressed that they would like [Resident #13's] TV [television] turned on the church on Sunday AM. . . ." Resident #13's current care plan failed to identify that staff should turn on the television to the church program on Sunday mornings.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to obtain laboratory (lab) studies for 1 of 1 sampled resident (Resident #4) with physician's orders for yearly iron studies. Failure to obtain the ordered lab studies did not allow the physician to accurately monitor the resident's iron blood levels. Findings include: http://www.webmd.com stated the following	F 281	F281 Services Provided to Meet Professional Standards 1. Resident #4's individual needs have been met by contacting the physician on 01/22/2015 regarding iron studies. The iron studies were done on 01/27/2015 and the results were sent to physician and placed in resident's medical record on 01/28/2015. 2. All residents with a physician order for lab studies have the potential to be affected by this deficiency. All resident's records will be reviewed for documentation of the orders, notification to the	

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F 281	Continued From page 16 regarding iron studies, "An iron test checks the amount of iron in the blood to see how well iron is metabolized in the body. Iron (Fe) is a mineral needed for hemoglobin, the protein in red blood cells that carries oxygen. Iron is also needed for energy, good muscle and organ function. . . . A test for iron is done to: * Check for iron deficiency anemia. . . . * Check to see if iron and nutritional treatment is working. . . ." Review of Resident #4's medical record occurred on January 13-15, 2015 and identified diagnoses including anemia and history of gastrointestinal bleed. The resident's current medications included ferrous sulfate (an iron supplement) 325 milligrams once a day for anemia. A physician's order, dated 05/07/14, stated, "Iron studies (ferritin [an iron compound], iron, IBC [iron binding capacity], % [percent] sat [saturation]) every Sept. [September] DX [diagnosis] Iron def. [deficiency] . . ." The resident's record lacked evidence staff obtained the ordered blood test in September 2014. When requested, on the morning of 01/15/15, two licensed nurses (#1 and #2) confirmed staff had not obtained the ordered iron studies in September 2014. Failure to obtain the iron studies limited the physician's ability to ensure the effectiveness of the current iron dosage for Resident #4.	F 281	physician on the results of the orders, all follow up orders were processed, and the completed lab work results will be scanned into the legal medical record. 3. All Unit Supervisors were educated on the importance of completing lab studies as ordered on 01/16/2015. System Change: a lab order schedule was developed 01/18/15 and all licensed nurses were educated on the importance of lab studies including the need for a physician order, obtaining and notifying the results of the lab studies, and ensuring the legal medical record on 1/17/15. 4. An audit tool will be developed to monitor physician orders for lab studies, follow up physician notifications, documentation of a progress note addressing the notification to the physician, if any additional orders were received and followed and if the results were scanned in to the legal medical record. This audit will be completed by HIM or designee 1-2 times a week for 1 month, then monthly x2, and then quarterly x3. The	
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,	F 309		

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F 309	Continued From page 17 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: DYSPHAGIA 1. Based on observation, record review, review of professional literature, review of facility policy and procedure, and staff interview, the facility failed to ensure 2 of 3 sampled residents (Resident #6 and #10) observed with signs/symptoms of dysphagia/aspiration received the care and services necessary to attain the highest degree of safety possible during meals. Failure to ensure residents with a known risk of aspiration were assessed per facility policy, alert, and positioned properly prior to providing food/liquid, resulted in Resident #10 aspirating and placed Resident #6 at an increased risk of aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, pages 8-9, 15, 125, 128, and the educational handouts identified, ". . . If a patient isn't alert, it may be better to delay the intervention [meal] until later. . . . A patient showing drooling . . . usually means he isn't swallowing his secretions . . . Coughing and choking are very obvious symptoms of dysphagia . . . changes in eating or drinking habits may be an unconscious reaction to difficulty handling certain textures or types of foods. . . . A patient with dementia often doesn't recognize food (an agnosia). When food is placed	F 309	results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. If concerns are identified, corrective action will be implemented. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015 F309 Provide Care/SErvices for Highest Well-Being Part I-Dysphagia 1. Resident #10: Staff member who completed MDS was interviewed and stated that signs and symptoms of a swallowing disorder was not witnessed by staff during MDS assessment period. Therefore, the MDS was coded correctly. Physician notified and ordered swallow evaluation. Swallow evaulation will be completed on 02/06/15, care plan will be revised following OT recommendatons from swallow evaluation/physician's orders. Staff was educated on proper feeding technique and dignity and to not mix food together. Resident #6 had a swallowing evaluation completed on 01/20/15, OT recommendations discussed at	

