STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355087	A. BUILDING _____ B. WING _____	07/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD MANOR	804 MAIN ST W CAVALIER, ND 58220

(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 07/12/10 and completed on 07/14/10 the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident 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	To ensure 'Notification of Change' for Resident #8, her Primary Care Provider (PCP) was updated on her status and notified of her refusal of medications. 07/16/10 Resident #8's plan of care was updated to reflect the need to notify her PCP and family member/legal representative of any change in her status. 07/16/10 To address Resident #8 and any other resident that may be affected, the facility will re-educate licensed nursing staff to inform the resident, consult with the resident's physician, and if applicable notify the resident's legal representative or interested family member when there is any significant change in resident status as specified in §483.12 (a); refer to the policy on 'Notification of Change' (**Att. A**). 08/16/10 Documentation in progress notes and the procedure for communication to the PCP via a notification form was revised to ensure 'Notification of Change' process is completed (**Att. B**). The DON or appropriate designee in her absence will monitor weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year to ensure notification 08/20/10	

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

Patti Johnson — Administrator — 08/13/10

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

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F 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, review of facility policy, family interview, and staff interview, the facility failed to inform 1 of 1 sampled resident (Resident #8)'s physician and family regarding the residents' continuous refusal of medications. Failure to inform the physician and family may have resulted in Resident #8 experiencing adverse effects due to no treatment for behaviors, gastroesophageal reflux disease (GERD), and constipation. Findings include: Review of the facility policy titled "Informed Family and legal representative" occurred on 07/14/10. This policy, dated 1997, stated, ". . . Per residents request, family members and/or legal representative will be notified regarding the following: . . . A significant change in your physical, mental, or psychosocial status . . . According to the Resident Bill of Rights and if the resident request [sic], family will also be notified within 24 hours of any accident/occurrence, significant change in resident physical, mental, or psychosocial status, or change in your treatment and/or medication which has been significant." Please refer to F333 for detailed findings. Review of Resident #8's medical record occurred on July 13-14, 2010. Medical diagnoses included Alzheimer's disease, dementia, behaviors	F 157	of change occurs. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The DON will submit a report of the monitoring results to the QA committee during the scheduled monthly meetings.	

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F 157	Continued From page 2 secondary to dementia, constipation, arthritis, degenerative joint disease, anemia, hypothyroidism, and gastroesophageal reflux disease (GERD). Daily medications included Tylenol, Remeron (antidepressant also used to increase appetite), Synthroid (hypothyroidism), Prilosec (GERD), Seroquel (antipsychotic), iron (anemia), and colace (constipation). Review of Resident #8's Medication Administration Records (MARs) between 06/19/10 and 07/14/10, showed Resident #8 refused most of her medications every day except July 4-5, 2010. This review showed Resident #8 refused her scheduled medications 24 out of 26 consecutive days. Resident #8's medical record revealed the facility did not contact the resident's family, or physician, until the resident had refused to take her medications for 12 days and exhibited behaviors, vomiting, stomach upset, and bowel problems. During interview on 07/14/10 at 8:55 a.m., Resident #8's family member (#1) stated Resident #8 is not "mentally capable" to refuse her medications. During an interview on the afternoon of 07/14/10, an administrative nurse (#1) stated Resident #8 routinely refused her medications and the physician's awareness to this behavior. Review of the physician nursing home notes dated 06/21/10, 05/27/10, 05/24/10, 04/26/10, and 03/29/10, failed to identify the physician's awareness of Resident #8's routine of refusing medications. Failure to notify the physician did not allow the physician the opportunity to receive pertinent	F 157		

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F 157	Continued From page 3 information regarding Resident #8's continuous refusal of medications and the ability to alter the resident's treatment and many have resulted in the resident's increase in behaviors, vomiting, stomach upset, and bowel problems.	F 157		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/17/09. Based on observation, record review, and staff interview, the facility failed to promote an environment that maintains or enhances dignity for 1 of 1 sampled resident (Resident #6) observed with bilateral half side rails covered in sheepskin. The use of side rails covered with sheepskin for a resident who does not require them for bed mobility obstructs the resident's vision and is an infringement on the resident's right to be treated with dignity and respect. Findings include: Review of Resident #6's medical record occurred on July 13-14, 2010. Diagnoses included Alzheimer's dementia, bilateral hand contractures, and osteoarthritis. Resident #6's most recent Minimum Data Set (MDS), dated July 12, 2010, indicated Resident #6 required total assistance from two or more staff for bed mobility	F 241	To ensure 'Dignity and Respect of Individuality' for Resident #6, OT/PT are assessing Resident #6's current restorative programs, completing a side rail assessment, and need for a sheep skin. The sheepskin was removed from Resident #6's side rails on 7-19-10. To ensure dignity and respect for Resident #6 and all other residents in the facility, a side rail assessment is completed on admission, quarterly, annually, and with a significant change, and will involve the interdisciplinary team, resident, and/or legal representative. All nursing staff will review the 'Side Rail Assessment Policy' (Att. C) and an in-service will be completed on dignity and respect. Monitoring of Resident #6 and sample of other residents that may be affected by this practice will be completed by the CRA Coordinator or appropriate designee in her absence weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	08/20/10 08/16/10 08/20/10

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F 241	Continued From page 4 and transferring. Resident #6's Resident Assessment Protocol (RAPs), stated, ". . . Is dependent on staff to sit-up, lie down, and reposition once in bed. . . ." Observation during the initial tour on July 12, 2010 at 2:10 p.m. showed Resident #6 lying in bed with bilateral half side rails up and the upper half of each side rail covered in sheepskin. The resident held hand rolls in each hand and had contractures of the fingers and wrists. Observations throughout the survey showed the side rails and sheepskin positioned as described above whenever Resident #6 laid in bed. During an interview on July 13, 2010 at approximately 10:30 a.m., a certified nursing assistant (CNA) (#6) stated Resident #6 does not move unless staff move her, and the sheepskin covers were used so the resident would not bump her face on the side rails during repositioning. The CNA also stated the side rails do not really serve a purpose since the resident is dependent on staff for repositioning and transferring. The use of side rails and sheepskin in this manner is demeaning to the resident and obstructs the resident's view. The negative impact this can have on the resident's self esteem may lead to a decreased quality of life.	F 241		
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.	F 248	Resident #6's activity program was revised and her plan of care was updated by the Interdisciplinary Team to provide an on-going meaningful activity program to meet Resident #6's physical,	08/05/10

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F 248	Continued From page 5 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON June 17, 2009. Based on on observation, record review, family interview, and staff interview, the facility failed to provide an ongoing, meaningful activity program to meet the physical, mental, and psychosocial needs for 1 of 4 residents (Resident #6) dependent on staff to attend activities. Activities are a valuable component of residents' lives and vital to achieve their highest level of well-being. Failure to provide meaningful activities designed to reflect each resident's interests and lifestyle has the potential to negatively impact a resident's sense of self-worth and belonging. Findings include: Review of Resident #6's medical record occurred on July 13-14, 2010. Diagnoses included expressive aphasia, Alzheimer's dementia, cataracts, and bilateral hand contractures. Resident #6's most recent Minimum Data Set (MDS), dated July 12, 2010, indicated the resident required total assistance of one person for locomotion on and off the unit, had minimal difficulty hearing, and had highly impaired vision. The MDS also indicated Resident #6 did not speak. The "Activities" portion of the MDS showed Resident #6's preferred activities included music, reading/writing, spiritual/religious activities, watching TV, and gardening/plants; and Resident #6 spent 1/3 to 2/3 of her time involved in activities. Resident #6's current care plan stated, ". . .	F 248	mental, and psychosocial needs. To ensure all resident's needs are met, the facility will identify each resident's needs with an initial admission activity assessment to involve the residents in an ongoing program of activities designed to appeal to his or her interests. A quarterly reassessment questionnaire will be implemented, to ensure their activity program reflects each resident's current needs/interests, accordingly with their MDS schedule **(see Att. D).** 08/16/10 Activity and Nursing employees will work as a team to ensure that residents are involved and assisted to activities of their choice **(see Att. E).** Documentation training was completed with activity personnel to ensure that the 08/12/10 resident responses are appropriately captured for each activity. The monthly 08/10/10 activity schedule times were adjusted to coordinate with resident needs/schedules. The Activity Director 08/20/10 or appropriate designee in her absence will monitor activity programs for resident #6 and a diverse sample of residents to ensure activity needs are being met weekly x 1 month, monthly x 3 months and quarterly thereafter. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The Activity Director will submit a report of the monitoring results during the scheduled monthly meetings.	