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F 309	Continued From page 18 in his mouth, it's as if he has forgotten what to do with the bolus [bite/sip] of food (swallowing apraxia). The staff . . . may report that the patient won't swallow even when persuaded to take some food into his mouth. . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle . . . The 90 degree position allows the patient to control material in the oral cavity with a minimal impact of gravity. This position must be maintained during and following the meal. Repositioning is frequently required during the meal. . . . Pillows may need to be placed . . . to achieve the correct position. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . . Controlling the bolus size is important in relation to how much a patient can hold in the oral cavity as well as how much the valleculae and pyriform sinuses [parts of the throat] can hold. As long as the bolus size is controlled to a small amount . . . the bolus can rest in the valleculae and pyriforms without aspiration during a delayed swallowing response. . . ." The facility policy titled "Dysphagia," revised September 2012, stated, ". . . Dietary/nursing staff will observe for signs and symptoms of dysphagia when interacting with residents or when observing meal service. . . . The . . . nurse will contact the physician if risk factors do exist to request an . . . order by a dysphagia therapist (speech language pathologist or occupational therapist). . . . The speech therapist will evaluate the resident to determine if diet modifications or swallowing interventions are indicated. . . . Nursing staff will contact the physician to obtain the diet order recommended by the speech	F 309	resident's care conference. Family was educated on the risks of choking and aspiration 01/22/15. Family stated they prefer resident to continue eating in her room. Fax with OT recommendations was sent to the physician on 01/22/2015 and a response regarding MD agreeing with family for resident to eat where she wishes was received back on 01/22/2015. For positioning see F246 POC. 2. All residents have the potential to be affected by this deficiency. If signs and symptoms of dysphagia are observed, staff are to report it to the nurse in charge and notify the physician and follow any additional orders or recommend-ations. 3. Nursing staff and all staff were educated on 02/17/2015 on procedure titled, "Dysphagia" with a focus on the need for staff to provide proper feeding techniques, monitoring for proper positioning, the risks for choking and aspiration and communicating to appropriate staff person if signs and symptoms of dysphagia are observed. 4. An audit tool was developed	

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F 309	Continued From page 19 therapist. . . . Dietary and nursing staff will receive education and training . . . on dysphagia during orientation and annually. Education and training will include: . . . How to identify residents at risk of dysphagia . . . How to decrease the risk of aspiration . . . How to maximize oral intake using the most normal solids and liquid that the resident can safely swallow . . ." - Review of Resident #10's medical record occurred on January 14-15, 2015. Diagnoses included advanced Alzheimer's dementia and pending oral surgery for loose, carious teeth. The quarterly Minimum Data Set (MDS), dated 12/20/14, identified severely impaired cognition, extensive assistance required for eating, transfers, and mobility, and a mechanically altered diet. The MDS failed to identify any signs/symptoms of a swallowing disorder witness by staff. The physician's order, dated 02/05/13, identified, "Blenderized Diet texture, Regular fluid consistency." The current care plan addressing Resident #10's individualized needs identified the following: * Nutrition: "Interventions . . . Regular - warm liquified [sic] diet. . . ." * Activities of Daily Living (ADL): "Interventions . . . Resident requires total assistance to eat. [According to the MDS the resident required extensive assistance to eat.] . . . Resident has some natural teeth, and a lower partial she does not wear. . . ." Observation showed the following: * On 01/13/15 at 8:30 a.m., Resident #10 sat in her wheelchair at an assisted table in the dining	F 309	for monitoring proper positioning, cueing, small portions when assisting with eating, and observing for signs and symptoms of dysphagia. Audits will be completed by DNS or designee, 3-5 times per week monitoring 1-2 meals for 4 weeks, then 1-2 times per month for 2 months, and then quarterly for 3 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 309	Continued From page 20 room. The Certified Nursing Assistant (CNA) (#17) looked about the dining room as she held a three ounce glass containing blenderized foods up to Resident #10's mouth until she drank the contents of the glass (placing Resident #10 at an increased risk of aspirating during a delayed swallowing response). Resident #10 swallowed repeatedly; drooling out of both sides of her mouth (an indication Resident #10 did not swallow her secretions) and coughing (an indication the liquids entered Resident #10's airway) as she drank. This occurred twice during the observation. * On 01/13/15 at 12:30 p.m., Resident #10 sat in her wheelchair at an assisted table in the dining room. The CNA (#18) held a three ounce glass containing blenderized foods up to Resident #10's mouth until she drank the contents of the glass, even though her eyes were closed. She failed to cue the resident prior to presenting the glass of liquid (placing Resident #10 at an increased risk of aspirating as she was unaware of the bolus). Resident #10 swallowed repeatedly until the glass was emptied; drooling out of both sides of her mouth. * On 01/14/15 at 8:44 a.m. and 12:25 p.m., Resident #10 sat in her wheelchair at an assisted table in the dining room. The CNA (#19) conversed with other staff members as he held a three ounce glass containing blenderized foods up to Resident #10's mouth until she drank the contents of the glass, and held the back of her head with his other hand which prevented her from moving away from the glass. Resident #10's eyes were closed off and on throughout the meal. The CNA (#19) failed to cue the resident prior to presenting each glass of liquid. Resident #10 swallowed repeatedly until the glass was emptied; showing residue above her upper lip, drooling out	F 309		

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F 309	Continued From page 21 of both sides of her mouth, and sputtering/coughing as she drank. This occurred ten times between the two observations. During interviews on 01/14/15 at 9:00 a.m. and 1:15 p.m., a managerial dietary staff member (#4) reported Resident #10 had dental issues leading to poor intake, and has been on a full liquid diet since August 2013. She stated staff "tried purees," but Resident #10 "drinks the best." She further reported she found no evidence the resident's swallow had ever been assessed per facility policy. The facility failed to: * Assess Resident #10's swallow per facility policy in order to determine the safest/least restictive diet for her, * Ensure Resident #10 was alert prior to feeding her, * Control the volume size of the bolus, offering Resident #10 teaspoon sized bites of food and/or sips of liquid, * Recognize Resident #10's ongoing signs/symptoms of dysphagia/aspiration (drooling, sputtering/coughing). The observations during survey demonstrated facility staff were unaware of the proper techniques for feeding Resident #10. The care and services provided placed Resident #10 at an increased risk of aspiration and caused her to take food/liquids into her airway. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, neoplasm of the mouth, osteoarthrosis, spondylosis, and history of multiple compression fractures. The quarterly Minimum Data Set (MDS), dated 11/29/14,	F 309		

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F 309	Continued From page 22 identified moderately impaired cognition, set-up assistance required for eating, and extensive assistance required for transfers and mobility. The physician's order, dated 01/13/13, identified, "Dental Soft texture, Regular fluid consistency, soft meats." The current care plan addressing Resident #6's individualized needs identified the following: * Nutrition: " Interventions . . . Resident prefers to sit in her room during meals. . . . Adaptive equipment needed lipped plate and weighted silverware. . . ." * Mobility: "Interventions . . . Resident uses high-back wheelchair . . ." Observation showed the following: * On 01/13/15 at 8:40 a.m., Resident #6 sat in her wheelchair, alone in her room, leaning to her right side as she ate her breakfast. On two occasions she was observed clearing her throat afterconsuming a large volume of liquid (an indication Resident #6 was unable to clear the material). * On 01/13/15 at 12:38 p.m., Resident #6 sat in her wheelchair, alone in her room, leaning to her right side as she ate her dinner. During an interview on 01/15/15 at 9:25 a.m., a physical therapy staff member (#16) confirmed staff should ensure Resident #6 is positioned as close to midline as possible during meals. During interviews on 01/14/15 at 9:00 a.m. and 1:15 p.m., a managerial dietary staff member (#4) confirmed staff are to ensure residents are alert and positioned properly prior to any feeding attempts, should control the volume size of the	F 309		