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F 248	Continued From page 6 Problem . . . Alt. [alteration] in leisure pursuits . . . Approach . . . Remind, invite, escort as needed to oor [out of room] activities of int [interest] such as but not limited to: coffee time, church, music, hair care, small group activities, sensory groups, table ball, intergenerational, and more . . . Previous interests include reading, outings, TV watching, and more . . ." Resident #6's "Activity Pursuit Patterns" assessment, dated October 31, 2005, identified the resident's current interests as music, reading, talking/conversing, wheeling outside, watching TV, spiritual/religious, radio/music, and baking. During an interview on July 13, 2010 at 11:30 a.m., a family member (#2) stated Resident #6 used to be social and outgoing, a good cook, and very active in her church; and also enjoyed gardening. An interview with a CNA (#6) occurred on July 13, 2010 at approximately 7:40 a.m. The CNA stated she usually gets Resident #6 ready for the day later in the morning, after breakfast. Later in the afternoon, a CNA (#10) stated Resident #6 goes to bed about 7:00 p.m. each night. Observations of Resident #6 occurred throughout the survey and revealed the following: * July 12, 2010 at 2:40 p.m.: In bed asleep * July 12, 2010 at 4:35 p.m.: In unit lounge area sitting at the dining table in her wheelchair with her back to the TV (facing a wall) and no other staff/residents around * July 12, 2010 at 5:40 p.m.: After toileting, taken to the unit lounge area and pushed to the dining table in her wheelchair (facing a wall) with her back to the TV and other residents	F 248		

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F 248	Continued From page 7 * July 13, 2010 at 7:40 a.m.: In bed asleep * July 13, 2010 at 9:21 a.m.: Fed breakfast in her bed by a staff member, no music or TV on * July 13, 2010 at 10:40 a.m.: Assisted to the unit lounge area and pushed to the dining table in her wheelchair (facing a wall) with her back to the TV and other residents * July 13, 2010 at 1:15 p.m.: Lying in bed on her left side, bilateral half side rails up and covered with sheepskin, no music or TV on * July 13, 2010 at 4:30 p.m.: In lounge area sitting at the dining table in her wheelchair (facing a wall) with her back to the TV and no other staff/residents around * July 14, 2010 at 7:48 a.m.: In bed asleep * July 14, 2010 at 9:25 a.m.: Fed breakfast in her bed by a staff member, no music or TV on * July 14, 2010 at 10:45 a.m.: Assisted to the unit lounge area and sat in front of the TV in her wheelchair with the TV turned to a community announcement station * July 14, 2010 at 1:00 p.m.: Attended a music program in the main dining room * July 14, 2010 at 1:55 p.m.: In bed with bilateral half side rails up and covered with sheepskin, no music or TV on * July 14, 2010 at 4:11 p.m.: In the unit lounge area at the dining table (facing a wall) with her back to the TV and other residents * Throughout these observations of Resident #6 in the unit lounge area, no interaction from staff or any other type of stimulating activity occurred. Review of Resident #6's "Activities Participation" monthly flowsheets revealed the following regarding attendance of activities from April 1 to July 13, 2010: *Cards/Games: - Sleeping, invitation declined, or unable 36 of 104	F 248		

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F 248	Continued From page 8 days; observed activity 2 of 104 days *Fine Arts (Music, Art, Crafts): This activity is identified on Resident #6's MDS as a preferred activity. - Sleeping, invitation declined, or unable 30 of 104 days; observed activity or actively participated 6 of 104 days *Exercise/Sports: - Sleeping, invitation declined, or unable 9 of 104 days; observed activity or actively participated 2 of 104 days *Reading/Writing: This activity is identified on Resident #6's MDS as a preferred activity. - Sleeping, invitation declined, or unable 22 of 104 days; actively participated 4 of 104 days *Spiritual/Religious: This is an activity identified by the resident's family as being important to Resident #6; it is also identified on the MDS as a preferred activity. - Sleeping, invitation declined, or unable 68 of 104 days; actively participated 2 of 104 days *Shopping/Outdoors/Outing: - Sleeping, invitation declined, or unable 7 of 104 days; actively participated 7 of 104 days *Watch/Listen TV, Radio, Video: - Sleeping, invitation declined, or unable 16 of 104 days; actively participated 17 of 104 days *Gardening/Nature: This is an activity identified by the resident's family as being important to Resident #6; it is also identified on the MDS as a preferred activity. - Sleeping, invitation declined, or unable 3 of 104 days; actively participated 1 of 104 days *Talking/Conversing/Socializing: - Sleeping, invitation declined, or unable 95 of 104 days; actively participated 4 of 104 days *Visitors: - Actively participated 4 of 104 days *1:1's	F 248		

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F 248	Continued From page 9 - Sleeping, invitation declined, or unable 1 of 104 days; actively participated 25 of 104 days *Pet Therapy/Bird Watching: - Sleeping, invitation declined, or unable 5 of 104 days; actively participated 7 of 104 days *Hair Care/Manicures: - Sleeping, invitation declined, or unable 12 of 104 days; actively participated 7 of 104 days *Sensory/Sundowners/Small Group: - Sleeping, invitation declined, or unable 3 of 104 days; actively participated 4 of 104 days *Baking/Cooking: This is an activity identified by the resident's family as being important to Resident #6. - Sleeping, invitation declined, or unable 11 of 104 days Review of the facility's monthly activities calendars showed activities such as devotions, Bible trivia, "news and views", crafts, and baking occurred most frequently in the morning (before facility staff performed morning cares and assisted Resident #6 out of bed). An interview with an activities staff member (#12) occurred the morning of July 14, 2010. The staff member stated she announces activities over the loud speaker, asks the CNAs to invite residents, or sometimes the activities staff will personally invite residents. She also stated that if residents do not attend an activity, they are automatically coded an "I" (meaning invitation declined) on their activities flowsheets. The facility failed to develop an individualized activity program to meet Resident #6's physical, mental, and psychosocial needs and to engage the resident in activities (such as cooking/baking, gardening, and spiritual/religious) which were	F 248		