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F 309	Continued From page 23 bolus, and report any signs/symptoms of dysphagia to nursing staff. The facility failed to ensure Resident #6 was positioned as close to 90 degrees as possible prior to allowing her to feed herself unattended. The care and services provided placed Resident #10 at an increased risk of aspiration. CONSTIPATION 2. Based on observation, record review and review of facility policy, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #1) with a manual extraction. Failure to implement appropriate interventions as per facility protocol/physicians orders may result in unnecessary discomfort and/or fecal impaction. Findings include: Review of the facility procedure titled "Bowel Management Procedure" occurred on 01/15/15. This policy, dated 01/30/14, stated, ". . . 5. If no bowel movement within 2-3 days administer MOM [milk of magnesia], Bisacodyl suppository, or enema. . . . b. If No BM [bowel movement] on day 2 administer a bowel aide such as prunes, prune juice, fruit ball, or MD [medical doctor] or for laxative of choice per physician orders. . . . c. If no BM on the 3rd day give a suppository or fleets enema. d. If no BM on the 4th day listen to bowel sounds and check for tenderness or distension and administer either a suppository or enema or other bowel aide medication per physician orders."	F 309	F309 Part II - Constipation 1. Resident #1's individual needs have been net as she is having a bowel movement at least every third day. Miralax started 01/08/2015. 2. All residents with a diagnosis of constipation have the potential to be affected in this area. All residents on this list will have their bowel management program reviewed to ensure compliance in this area. 3. A Nursing inservice will be held on 02/17/2015 to educate the staff on the procedure title, "Bowel Management" with a focus on the need to follow the facilty bowel management program. Staff will offer fluids during cares. The daily bowel movement record will be revised to match the procedure. 4. An audit will be developed	

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F 309	Continued From page 24 Review of Resident #1's medical record occurred on all days of survey. Diagnoses included constipation. Current scheduled medications to manage constipation included Senna-Plus twice a day and Miralax powder daily started on 01/07/15. Current as needed (PRN) medications included Dulcolax suppository daily as needed, Fleets enema daily as needed, and MOM daily as needed. Resident #1's current care plan stated, "Focus: The resident has constipation R/T [related to] constipation, decreased mobility, medications, h/o [history of] small bowel obstructions . . . requires bowel meds [medications] . . . Interventions: Increase fiber and fluid intake to provide more bulk in diet. . . . Gets a prune juice with breakfast daily. . . ." Observation on 01/13/15 at 1:35 p.m. showed two certified nurse assistants (CNA) (#6 and #7) toileted Resident #1 and failed to offer her fluids. Review of Resident #1's bowel records identified a BM on 12/8/14 at 11:15 a.m. and on 12/10/14 at 11:04 a.m. and 2:14 p.m.. A progress note, dated 12/10/14 at 7:37 p.m., stated, "CN [charge nurse] manually removed a large round solid BM from [Resident #1's] rectum. Tolerated the procedure well." Review of Resident #1's bowel records identified a BM on 12/17/14. The 12/19/14 medication administration record (MAR) showed Resident #1 received a Dulcolax suppository at 1:00 a.m., a Fleets enema at 3:00 a.m., and MOM at 3:47 a.m.. Facility staff failed to follow the facility procedure. Review of the bowel records showed Resident #1 had three BM's on 12/19/14. Facility	F 309	to monitor the no BM reports. The report will indicate which residents have not had a BM on day 2, 3 or 4 and to ensure fluids are being offered to those residents. The bowel management procedure will be followed. The Audits will be completed by DNS or designee, 3-5 times per week for 4 weeks, then 1-2 times per month for 1 month and then monthly for 3 months, then quarterly for 2 quarters. The results of the audits will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 309	Continued From page 25 staff failed to follow the facility protocol and may have performed invasive procedures unnecessarily (suppository and enema). Resident #1's bowel records and MAR showed the following: * 01/01/15 at 9:39 a.m.: MOM * 01/01/15 at 1:53 p.m.: medium BM * 01/02/15: No interventions and no BM * 01/03/15: No interventions and no BM * 01/04/15 at 10:20 a.m.: MOM and no BM * 01/05/15 at 7:30 a.m.: suppository and no BM * 01/05/15 at 9:02 a.m.: MOM and no BM * 01/06/15 at 5:01 a.m.: enema * 01/06/15 at 5:44 a.m.: small BM * 01/06/15 at 12:21 p.m.: suppository * 01/06/15 at 1:22 p.m.: small BM * 01/06/15 at 8:47 p.m.: suppository * 01/07/15: three BMs documented Facility staff failed to follow Resident #1's physician orders by administering two Dulcolax suppositories on 01/06/15; failed to follow the facility protocol; and may have performed invasive procedures unnecessarily (suppositories and enema). Review of a physician progress note dated 01/08/15 stated, ". . . Patient has had increased constipation. . . . Miralax has been added already for constipation, so we will see how that goes for the resident before starting anything additional." Facility staff failed to administer a bowel stimulant for Resident #1 according to facility procedure and failed to provide fluids during cares, which may have resulted in a manual extraction and unnecessary discomfort.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 26 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain good nutrition for 1 of 1 sampled resident (Resident #2) who required staff assistance with eating. Failure to provide residents with assistance during meals resulted in Resident #2 being at an increased risk of weight loss and contributed to her limited intake. Findings include: Review of the facility policy titled "Resident-Assisted Dining" occurred on 01/15/15. This policy, revised November 2009, stated, ". . . 5. Encourage resident in feeding self, assisting as needed . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included osteoarthrosis, pain to right shoulder, and visual deficit secondary to macular degeneration. The significant change MDS, dated 11/14/14, identified moderately impaired cognition, limited assistance required for eating, and a mechanically altered diet. The physical therapy plan of treatment, dated	F 312	F312 ADL Care Provided for Dependent Residents 1. Resident #2's care plan was revised on 01/15/2015 to include assistance with finishing meal when she begins to tire, a colored plate and bowl to help her see when she eats. On 02/04/2015, care clan revised to offer to re-heat food per resident's request. 2. All residents have the potential to be affected by this deficiency. 3. An all staff inservice will be held on 02/17/2015 to address the procedure for REsident Assisted dining. 4. An audit will be developed to observe assistance being offered to residents during meals, including assistance with finishing meal when resident becomes fatigued. If adaptive equipment is needed to help with vision impaired residents, and to monitor if staff offer to re-heat food per resident's request. Audits will be completed by designated staff 3 meals per day x2 weeks, one of each meal 1x a week x2 weeks, one meal monthly x3 months and 1 meal per quarter	