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F 248	Continued From page 10 identified as having special meaning to the resident.	F 248		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, and staff interview, the facility failed to ensure the	F 278	The facility will revise their current 'Urinary Continence Rehabilitation Program' **(Att. F).** Residents #5, 6, 8, and 10 will have a bowel/bladder assessment completed and their plan of care updated to ensure the assessment accurately reflects the resident's current status and promotes their highest level of physical, mental, and psychosocial functioning. A Bowel/Bladder assessment will be completed upon admission, quarterly, annually, and with any significant change to ensure any other residents in the facility have an accurate assessment of their bowel/bladder function and an appropriate program identified in their plan of care. The Nursing Department will be in-serviced on the revised 'Urinary Continence Rehabilitation Program' and changes in documentation to accurately reflect individual toileting programs. The interdisciplinary team involved in the completion of MDS's will review Section H of the MDS v2.0 Users Manual and will attend scheduled training on the MDS 3.0 to ensure that assessments are accurately captured on the MDS. The CRA Coordinator will monitor the 'Urinary Continence Rehab Program' for Resident #5, 6, 8, 10 and a random sample of residents to ensure assessments accurately reflect the current status of residents. The MDS	08/12/10 08/20/10 08/16/10 8/16/10 08/20/10

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F 278	Continued From page 11 Minimum Data Set (MDS) accurately reflected toileting needs for 4 of 5 sampled residents (Resident #5, #6, #8, and #10) incontinent of bladder and coded on the MDS for a toileting program. Failure to accurately assess and code the MDS to reflect the resident's current status may affect the level of care provided by staff, and prevent the resident from attaining their highest level of physical, mental, and psychosocial functioning. Findings include: Review of the facility policy, titled "Urinary Continence Rehabilitation Program" occurred on 07/14/10. This policy, dated June 2006, stated, ". . . OBJECTIVES: 1. To establish a uniform method of assessment, documentation, and evaluations of urinary incontinence. 2. To effectively identify the appropriate interventions for each individual. 3. To decrease incidents of urinary incontinence. 4. To decrease resources (equipment, people and time) utilized in urinary incontinence interventions. 5. To maintain the resident at their highest functional level. PROCEDURE: 1. Assessments will be completed for: A. All new admissions. B. All residents with a change in cognition, physical ability . . . 2. The CRA [certified resident assistant] coordinator is responsible to see that an assessment is completed and the appropriate program . . . is initiated. Appropriate programs include bladder training, habit training/scheduled voiding, prompted voiding/routine toileting . . . 5. The Care Plan will address the type of incontinence and provide a detailed intervention plan which will be re-evaluated and revised as needed to meet the needs of the individual resident . . ."	F 278	Coordinator will oversee the interdisciplinary team to ensure the MDS assessment is completed as per guidelines of the Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2008. The CRA Coordinator or appropriate designee in her absence will monitor that appropriate continence rehab programs are in place for Resident #5, 6, 8, 10, and a sample of other residents weekly x 1 month, monthly x 3 months, and quarterly thereafter. The MDS Coordinator will monitor that resident assessments accurately reflect the current status of resident #5, 6, 8, 10 and a sample of other residents. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The CRA Coordinator and MDS Coordinator will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	08/20/10

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F 278	Continued From page 12 The Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2008, stated, ". . . There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word 'scheduled' refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of 'toileting' refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A 'program' refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void . . . If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident . . . Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly . . ." Please refer to F315 for detailed findings. - Review of Resident #5's medical record occurred on all days of survey. The MDS, dated 04/20/10, identified the resident required extensive assistance for toilet use, frequently incontinent of bladder, and on a scheduled toileting plan. Resident #5's care plan identified a routine toileting plan. The routine toileting plan for this resident identified an every two hour toileting program.	F 278		

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F 278	Continued From page 13 Review of Resident #5's "Bowel Bladder Program Intervention Tracking Form" three day summary, dated June 2006, stated to precede with a "scheduled program adjusted to meet residents needs." Facility staff could not provide a more current intervention tracking form. Review of Resident #5's "Routine Toileting Schedule" records for the months of April, May, and June 2010 indicated facility staff assisted Resident #5 with toileting every two hours daily. The records showed the following: * April 2010 - Resident #5 experienced 158 episodes of urinary incontinence. Facility staff failed to offer toileting 131 of the 158 episodes and changed the resident's wet brief at these times. * May 2010 - Resident #5 experienced 150 episodes of urinary incontinence. Facility staff failed to offer toileting 117 of the 150 episodes and only changed the wet brief at these times. * June 2010 - Resident #5 experienced 143 episodes of urinary incontinence. Facility staff failed to offer toileting 103 of the 143 episodes and only changed the wet brief at these times. - Review of Resident #8's medical record occurred July 13-14, 2010. The MDS, dated 06/14/10, identified the resident required total assistance by staff for toilet use, frequently incontinent of both bowel and bladder, and on a scheduled toileting program. Resident #8's care plan identified a "toileting program established." The toileting program established for this resident identified an every two hour toileting program. Review of Resident #8's "Bowel Bladder Program Intervention Tracking form" three day summary, dated March 9-11, 2010, identified facility staff	F 278		

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F 278	Continued From page 14 failed to assess the resident's continence level on 03/09/10 at 7 a.m., 1 p.m., and 3 p.m.; on 03/10/10 at 9 a.m., 11 a.m., 1 p.m., 5 p.m., and 9 p.m.; on 03/11/10 at 7 a.m., 1 p.m., 3 p.m., 5 p.m., 7 p.m., and 9 p.m. A hand written note on the tracking form stated, "03/12/10 Will proceed with routine toileting program." Review of Resident #8's "Routine Toileting Schedule" records for the months of April, May, and June 2010 indicated facility staff assisted Resident #5 with toileting every two hours. The records showed the following: * April 2010 - Resident #8 experienced 83 episodes of urinary incontinence. Facility staff failed to offer toileting 67 of the 83 episodes and only changed the resident's wet brief at these times. * May 2010 - Resident #8 experienced 83 episodes of urinary incontinence. Facility staff failed to offer toileting 70 of the 83 episodes and only changed the resident's wet brief at these times. *June 2010 - Resident #8 experienced 86 episodes of urinary incontinence. Facility staff failed to offer toileting 64 of the 86 episodes and only changed the residents's wet brief at these times. - Review of Resident #6's medical record occurred July 13-14, 2010. The resident's most recent MDS, dated July 12, 2010, indicated Resident #6 required total assistance of two or more people for toilet use, was frequently incontinent of bladder, and participated in a regularly scheduled toileting plan. The resident's current Resident Assessment Protocols (RAPs) stated, ". . . Has been placed on a routine toileting program to maintain what control is present. . . ."	F 278		

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F 278	Continued From page 15 Resident #6's current care plan stated, ". . . Toileting: Dependent on staff. Check every 2 hours and change as needed. . . ." The record included a form entitled "Bowel/Bladder Program Intervention Tracking Form." This form documented Resident #6's bladder continence over a three-day period (August 16-18, 2006). A handwritten note on the form stated, "Proceed [with] routine toileting." Facility staff could not provide a more recent tracking form. A "Routine Toileting Schedule" form, located in Resident #6's medical record, indicated facility staff toileted the resident every two hours daily. Review of the form for the months of June, May, and April revealed the following: * June 2010: Resident #6 experienced 216 episodes of incontinence. Facility staff failed to offer toileting 180 of the 216 episodes and only changed the resident's wet brief at those times. * May 2010: Resident #6 experienced 200 episodes of incontinence. Facility staff failed to offer toileting 161 of the 200 episodes and only changed the resident's wet brief at those times. * April 2010: Resident #6 experienced 191 episodes of incontinence. Facility staff failed to offer toileting 172 of the 191 episodes and only changed the resident's wet brief at those times. Observation on July 13, 2010 at 9:21 a.m. showed a CNA (#6) checked and changed Resident #6's wet brief while the resident laid in bed. An interview with a CNA (#10) occurred on July 13, 2010 at 5:40 p.m. The CNA stated she checked and changed Resident #6's wet brief	F 278		