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F 312	Continued From page 27 11/21/14, stated, ". . . [Resident #2] has a long standing right shoulder problem with pain and dysfunction. . . . She has very limited and painful function in the right shoulder. . . ." The current care plan identified the following: * Vision: ". . . The resident has impaired visual function R/T [related to] macular degeneration E/B [evidenced by] very poor vision, sees shadows. . . ." * Eating: ". . . Resident requires reminding, prompting, cueing assistance to eat. . . .: The progress notes identified the following: * 11/08/14, "resident was up to dining room for both breakfast and lunch, . . . complained of pain . . ." * 11/16/14, ". . . Resident does not eat much at meals . . ." * 11/19/14, "She continues to sit at an assisted table as she requires reminding, cueing assistance to eat. Amount eaten records shows that she is eating majority of her meals at 0%-25%. This is a decline in her intake. . . . . resident expresses concerns with food . . . dislikes items too cold. . . ." * 11/21/14, ". . . Resident has been eating less and less. Resident is crying and wincing in pain when family was visiting with her at dinner table. . . ." * 11/27/14, ". . . Residents eating has been poor lately. Resident only ate about 1/4 a bowl of oatmeal today, and drank 1/2 her hot choc [chocolate]. . . ." * 11/29/14, ". . . does have c/o [complain of] pain through out entire body . . . she has had little intake, and refuses to eat at times. . . ." * 11/30/14, ". . . needs frequent cueing/encouragement during mealtime. . . .	F 312	x3 quarters. The results of the audit will be reported to the QAPI committee for further recommendations and/or the need for additional audits. In addition, the QAPI committee will review elements of the 2015 state survey once a quarter for the first year to assure continued compliance. 5. 02/19/2015	

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F 312	Continued From page 28 Resident was saying this am [morning] that she couldn't attempt to feed herself . . . Resident says, 'You don't understand, I am incapable of doing it.' . . . Nurse took fingers and closed them around the spoon. . . . Resident fed herself half the bowl of hot cereal. . . . Resident had stopped eating and drinking. . . . Cook asked resident if she was still eating. Resident said in a whimpering voice, 'I don't know, I don't know how much I have eaten.' . . . Nurse said, 'Why don't you finish your hot chocolate.' Again resident started to say she couldn't do it and she [sic] incapable. . . . Nurse place the cup touching her fingers so that she knew it was there. . . ." * 12/10/14, "Resident continues to relate to us "that she can't do anything for herself" - seems to be feeling sorry for herself and is gently encouraged per staff to do what she can such as . . . feeding herself in the dining room . . ." * 12/28/14, "ate fair to poor for meals . . . c/o general aches and pains . . ." * 12/31/14, ". . . [Resident #2] has arthritis especially in right shoulder . . . Resident ate poor at meals today . . . Did complain of . . . pain all over . . ." * 01/02/15, "Resident has started to not want to feed self. Resident asks when she is out at the table, who is going to feed me. . . . Resident is saying she can't use her right arm at all anymore. Resident started feeding herself with her left hand . . . CNA sat down with resident and immediately resident said she just couldn't do it, she couldn't feed herself with her left hand etc. . . . At lunch nurse instructed CNA's to set up residents tray . . At first resident just looked around as if looking for someone to come and feed her. When there was no CNA's in her site [sic], resident picked up the spoon and started feeding herself with her left hand. . . . Resident ate for about 5 min [minutes]	F 312		