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F 278	Continued From page 16 around 3:30 p.m. She further stated that if Resident #6 is in bed, she is a check and change; and if she is up in her wheelchair, they will take her to the toilet. - Review of Resident #10's medical record occurred on July 13-14, 2010. Resident #10's most recent MDS, dated May 18, 2010, indicated the resident required extensive assistance from one person for toilet use, was frequently incontinent of bladder, and participated in a regularly scheduled toileting plan. Resident #10's current RAPs stated, ". . . Is on a routine toileting program to maintain cleanliness and what control may be left. . . ." The resident's current care plan stated, ". . . Dependent with toileting. Routine toileting program. . . ." The record lacked documentation of any type of bowel and bladder tracking form or assessment, and facility staff were unable to locate one for Resident #10. A "Routine Toileting Schedule" form, located in Resident #10's medical record, indicated facility staff toileted the resident every two hours daily. Review of the form for the months of June, May, and April revealed the following: * June 2010: Resident #10 experienced 125 episodes of incontinence. Facility staff failed to offer toileting 113 of the 125 episodes and only changed the resident's wet brief at those times. * May 2010: Resident #10 experienced 111 episodes of incontinence. Facility staff failed to offer toileting 95 of the 111 episodes and only changed the resident's wet brief at those times. * April 2010: Resident #10 experienced 111 episodes of incontinence. Facility staff failed to offer toileting 98 of the 111 episodes and only changed the resident's wet brief at those times.	F 278		

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F 278	Continued From page 17 Observation on July 14, 2010 at 7:52 a.m. showed two CNAs (#10 and #11) checked and changed Resident #10's wet brief while the resident laid in bed. During an interview on July 14, 2010 at 11:25 a.m., a CNA (#10) stated she checked and changed Resident #10's wet brief at approximately 10:30 a.m. She further stated they (the staff) check and change Resident #10's brief because she rarely gets out of bed and that Resident #10 does not use the toilet. The facility failed to assess and utilize current supporting documentation to determine Resident #5, #6, #8, and #10's toileting needs and to implement a toileting plan accordingly. The lack of complete and accurate assessment does not provide a means of determining these residents' overall continence performance through all shifts, and does not provide accurate baseline data to develop an individualized plan to allow the residents to improve/attain maximum bladder continence.	F 278		
F 315 SS=E	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.	F 315	To ensure the facility adequately assesses the voiding habits/patterns, develops appropriately scheduled toileting times, and implements consistent scheduled toileting times, the facility revised their 'Urinary Continence Rehabilitation Program' and will complete reassessments on residents #4, 5, 6, 8, and 10, updating their continence programs and their plan of care to reflect their individual needs. The 'Urinary Continence Rehabilitation	08/12/10 08/20/10

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F 315	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference, and staff interview, the facility failed to adequately assess the voiding habits/patterns, develop appropriate scheduled toileting times, and implement scheduled toileting times consistent with the assessment for 5 of 10 sampled residents (Resident #4, #5, #6, #8, and #10) who experienced bladder incontinence and who's care plan identified a scheduled toileting plan. Failure to assess and implement scheduled toileting plans, at times consistent with the residents' determined voiding habits/patterns, prevented the residents from maintaining their highest level of continence and has the potential to compromise the residents' dignity. Findings include: Review of the facility policy titled "Urinary Continence Rehabilitation Program" occurred on 07/14/10. This policy, dated 2006, stated, ". . . OBJECTIVES: 1. To establish a uniform method of assessment, documentation, and evaluations of urinary incontinence. 2. To effectively identify the appropriate interventions for each individual. 3. To decrease incidents of urinary incontinence. 4. To decrease resources (equipment, people and time) utilized in urinary incontinence interventions. 5. To maintain the resident at their highest functional level. PROCEDURE: 1. Assessments will be completed for: A. All new admissions. B. All residents with a change in cognition, physical ability . . . 2. The CRA [certified resident assistant] coordinator is responsible to see that an assessment is completed and the appropriate program . . . is	F 315	Program' will be implemented upon admission, reviewed quarterly, annually and with any significant change to ensure other residents in the facility have an accurate assessment and care plan to meet their needs. The nursing department will attend an in-service on the revised 'Urinary Continence Rehabilitation Program' and receive training to accurately reflect individual toileting programs. The CRA Coordinator will monitor the 'Urinary Continence Rehab Program' for resident #4, 5, 6, 8, 10 and an appropriate sample of other residents weekly x 1 month, monthly x 3 months, and quarterly thereafter. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA committee during the scheduled monthly meetings.	08/20/10

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initiated. Appropriate programs include bladder training, habit training/scheduled voiding, prompted voiding/routine toileting . . . 5. The Care Plan will address the type of incontinence and provide a detailed intervention plan which will be re-evaluated and revised as needed to meet the needs of the individual resident . . ."

The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 2.0, revised December 2008, page 3-125, stated, ". . . A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated . . . If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing . . . Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly . . ."

- Observations of Resident #5 assisted by staff for toileting needs occurred on 07/13/10 at 8:30 a.m., and 11:30 a.m. At 8:30 a.m., the resident verbally refused to void. At 11:30 a.m., observations showed Resident #5's brief wet and she voided on the toilet.

Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included dementia and constipation. The resident's Minimum Data Set (MDS), dated 04/20/10, identified short and long term memory difficulties, severely impaired in making daily decisions, rarely understands others, required extensive assistance for toilet use, frequently incontinent of bladder and on a scheduled toileting plan. Resident #5's care plan identified a routine

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F 315	Continued From page 20 toileting plan. The routine toileting plan for this resident identified every two hours. Review of Resident #5's "Bowel Bladder Program Intervention Tracking Form" three day summary, dated June 2006, identified three episodes of total wetness, 28 episodes of dryness, 31 episodes of voiding on the toilet, six brief changes, three total linen/clothing changes, and to precede with a "scheduled program adjusted to meet residents needs." Facility staff could not provide a more current intervention tracking form. Review of Resident #5's "Routine Toileting Schedule" records for the months of April, May, and June 2010 indicated facility staff assisted Resident #5 with toileting every two hours daily. The records showed the following: April 2010: * 24 episodes at 11 p.m. * 25 episodes at 1 a.m. * 29 episodes at 5 a.m. * 19 episodes at 7 a.m. * 15 episodes at 3 p.m. * 17 episodes at 7 p.m. * 16 episodes at 9 p.m. * Resident #5 experienced 145 episodes of urinary incontinence at the above listed times. Facility staff failed to offer toileting 131 of the 145 episodes and only changed the wet brief. May 2010: * 20 episodes at 11 p.m. * 20 episodes at 1 a.m. * 29 episodes at 5 a.m. * 30 episodes at 7 a.m. * 12 episodes at 1 p.m. * 15 episodes at 9 p.m. * Resident #5 experienced 126 episodes of urinary incontinence at the above listed times.	F 315		

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F 315	Continued From page 21 Facility staff failed to offer toileting 108 of the 126 episodes and only changed the wet brief. June 2010: * 29 episodes at 11 p.m. * 17 episodes at 1 a.m. * 28 episodes at 5 a.m. * 22 episodes at 7 a.m. * 11 episodes at 4 p.m. * 14 episodes at 9 p.m. * Resident #5 experienced 121 episodes of urinary incontinence at the above listed times. Facility staff failed to offer toileting 84 of the 121 episodes and only changed the wet brief. Resident #5's medical record lacked evidence facility staff analyzed the above referenced data, determined most incontinence episodes occurred between 9 p.m. and 7 a.m., and implemented the necessary changes/revisions to promote increased continence. - Observations of Resident #8 assisted by facility staff for toileting needs occurred on 07/14/10 at 11:45 a.m. and 1:05 p.m. Observation showed the resident's brief wet at 11:45 a.m. and she voided on the toilet. At 1:05 p.m., Resident #8's brief remained dry and she failed to void on the toilet. Review of Resident #8's medical record occurred July 13-14, 2010. Medical diagnoses included Alzheimer's disease, dementia, and chronic renal failure. The resident's MDS, dated 06/14/10, identified long and short term memory difficulties, moderately impaired in making daily decisions, required total assistance by staff for toilet needs, frequently incontinent of both bowel and bladder, and on a scheduled toileting program. Resident #8's care plan identified a "toileting program	F 315		