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F 312	Continued From page 29	F 312		

alone. . . . resident was tapping around the bowl like she couldn't find the center. . . . She would take a bite and then sit back in her chair really hard as if the act of feeding herself was just completely exhausting. Resident kept saying, aren't you going to feed me? . . . Resident ate 3/4 of a bowl of cream of wheat on her own. . . . Resident said, I can't believe they . . . won't feed me. . . . Resident said, I have a bad right shoulder and the doctor said I am not supposed to use the shoulder at all. . . . Resident said, well my fingers have arthritis and so it is hard for me to hold on to the spoon. Nurse said, well there are adaptive devices that we can put on your silverware . . . Resident said . . . I am tired. . . . Resident then said, well my food gets cold. . . ."

Observations identified the following:
* 01/13/15 at 8:30 a.m., Resident #2 sat in her wheelchair at an assisted table in the dining room. She fed herself for the initial five-to-ten minutes of the observation, after which she only took a few bites food from the white bowl. Approximately 15-to-20 minutes later, a CNA (#24) approached Resident #2 and offered her assistance, which she immediately accepted.
* 01/13/15 at 12:30 p.m., Resident #2 sat in her wheelchair at an assisted table in the dining room. Initially, she made attempts to feed herself from the white bowl. Approximately 15-to-20 minutes later, a CNA (#24) approached Resident #2 and asked her if she would like assistance. Resident #2 stated, "Yes, I sure would. I can't get my hand to go to my mouth."
* 01/14/15 at 12:25 p.m., Resident #2 sat in her wheelchair at an assisted table in the dining room. During the first 12 minutes of the observation, she ate cereal from a white bowl. During the next seven minutes, she took two bites

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F 312	Continued From page 30 of cereal and reached for items on the table that were not there. An unidentified CNA, sitting across the table from Resident #2, observed her behavior without providing cues to the location of her tray items. During the next nine minutes, Resident #2 attempted to take three more bites of cereal. Two of the bites of cereal fell from her spoon (onto her plate), never reaching her mouth. A second, unidentified CNA walked up to the table and asked, "Are you still eating?" Resident #2 replied, "I don't know. How am I doing?" She then attempted to take two more bites of cereal, Both fell from her spoon (onto her plate), never reaching her mouth. After getting no response, Resident #2 repeated her question, "How am I doing?" The CNA then looked at the remaining cereal in her bowl and replied, "Less than 50%. You need help [Resident #2]?" Thirty minutes after passing Resident #2's tray, the CNA sat down to assist her with her meal. She failed to reheat Resident #2's food prior to assisting her. During interviews on 01/14/15 at 9:00 a.m. and 1:15 p.m., the managerial dietary staff member (#4) confirmed Resident #2 does have difficulty seeing the items on her tray and has experienced fatigue and possibly shoulder pain while feeding herself. She also commented, "They should have reheated [Resident #2's] food [when the CNA sat down to assist her]." A progress note, dated 01/15/14, identified, "Kitchen to start sending food out on Blue plate and/or red bowl (cereal/soups) For [Resident #2] to be able to see food better." The facility failed to: * Acknowledge Resident #2's request for feeding assistance, instead describing her as	F 312		

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F 312	Continued From page 31 "whimpering, feeling sorry for herself," and acting as if "the act of feeding herself was just completely exhausting." * Provide Resident #2 with feeding assistance when she begins to show signs of fatigue, approximately 10 minutes into the meal. * Recognize Resident #2's "very poor vision [sees shadows], very limited and painful function in her right shoulder, and fatigue" as contributing factors to her limited intake. * Recognize Resident #2 had little choice, but to attempt to feed herself, when staff refused to provide assistance. * Acknowledge and/or provide adaptive eating equipment (colored dishware, light silverware) when Resident #2 voiced concerns regarding her inability to see her meal and/or hold her silverware secondary to the arthritis in her fingers. * Recognize Resident #2's complaints regarding cold food may be related to the length of time it takes her to feed herself. The care and services provided placed Resident #2 at an increased risk of weight loss and contributed to her continued limited intake.	F 312		
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:	F 323	F323 Free of Accident Hazards/ Supervision/Devices Falls 1. Resident #1 has had no further falls since 12/29/2014. Resident #5 has had no further falls since 01/09/2015. Staff were educated on 01/27/2015 regarding the importance of responding to sensor alarms and placing bed and chair sensors when resident is transferred.	

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F 323	Continued From page 32 FALLS 1. Based on observation, record review, and staff interview, the facility failed to provide assistive devices and supervision necessary to prevent accidents for 2 of 2 sampled residents (Resident #1 and #5) who experienced falls without preventative measures in place. Failure to utilize Resident #1's bed alarm and Resident #2's chair alarm may have resulted in avoidable falls and/or injuries. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and osteoarthrosis. The quarterly Minimum Data Set (MDS), dated 12/01/14, identified severely impaired cognition, extensive assistance from two or more people for transfers and bed mobility, and two falls without injury. Resident #1's current care plan stated, ". . . Focus: The resident has had an actual fall with no injury R/T [related to] physical limitations, and cognitive losses, dementia, arthritis, h/o [history of] syncope, E/B [evidenced by] non-ambulatory, safety awareness deficit (attempts self transfer). . . . Interventions . . . PERSONAL ALARM: sensor mat in bed and chair, used to alert staff to resident's movement and to assist staff in monitoring movement. . . ." The fall report dated 12/29/14 at 10:08 p.m. stated, "Patient found on floor per CNA's. Patient sitting up along side bed. PAtient [sic] on top of body pillows and blankets when found. CNA's forgot to place patient sensor mat under patient	F 323	2. All residents who use sensor mats have the potential to be affected by this deficiency. 3. All staff inservice will be held on 02/17/2015 to educate about the importance of responding to sensor alarms and placing ed and chair sensors when resident is transferred. 4. Falls: An audit tool will be developed to boserve placing a sensor mat to chair and/or chair after resident transferred, observing staff responding to bed or chair alarm immediately, and to observe chair or bed sensor in place for residents who have orders for the same. The audit will be completed 3-5 times weekly for two weeks, then will be completed 3-5 times for 4 weeks, then one time per week for two weeks, then monthly for 2 months, and quarterly for 3 quarters. Sit and Stand to Lift transfers: 1. Resident #2 - nursing staff educated regarding appropriate use of mechanical lift and to notify appropriate staff member if resident having pain or lift no longer appropriate for resident. Care plan revised to use total mechanical lift for	

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F 323	Continued From page 33 when putting to bed minutes prior Body inspected no pain or signs of injury at this time. Bed was in low position. Patient has strong hand grip, eyes reactive. Patient incontinent of BM [bowel movement], patient changed and vitals obtained. . . . No injuries observed . . ." The staff failed to apply Resident #1's bed alarm which may have alerted staff of the resident's activity. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included muscle weakness and macular degeneration. The quarterly MDS, dated 11/29/14, identified intact cognition, extensive assistance from two or more people for transfers and toilet use, and two falls without injury. Resident #5's current care plan stated, ". . . Focus: The resident is at risk for falls R/T left hip fx [fracture] . . . CVA [cerebrovascular accident] with left sided weakness, mobility and balance deficits E/B frequent falls, impulsiveness, poor safety judgement, self transfers though has been educated not to. . . . Interventions . . . PERSONAL ALARM: Sensor mat to bed and chair used to alert staff to resident's movement and to assist staff in monitoring movement. Resident benefits from interventions that minimize the potential for falls while providing diversion and distraction such as: Offer her to be in her recliner when returning to room. Attempt to leave the door to her room partially open, so alarms may be heard. . . ." Observation on 01/12/15 at 4:20 p.m. showed Resident #5 sitting in a chair without her chair alarm (chair alarm observed on the wheelchair).	F 323	transfers. 2. All residents who use the sit to stand lift have the potential to be affected by this deficiency. A list of residents who use the sit to stand lift will be generated and reviewed by LPTA and care plan will be revised if needed. 3. All staff inservice will be on 02/17/2015 to educate staff on procedure for mechanical lift transfers, report if resident has pain or discomfort to nurse, cueing of resident to stand and report to appropriate staff member if sit to stand lift no longer appropriate for resident. 4. An audit toll will be developed to observe if the transfer using a sit to stand lift was performed correctly, observing staff, cueing the resident to stand, observing if resident was able to bear weight throughout the transfer and if not, was it reported to the appropriate staff member, and did the resident complain of pain/discomfort during the transfer and if yes, was it rported to the nurse. The Audit will be completed 3-5 times weekly for two weeks, then will be completed 3-5 times for 4 weeks then monthly for 2 months and	