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F 315	Continued From page 22 established." The toileting program established for this resident identified every two hours. Review of Resident #8's "Bowel Bladder Program Intervention Tracking form" three day summary, dated March 9-11, 2010, identified facility staff failed to complete the tracking form on 03/09/10 at 7 a.m., 1 p.m., and 3 p.m.; on 03/10/10 at 9 a.m., 11 a.m., 1 p.m., 5 p.m., and 9 p.m.; on 03/11/10 at 7 a.m., 1 p.m., 3 p.m., 5 p.m., 7 p.m., and 9 p.m. At hand written note on the tracing form stated, "03/12/10 Will proceed with routine toileting program." Review of Resident #8's "Routine Toileting Schedule" records for the months of April, May, and June 2010 indicated facility staff assisted Resident #5 with toileting every two hours daily. The records showed the following: April 2010: * 12 incontinence episodes at 5 a.m. * 15 incontinence episodes at 7 a.m. * Resident #8 experienced 27 episodes of urinary incontinence at the above listed times. Facility staff failed to offer toileting 22 of the 27 episodes and only changed the wet brief. May 2010: * 16 incontinence episodes at 5 a.m. * 24 incontinence episodes at 7 a.m. * Resident #8 experienced 40 episodes of urinary incontinence at the above listed times. Facility staff failed to offer toileting 30 of the 40 episodes and only changed the wet brief. June 2010: * 10 episodes at 11 p.m. * 22 episodes at 7 a.m. * Resident #8 experienced 32 episodes of urinary	F 315		

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incontinence at the above listed times. Facility staff failed to offer toileting 26 of the 32 episodes and only changed the wet brief.

Resident #8's medical record lacked evidence facility staff analyzed the intervention tracking form or the routine toileting schedule to determined most incontinence episodes occurred between 5 a.m. and 7 a.m., and implemented the necessary changes/revisions to promote increased continence.

- Review of Resident #4's medical record occurred July 12-14, 2010. The record included Resident #4's most recent quarterly MDS completed 06/27/10, a quarterly MDS review completed 09/05/09, and a significant change review completed 06/05/09. The MDS assessments identified Resident #4 as continent of bowel, occasionally incontinent of bladder, occasionally incontinent of bladder and on a "scheduled toileting plan."requiring extensive assistance of one staff person for toileting. The 06/05/09 MDS identified Resident #4's bladder continence had "deteriorated. . . ." The record lacked evidence of a bladder incontinence assessment completed at the time of the 06/05/09 identified decline in Resident #4's bladder continence, as per facility policy.

The record included a "Bowel/Bladder Program Intervention Tracking Form." The form consisted of tracking/recording Resident #4's bladder continence for a three day period (September 04-06, 2009). The form showed during the three day period Resident #4 experienced "no incontinent episodes." The record lacked evidence of additional/further assessment of Resident #4's bladder incontinence and

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F 315	Continued From page 24 needs/problems. Resident #4's plan of care included an undated approach/intervention of, "Routine toileting program established." Observation at 7:40 a.m. on 07/13/10 showed Resident #4 in the bathroom using the toilet unassisted. Observation at 8:20 a.m. on 07/13/10 showed a certified nurse assistant (CNA) (#3) assist Resident #4 to the toilet. During both observations, Resident #4 had a bowel movement. Random observations throughout the survey showed a urinal on the foot board of Resident #4's bed. During an interview with a CNA (#3) at 8:20 a.m. on 07/13/10, the CNA indicated Resident #4 uses the bathroom toilet for bowel movements, and uses the urinal on his own for voiding.The CNA indicated staff do come in every two hours and remind, encourage, or assist Resident #4 with toileting if required. Review of Resident #4's "Routine Toilet Schedule" records for the months of April, May, and June 2010 indicated staff assisted Resident #4 with toileting every two hours daily. The records showed: * In April 2010, Resident #4 experienced twenty-six episodes of urinary incontinence, with thirteen of the incontinent episodes recorded at 7 a.m. The other incontinent episodes occurred at various times. * In May 2010, Resident #4 experienced nineteen episodes of urinary incontinence, with ten of the episodes recorded at 7 a.m. * In June 2010, Resident #4 experienced twenty-five incontinent episodes, with fourteen	F 315		

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F 315	Continued From page 25 episodes recorded at 7 a.m. The record lacked evidence the facility had analyzed the above referenced data, determined fifty percent of Resident #4's incontinence occurred between 5 a.m. and 7 a.m., and implemented the necessary changes/revisions to promote increased continence. During an interview with a licensed nurse (#4) on the afternoon of 07/14/10, the nurse indicated the facility had not completed any further assessment of Resident #4's bladder incontinence, nor had the reason for the resident's change/decline in urinary continence been assessed/determined, the voiding habits/patterns of the resident been assessed/determined, and the appropriate interventions/plan been established and implemented to assist the resident in restoring bladder continence. - Review of Resident #6's medical record occurred on July 13-14, 2010. Diagnoses included Alzheimer's disease, expressive aphasia, renal disease, and a history of recurrent urinary tract infections. The resident's most recent MDS, dated July 12, 2010, indicated Resident #6 required total assistance of two or more people for toilet use, was frequently incontinent of bladder, and participated in a regularly scheduled toileting plan. The resident's current Resident Assessment Protocols (RAPs) stated, ". . . Has been placed on a routine toileting program to maintain what control is present. . . ." Resident #6's current care plan stated, ". . . Toileting: Dependent on staff. Check every 2 hours and change as needed. . . ." The record included a form entitled "Bowel/Bladder Program Intervention Tracking Form." This form	F 315		

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F 315	Continued From page 26 documented Resident #6's bladder continence over a three-day period (August 16-18, 2006). Resident #6 experienced 12 incontinent episodes and 16 continent episodes. A handwritten note on the form stated, "Proceed [with] routine toileting." Facility staff could not provide a more recent tracking form. A "Routine Toileting Schedule" form, located in Resident #6's medical record, indicated facility staff toileted the resident every two hours daily. Review of the form for the months of June, May, and April revealed the following: June 2010: 216 episodes of incontinence and 180 brief changes without toileting The most frequent incontinent episodes occurred as follows: * 28 episodes at 11 p.m. * 26 episodes at 1 a.m. * 30 episodes at 5 a.m. * 22 episodes at 7 a.m. * 26 episodes at 3 p.m. * 27 episodes at 7 p.m. May 2010: 200 episodes of incontinence and 161 brief changes without toileting. The most frequent incontinent episodes occurred as follows: * 22 episodes at 11 p.m. * 28 episodes at 1 a.m. * 26 episodes at 5 a.m. * 24 episodes at 7 a.m. * 26 episodes at 3 p.m. * 24 episodes at 7 p.m. April 2010: 191 episodes of incontinence and 172 brief changes without toileting. The most frequent incontinent episodes occurred as follows: * 22 episodes at 11 p.m. * 27 episodes at 1 a.m.	F 315		