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 _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 34 At 4:37 p.m. Resident #5 transferred herself from the chair to the wheelchair and the alarm sounded when Resident #5 sat in the wheelchair. Facility staff failed to respond to the alarm. Nurses' notes showed the following: * 01/09/15 at 9:25 p.m.: "Resident found on floor in bathroom. Blood noted to Residents left side of forehead in hair. Resident denies pain to any part of the body. No redness or bruising noted to any part of the body at this time. Neurochecks completed and found within normal limits. Resident states 'I was getting off the toilet. I tried to pull up my underwear and I fell forward and hit my head on the wall.'" * 01/09/15 at 9:25 p.m.: "No chair alarm on Resident's wheelchair." The fall report dated 01/09/15 at 9:25 p.m. stated, ". . . Abrasion to left side of forehead in hair. . . . No alarm on wheelchair. . . ." During an interview on 01/14/15 at 9:16 a.m., a certified nursing assistant (CNA) (#5) stated Resident #5 "wheeled self into bathroom" and fell while she transferred herself. There was "no chair alarm on [the]wheelchair." The staff failed to apply Resident #5's chair alarm which may have alerted staff to her activity. SIT-TO-STAND LIFT TRANSFERS 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 1 of 2 sampled residents (Resident #2) observed during sit-to-stand lift transfers. Failure to ensure staff used a mechanical lift appropriately caused Resident #2 pain and	F 323	quarterly for 3 quarters. 5. 02/19/2015	

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F 323	Continued From page 35 placed her at risk for a fall during transfers. Findings include: Review of the facility policy titled "Mechanical Lift" occurred on 01/15/15. This policy, revised November 2013, stated, ". . . Sit-to-Stand For residents who demonstrate leg strength for weight bearing and are able to hold torso in an upright position . . . Must be able to cognitively follow cues and cooperate with procedure." Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included osteoarthrosis, chronic pain with arm movement, and history of a hip fracture. The quarterly Minimum Data Set (MDS), dated 04/19/14, identified moderately impaired cognition and extensive assistance of one person required for transfers. The physical therapy plan of treatment plan, dated 11/21/14, stated, ". . . [Resident #2] has a long standing right shoulder problem with pain and dysfunction. . . . She has very limited and painful function in the right shoulder. . . ." The current care plan stated, ". . . Focus: . . . mobility deficits, osteoporosis . . . poor tolerance for weight bearing on the right . . . Interventions: . . . Sit-stand lift assist of 2 . . ." Observations showed the following: * 01/13/15 at 10:09 a.m., two certified nursing assistants (CNA) (#20 and #21) transferred Resident #2 from the toilet to her bed using the sit-to-stand lift. As the two CNAs raised the lift to perform pericares, Resident #2 stated, "I can't hold on with this [right] hand. It hurts too bad."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 36 She did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #2's axillae (armpits), her shoulders raised to ear level. She remained in this position throughout observation. As the two CNAs (#20 and #21) transferred her to the bed, she stated, "Oh, that hurts!" * Midmorning on 01/14/15, two CNAs (#22 and #23) transferred Resident #2 from the toilet to her bed using the sit-to-stand lift. As the two CNAs raised the lift, Resident #2 stated, "This [right] arm hurts so!" The resident did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #2's axillae, her shoulders raised to ear level. Staff failed to cue Resident #2 to stand, ensure she was able to bear weight throughout the stand lift transfers, and report her inability to bear weight and/or her obvious discomfort/pain to the nurse. During an interview on 01/15/15 at 9:25 a.m., a physical therapy staff member (#16) confirmed a resident should be able to bear their own weight if a sit-to-stand lift is used. She also stated, "They [CNAs] should have sat her down [in her wheelchair] and wheeled her to the bed, then called the nurse."	F 323		