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F 315	Continued From page 27 * 29 episodes at 5 a.m. * 17 episodes at 7 a.m. * 25 episodes at 3 p.m. * 28 episodes at 7 p.m. Observation of toileting with Resident #6 occurred on July 12, 2010 at 5:40 p.m. A CNA (#9) assisted Resident #6 to the toilet using a sit-to-stand mechanical lift. The resident was incontinent and did not void on the toilet. Observation on July 13, 2010 at 9:21 a.m. showed a CNA (#6) checked and changed Resident #6's wet brief while the resident laid in bed. An interview with a CNA (#10) occurred on July 13, 2010 at 5:40 p.m. The CNA stated she checked and changed Resident #6's wet brief around 3:30 p.m. She further stated that if Resident #6 is in bed, she is a check and change; and if she is up in her wheelchair, they will take her to the toilet. - Review of Resident #10's medical record occurred on July 13-14, 2010. Diagnoses included end-stage dementia and renal cysts. Resident #10's most recent MDS, dated May 18, 2010, indicated Resident #10 required extensive assistance from one person for toilet use, was frequently incontinent of bladder, and participated in a regularly scheduled toileting plan. Resident #10's current RAPs stated, ". . . Is on a routine toileting program to maintain cleanliness and what control may be left. . . ." The resident's current care plan stated, ". . . Dependent with toileting. Routine toileting program. . . ." The record lacked documentation of any type of bowel and bladder tracking form or assessment, and	F 315		

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F 315	Continued From page 28 facility staff were unable to locate one for Resident #10. A "Routine Toileting Schedule" form, located in Resident #10's medical record, indicated facility staff toileted the resident every two hours daily. Review of the form for the months of June, May, and April revealed the following: June 2010: 125 episodes of incontinence and 113 brief changes without toileting. The most frequent incontinent episodes occurred as follows: * 15 episodes at 11 p.m. * 18 episodes at 7 a.m. * 16 episodes at 1 p.m. * 26 episodes at 7 p.m. May 2010: 111 episodes of incontinence and 95 brief changes without toileting. The most frequent incontinent episodes occurred as follows: * 12 episodes at 5 a.m. * 12 episodes at 1 p.m. * 21 episodes at 3 p.m. * 24 episodes at 7 p.m. April 2010: 111 episodes of incontinence and 98 brief changes without toileting. The most frequent incontinent episodes occurred as follows: * 16 episodes at 7 a.m. * 13 episodes at 11 a.m. * 25 episodes at 3 p.m. * 21 episodes at 7 p.m. Observation on July 14, 2010 at 7:52 a.m. showed two CNAs (#10 and #11) checked and changed Resident #10's wet brief while the resident laid in bed. During an interview on July 14, 2010 at 11:25	F 315		

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F 315	Continued From page 29 a.m., a CNA (#10) stated she checked and changed Resident #10's wet brief at approximately 10:30 a.m. She further stated they (the staff) check and change Resident #10's brief because she rarely gets out of bed and that Resident #10 does not use the toilet. Resident #6 and Resident #10's medical record lacked evidence facility staff further assessed their incontinence and analyzed the above data to determine when most incontinent episodes occurred. No individualized interventions were put in place to ensure that Resident #6 and Resident #10 retained as much bladder continence as possible.	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 JUNE 17, 2009. Based on observation, record review, review of facility incident reports, review of policy/procedures, and staff interview, the facility failed to provide adequate supervision and assistive devices (gaitbelt and/or mechanical lift) for 2 of 2 sampled residents (Resident #3 and #6) who required assistance with transfers, and failed	F 323	The facility will review it's policies on 'Safe Resident Lifting and Repositioning and Wheel Chair Transportation' during a mandatory meeting with all CRA's and nursing staff to ensure the facility maintains an environment that assures residents #3, 5, 6, and any other resident that may be affected remain as free of accident hazards as possible, and each resident receives adequate supervision and assistance devices to prevent accidents. To improve communication to CRA's regarding the resident's plan of care, a kardex (see Att. G) was developed as a tool for nursing staff to ensure appropriate transfers with use of gait belt and appropriate assistance devices are utilized to meet resident # 3,	08/16/10 08/01/10

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F 323	Continued From page 30 to remove assistive devices (foot pedals) after transport for 1 of 1 sampled resident (Resident #5) and 1 of 1 closed resident record (Resident #11). Failure to use gaitbelts and/or mechanical lifts during transfers and failure to remove foot pedals from the wheelchairs following transportation places residents at risk for injury. Findings included: Review of the facility's policy titled "Wheelchair transportation" occurred on 07/14/10. This policy, dated 7-09 [July 2009], stated; ". . . The leg rests are to be removed if the resident [sic] is able to self propel and is not being pushed. . . ." - Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included osteoporosis, osteoarthritis, and dementia. The annual MDS, dated 04/20/10 identified the resident as having long and short term memory problems, severely impaired in making daily decisions, and rarely/never understands others. Resident #5's RAP, dated 04/20/10, stated, ". . . needs assist with all ADL's [activities of daily living]. Does self transfer at times against recommendations . . ." Review of Resident #5's current care plan stated, "Therapy recommendation [sic] no foot rests in order to [increase] I [independence] [with] self propelling unless assisted [with] w/c [wheelchair] mobility. Remove when completed." Observations of Resident #5 on 07/13/10 showed the following: * At 8:20 a.m., an unidentified staff member transferred Resident #5 from the dining room to the C-wing lounge area via wheelchair with foot	F 323	5, 6, and other resident's individualized needs. A 'Patient Safety Project Plan Participant Agreement' has been signed with North Dakota Health Care Review, Inc., and they will be utilized in our continued effort to improve resident safety. The CRA Coordinator will monitor that resident #3,5,6 and a sample of other residents are monitored to ensure adequate supervision and assistive devices are used weekly x 1 month, monthly x 3 months, and quarterly thereafter. The Administrator will be notified of any issues. If issues are identified immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA Committee during the scheduled monthly meetings.	07/26/10 08/20/10

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F 323	Continued From page 31	F 323		

rests. The staff member left the resident unattended and failed to remove the foot rests from the wheelchair. Observation showed Resident #5 attempted to lift her legs over the foot rests.
* At 8:30 a.m., the certified nursing assistant (CNA) (#8) transferred the resident from the lounge area, to the bathroom, and then to the activity room via wheelchair with foot rests. The CNA failed to remove the foot rests from the wheelchair when Resident #5 arrived in the activity room.
* At 9:00 a.m., the activity aide (#7) transferred Resident #5 from the activity room to her room via wheelchair with foot rests. Observation showed the activity aide left the resident unattended in her room and the foot rests remained on the wheelchair.
* At 9:15 a.m., Resident #5 remained in her room unattended with the foot rests on the wheelchair.

Review of Resident #5's progress notes revealed the resident fell out of her wheelchair on 05/16/10. The note and incident report failed to indicate if the foot rests were on or off the wheelchair at the time of the fall. A progress note dated 07/10/10 at 4:44 p.m., stated, "Resident was found on floor by CRA [certified resident assistant]. Resident was laying on right side. A laceration . . . to center of forehead . . ." Later in the evening at 9:41 p.m., a progress note stated, "res [resident] up in w/c she kept trying to put her legs over foot rest and get out of w/c res kept near nurses station for closer observation . . ."

- Review of Resident #3's medical record occurred on July 12-13, 2010. Medical diagnoses included dementia, emphysema, and cardiomyopathy. The resident's quarterly MDS,

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F 323	Continued From page 32 dated 04/15/10, identified a short term memory problem, required limited assistance of one person for transfers and extensive assistance of one person for toilet use. Resident #3's current care plan stated, ". . . Transferring - use gait belt . . ." Observation on 07/13/10 at 10:55 a.m., showed the CNA (#6) assisted Resident #3 to a standing position in the bathroom by pulling up on her left arm. The CNA provided pericares and pivoted the resident back onto the wheelchair. The CNA (#6) failed to utilize a gait belt any time during the transfer. - Review of Resident #6's medical record occurred on July 13-14, 2010. Diagnoses included Alzheimer's dementia, osteoporosis, osteoarthritis, a frozen right shoulder, and bilateral hand contractures. The resident's most recent MDS, dated July 12, 2010, indicated the resident required total assistance from two or more staff members for transferring and toilet use. Resident #6's current care plan stated, ". . . Problem . . . Pot. [potential] for injury . . . *fall risk score high . . . *unsteady gait . . . *osteoporosis . . . Approach . . . [two] assists with tranfers via standaide [a type of sit-to-stand mechanical lift] and or [sic] may transfer with assist of [two] for ambulation [with] gait belt . . ." Observation on July 12, 2010 at 5:40 p.m. showed a CNA (#9) assisted Resident #6 onto the toilet using a standaide lift. The CNA stated, "Normally they [residents] are encouraged to hang on, but she can't." Observation showed Resident #6 positioned in the lift with the back strap around her back and under her arms. Resident #6's arms remained at her sides with	F 323		

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F 323	Continued From page 33 her fingers and wrists contracted bilaterally and physically unable to hold onto the handles of the lift. During an interview on July 13, 2010 at 5:40 p.m., a CNA (#10) stated two staff members are needed to transfer Resident #6 with the standaide lift because Resident #6 is unable to hold on to the handles and it is unsafe to transfer the resident with one staff member. Observation on July 13, 2010 at approximately 10:35 a.m. showed a CNA (#6) positioned a gait belt around Resident #6's waist. The CNA lifted the resident with the gait belt and transferred the resident to a wheelchair using a pivot transfer. During an interview on the afternoon of July 13, 2010, a CNA (#6) stated that after reviewing Resident #6's care plan, she realized Resident #6 is supposed to be a two-person transfer. During an interview the afternoon of 07/14/10, two administrative staff members (#1 and #2) confirmed staff members are expected to follow resident's care plans for transfers and foot rest use. - Resident #11's medical record, reviewed on July 14, 2010, identified diagnoses which included Alzheimer's dementia, anxiety, psychosis, impulse control, Parkinson's disease, and history of falls. The quarterly Minimum Data Set (MDS), completed 06/16/10, identified problems with short and long term memory, moderately impaired daily decision making skills, and wandering behaviors. The significant change	F 323		

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Resident Assessment Protocols (RAPS), completed 05/31/10, identified, ". . . Resident has history of falls related to unsteady gait and balance prior to admission to WWM [Wedgewood Manor]. He has had numerous falls since admission . . ."

The Resident Admission Care Plan, dated 06/10/09, stated, ". . . Self care deficit: . . . 7. Transferring: Independent [with] transfers. . . . Mobility: Ambulation (I) [independent] . . . Pot. [Potential] For Injury: Fall risk score high . . . 2. Keep environment/walkways free of clutter . . ."

The Progress Note, dated 11/19/2009 at 2156 [9:56 p.m.], stated, "1845 [6:45 p.m.] - Resident sitting in his room, in wc [wheelchair], watching TV. Attempted to stand without assist, tripped on wc pedals & [and] fell to buttocks. . . . No injuries received, movement UE [upper extremity] & LE [lower extremity] without pain."

The Incident Report for Resident #11, dated 11/19/09, stated, ". . . Falls: . . . Walking unassisted, Found on floor; from chair/wheelchair . . . Potential Contributing Factors: . . . Confused patient, Device related; not supposed to have w/c [wheel/chair] pedals . . . Brief Explanation: . . . Resident sitting in his room, in wc, watching TV. Attempted to stand [without] assist, tripped on w/c pedals . . . fall to buttocks . . . No injuries rec'd [received], movement UE ? [upper extremity questionable] . . . Findings/Follow-up Measures: w/c pedals to be removed when not being assisted [with] w/c mobility . . ."

Failure of facility staff to remove the foot pedals for a resident with poor short term memory and poor decision making skills, as well as previous

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F 323	Continued From page 35 unsafe behaviors, placed him at risk for injury.	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 observation, record review, review of professional literature, family interview, and staff interview, the facility failed to follow professional standards for medication administration for 1 of 1 sampled resident (Resident #8) who continually refused medications. Failure to follow professional standards and principles related to administration of medications, and refusal, placed Resident #8 at risk for increased behaviors, vomiting, stomach upset, and constipation problems. Findings include: Taylor, Lillis, and DeMone, Fundamentals of Nursing, The Art & Science of Nursing Care, 4th ed., J. B. Lippincott Company, Philadelphia, New York, and Baltimore, 2001, page 629, stated, "If the patient refuses a drug that is considered essential to the therapeutic regimen, the nurse should report this promptly. The nurse can often play an important role in determining the reason for the refusal and can help the patient accept needed drugs . . . The refusal to take prescribed drugs and the manner in which the situation was managed should be described on the patient's record . . ." Review of Resident #8's medical record occurred	F 333	To ensure that resident #8 and any other residents are free of significant medication error, licensed nursing staff and medication aides will complete a training module on Medication Administration and review the policy on 'Notification of Change'. (Att. A) The DON will monitor medication regimens of resident #8 and a sample of other residents weekly x 1 month, monthly x 3 months and quarterly thereafter. The Administrator and Consulting Pharmacist will be notified of any issues. If issues are identified, immediate corrective action will occur. The DON will submit a report of monitoring results to the QA Committee during the scheduled monthly meetings.	08/16/10 08/16/10 08/20/10

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on July 13-14, 2010. Medical diagnoses included Alzheimer's disease, dementia, behaviors secondary to dementia, constipation, arthritis, degenerative joint disease, anemia, hypothyroidism, and gastroesophageal reflux disease (GERD). Daily medications included Tylenol, Remeron (antidepressant also used to increase appetite), Synthroid (hypothyroidism), Prilosec (GERD), Seroquel (antipsychotic), iron (anemia), and colace (constipation).

Review of Resident #8's Minimum Data Set (MDS), dated 06/14/10, identified long and short term memory difficulties, moderately impaired in daily decision making, persistent anger towards self or others, physically abusive behaviors, resistive with cares, and mild pain less than daily. Review of Resident #8's care plan failed to identify the problem and approaches to address the resident's medication refusals.

Observation on 07/14/10 at 8:10 a.m. showed a certified nursing assistant (CNA) (#5) washed Resident #8's face and hands and applied her TED hose. The resident responded by grimacing and stated "ouch, owie, that hurts." The CNA stated she wasn't sure if the resident's legs or her stomach hurt. The CNA asked Resident #8 if she wanted to sleep some more and the resident closed her eyes. The CNA left the room.
Later, at 9:10 a.m., the CNA (#5) attempted to assist Resident #8 with breakfast. The CNA (#5) stated the resident refused to eat because of an upset stomach.

During interview on 07/14/10 at 8:55 a.m., Resident #8's family member (#1) stated a facility staff member called a couple of weeks ago and informed her Resident #8 experienced stomach

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pain and vomiting. This family member asked if the resident received her Prilosec and the staff member stated not for the past four days. The family member (#1) stated this staff member also informed her Resident #8 had refused other medications for the past 12 days. The family member stated Resident #8 is not "mentally capable" to refuse her medications. She requested facility staff call her when the resident refused her medications again and she would come to the facility to encourage Resident #8 to take her medications.

Review of the Medication Administration Records (MARs) from 06/19/10 to 07/14/10, showed Resident #8 refused most medications every day except on July 4-5, 2010.

Review of Resident #8's Progress Notes identified the following:
* 06/17/10 at 11:54 p.m. - "CNA [certified nursing assistant] reported resident having the dry heaves-did not have them after she had a large bm [bowel movement] . . ."
* 06/18/10 at 9:34 p.m. - "dipstick ua [urinalysis] done due to res [resident] behaviors refuses to take meds [medications] or eat hitting out when toileted dipstick neg [negative]" A dipstick urinalysis is a preliminary test completed by nursing staff to identify a urinary tract infection.
* 06/30/10 at 9:54 p.m. - "res not eating, drinking or taking her meds unable to tell us what was the matter burping and looked like she was nauseated has had bm's but when assessment done unable to hear bowel sounds fleet enema given with med [medium] bm some soft and formed some loose but very sour smelling and was moaning when stomach was palpated . . . daughter called and notified . . ."

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F 333	Continued From page 38 * 07/01/10 at 1:52 p.m. - " MD [medical doctor] called about resident not eating very well at meals, refusing medications via spitting them back out or refusing to open her mouth, bowels smelling foul, tenderness to abd [abdomen], today she had a temp [temperature] of 99.2 [degrees Farenheit] which is elevated . . . [Name of doctor] nurse called back and stated no new orders . . . Family here at lunch time and they thought she [Resident #8] was looking much better today after we got her to take her prilsec [sic] in ice cream." * 07/03/10 at 5:05 p.m. - "Resident refused am [a.m.] and noon meds. daughter was called for refusal of meds per request. Daughter cam [sic] in and administered meds. resident took the meds for daughter." * 07/10/10 at 2:36 a.m. - "CNA reported resident having a moderate amount of brown emesis on both sides of her bed- LS [lung sounds] clear thruout [sic]. HOB [head of bed] elevated . . ." During an interview on the afternoon of 07/14/10, an administrative nurse (#1) stated Resident #8 routinely refused her medications and stated the resident's physician was aware of this behavior. However, review of the physician nursing home notes dated 06/21/10, 05/27/10, 05/24/10, 04/26/10, and 03/29/10, failed to identify the physician's awareness of Resident #8's routine of refusing medications. The medical records revealed the facility failed to contact Resident #8's family or physician until the resident refused to take her medications for 12 days, exhibited behaviors, vomiting, stomach upset, and constipation.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 39 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	To ensure infection control standards of practice are followed for resident #4, 6, 10 and any other resident that may be affected, a facility wide review of hand hygiene/infection control practices will be held as per the standard guidelines set by CMS F441. The review on infection control and prevention will include re-education on the importance of assisting residents with hand hygiene. Infection Control and Prevention Policies are reviewed with all new employees during their orientation period, annually, and as needed. Infection control information is given to new admissions and their family members as needed, and reviewed with residents on an annual basis during resident council. The CRA Coordinator or appropriate designee will monitor that infection control practices are followed weekly x 1 month, monthly x 3 months and quarterly thereafter. The Administrator will be notified of any issues. If issues are identified, immediate corrective action will occur. The CRA Coordinator will submit a report of the monitoring results to the QA Committee during their monthly meeting.	08/16/10 08/20/10

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F 441	Continued From page 40 Based on observation, record review, professional reference review, and staff interview, the facility failed to follow infection control standards of practice for 3 of 10 residents (Resident #4, #6, and #10) observed during personal cares. Failure to follow these standards places residents in the facility, as well as staff members and visitors, at risk for facility-acquired infections. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding infection control which state hand hygiene (washing hands with soap and water or applying an alcohol-based hand rub) is the primary means of preventing the transmission of infections. Hand hygiene is required under certain conditions, including before and after assisting a resident with toileting, and before and after assisting a resident with personal care. - Observation on July 13, 2010 at 10:00 a.m. showed a certified nursing assistant (CNA) (#6) giving Resident #6 a bed bath. A small amount of stool was present on the washcloth after the CNA cleansed the front perineal area. The CNA put the washcloth into the wash basin and folded the washcloth over, exposing a new (clean) area of the cloth. Rolling the resident on her side, the CNA then cleansed the resident's bottom and disposed of the resident's soiled brief. The CNA removed her gloves and immediately put on new gloves. The CNA placed a new brief on the resident, applied deodorant, and assisted her with dressing. After completing these cares, the CNA emptied the water from the wash basin into the toilet (equipped with a sprayer arm), filled the	F 441		

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basin with water from the sink, and added soap to cleanse the basin. The CNA then emptied the water in the toilet again and washed her hands. The CNA failed to perform hand hygiene after contact with the resident's soiled perineal area and used the sink to cleanse the soiled wash basin, which created the possibility for contaminated water from the basin to splash onto clean surfaces.

- Observation on July 14, 2010 at 7:52 a.m. showed two CNA's (#10 and #11) giving Resident #10 a bed bath. Observation showed Resident #10 incontinent of bloody stool. After cleansing the resident's perineal area, the CNA (#11) handed the washcloth to the other CNA (#10), who put it in a garbage bag. The CNA (#11) removed her gloves and put on a clean pair of gloves without performing hand hygiene. The CNA (#11) then used a clean washcloth to wash Resident #10's face and placed a new brief under the resident. The CNA (#11) assisted the other CNA (#10) to reposition the resident and then washed her hands. The CNA (#11) failed to perform hand hygiene after contact with the resident's soiled perineal area.

During an interview on the morning of July 14, 2010, a staff member (#1) stated the CNAs received the CMS guidelines as education and were expected to follow those guidelines.

- Observation at 7:40 a.m. on 07/13/10 showed Resident #4 in the bathroom having a bowel movement unassisted. Resident #4 wiped his rectal area, pulled up his clothing and left the bathroom without cleansing his hands.

At 8 a.m. a caregiver (#3) served Resident #4 his

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breakfast in his room. No cleansing of the resident's hands occurred prior to the caregiver leaving the resident to eat his breakfast.

Observation at 8:20 a.m. on 07/13/10, showed a caregiver (#3) assist Resident #4 to the bathroom. While Resident #4 had a bowel movement, the caregiver left the resident alone in the bathroom, returning after several minutes to assist the resident with perineal care. After assisting the resident in the bathroom, and without providing the resident with hand cleansing, the caregiver returned the resident to his room to finish his breakfast. The caregiver exited the room and observation showed resident #4 eating his toast, cereal, and beverages.

During an interview with the caregiver (#3) at 8:20a.m., the caregiver indicated she did not know Resident #3 used the bathroom on his own at 7:40 a.m., and stated, "he is supposed to have assistance, but he goes in there [the bathroom] on his own. He uses the urinal on his own in his room, and the toilet for bowel movements."

Review of Resident #4's medical record occurred July 12-14, 2010, and included the resident's most recent Minimum Data Set (MDS) completed 06/27/10. The MDS identified Resident #4 as requiring extensive assistance of one staff person for completion of his personal hygiene needs.

During an interview with an administrative nurse staff member (#1) on the morning of 07/14/10, the staff member indicated the expectation would be that staff would cleanse a resident's hands after toileting and prior to meal service.

The above dewscribed obvservations, and the

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F 441	Continued From page 43 staff's knowlegde of Resident #4's toileting habits, and the failure to assist Resident #4 with hand cleansing after toileting and prior to eating, placed the resident at risk for an avoidable food borne related infection due to hand to food transfer of bacteria.	F 441		