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 _____	C 09/26/2016

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 and complaint survey, started on September 19, 2016 and completed on September 26, 2016, 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 seven (7) additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164		10/31/16

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

Electronically Signed | 10/14/2016

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 164	Continued From page 1 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to maintain the privacy and confidentiality of the residents' medical and personal information for 3 of 4 days of the on-site survey (September 20-22, 2016). Failure to secure residents' medical and personal information could allow resident's information to be viewed by unauthorized individuals. Findings include: Review of the facility policy "Notice of Privacy Practices" occurred on 09/22/16. The policy, effective 09/23/13, stated, ". . . We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. . . . We are required by law to make sure that medical information that identifies you is kept private . . ." - Observations of Corridor A and Corridor B (where the residents reside) on September 20-22, 2016 revealed the following: * On 09/20/16 at 8:15 a.m. in Corridor B - a binder labeled as "B-Wing Charting Book" located on a sink counter, and accessible to anyone in the corridor. * On 09/20/16 at 11:07 a.m. in Corridor B - a clipboard located on a sink counter, and accessible to anyone in the corridor. * On 09/21/16 at 8:15 a.m. and 9 a.m. in Corridor B - a binder labeled as "B-Wing Charting	F 164	The facility has taken the following action concerning the deficiency identified on the CMS-2567: 1. The binder on corridor A and B has been moved to the nurses'□ station 2. There is potential of other residents being at risk of having personal and medical information compromised by unauthorized individuals. Staff education on privacy practices and the need to leave the binders at the nurses□ station was provided on September 28th 2016. 3. To ensure that proper practices continue and compliance of personal privacy/confidentiality of records: i. Routine education shall be provided to old and new staff on privacy practices. Another series of education on privacy practices shall be provided on October 20th 2016. ii. Regular rounds shall be conducted by Administrator/Designee to ensure compliance daily X 1 month and weekly X 3 months. 4. The results of audit completed shall be submitted to monthly QA committee for review and follow up.	

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F 164	Continued From page 2 Book" and a clipboard located on a sink counter, and accessible to anyone in the corridor. * On 09/21/16 at 8:25 a.m. and 9:10 a.m. in Corridor A - a clipboard located on a sink counter, and accessible to anyone in the corridor. * On 09/21/16 at 11:20 a.m. in Corridor B - a binder labeled as "B-Wing Charting Book" and a clipboard located on a sink counter, and accessible to anyone in the corridor. * On 09/22/16 in the a.m. in Corridor B - a binder labeled as "B-Wing Charting Book" and a clipboard located on a sink counter, and accessible to anyone in the corridor. Observation showed the clipboards contained the following information for each resident: * residents' first names * resident room numbers * special diet, if applicable * glasses, dentures or hearing aides, if applicable * bowel movements * type of incontinent brief worn, if applicable * diet supplement percentage, if applicable * ambulation distance, if applicable * care plan items * fall interventions, if applicable Observation showed the binder contained the following information for each resident: * turn/reposition records, if applicable * bowel and bladder toileting records, if applicable * safety check list information, if applicable The facility failed to implement a system to ensure residents' medical and personal information remained private and confidential	F 164		

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F 164	Continued From page 3 from unauthorized individuals.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 5 of 10 sampled residents (Resident #1, #2, #3, #4, and #7) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to announce self before opening privacy curtains, knock on doors or wait for a reply before entering a resident's room (Resident #1, #2, #4, and #7), failure to provide privacy during personal cares (Resident #4), failure to remove a resident's clothing protector after meals (Resident #4) and failure to address a resident in a dignified manner (Resident #3) does not enhance the quality of life for each resident. Findings include: - Observation on 09/20/16 at 9:20 a.m., showed Resident #4 laying in bed covered up with a sheet and blanket. Resident #4 stated "I need to go to the bathroom," and pulled back the covers exposing her brief and started to swing her legs off the bed. The certified nursing assistant (CNA) (#23) stated "oh wait, I have to get rid of this tray first" and lifted Resident #4's legs back into bed	F 241	It has always been the policy and practice at Wedgewood Manor to provide individuality and respect of individuality. The facility has taken the following actions concerning deficiency cited. 1a. For resident #4, staff was in-serviced on the importance of ensuring resident is fully covered, shutting the door and pulling privacy curtain when providing treatment and/ or care of personal needs. Staff has also been educated to knock and wait for a response and or announce presence. Education was provided on the importance of removing cloth protector immediately after every meal. b. For resident #3, education was provided to staff to announce self before attempting to open privacy curtain. Staff was also educated to refrain from referring to resident #3 as "poo bear" or other pet names other than the names resident prefers to be addressed by. c. For resident #2, staff was educated to knock, wait for a response and announce self before entering resident□'s room.	10/31/16

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F 241	Continued From page 4 leaving her uncovered. The CNA (#23) picked up the breakfast tray and left the room, leaving the door open and Resident #4 visible to anyone in the hall or entering the room. The CNA (#23) returned to Resident #4's room at 9:30 a.m. (5 minutes later). - Observation on 09/20/16 at 9:46 a.m., showed two CNAs (#23 and #24) assisted Resident #4 with personal cares. A staff member (#7) knocked and entered Resident #4's room without waiting for a response or announcing herself. - Observation on 09/20/16 at 10:05 a.m., showed a CNA (#24) placed a clothing protector on Resident #4 before placing her breakfast in front of her. The clothing protector remained on Resident #4 while she sat in her wheelchair for restorative therapy at 10:40 a.m. The clothing protector remained on while sitting in the hallway at 11:45 a.m. and when in the dining room for lunch at 11:55 a.m. - Observation on 09/20/16 at 10:40 a.m. showed a CNA (#14) assisted Resident #7 with personal cares. During these cares, another CNA (#3) opened the closed privacy curtain without announcing herself, looked inside, and then exited the resident's room. - Observation on 09/20/16 at 11:15 a.m., showed a CNA (#14) transferred Resident #3 from a recliner to her wheelchair. The CNA (#14) stated "Come on Poo Bear". - Observation on 09/20/16 at 3:20 p.m. showed two CNAs (#15 and #16) transferred Resident #2 from the recliner to her bed using a full body	F 241	d. For resident #7, staff was educated to knock, wait for a response and announces self before entering resident□'s room or pulling privacy curtain. Staff was also educated to acknowledge resident before initiating conversation with staff. e. For resident #1, staff has been educated to knock, wait for a response and announce self before entering a resident□'s room. 2. The facility has identified other residents similar to those identified on the CMS 2567 and is taking the following actions: All residents will receive care in a manner and in an environment that maintains or enhances each resident□s dignity and respect. Education on Resident Rights with emphasis on Dignity and Respect of Individuality was provided to all staff on 9/28/16. 3. To ensure that proper practices continue, another in-service will be provided for all staff on dignity and respect of individuality for all residents in the facility on 10/20/16. The DON/Designee will monitor this POC through observational rounds through out the facility to assure compliance daily X 1 month and weekly X 3 months. 4. Results of audit shall be submitted to QA committee for review and follow up.	

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F 241	Continued From page 5 mechanical lift. The CNAs checked the resident's brief and positioned her in bed on her left side. During the observation, a staff member (#17) knocked on the door and entered the room without waiting for a response/announcing herself. - During an observation of Resident #1 on 09/21/16 at 8:05 a.m., an unidentified CNA opened the door to the resident's room and walked in without knocking or announcing him/herself. - Observation on 09/21/16 at 9:15 a.m., showed two CNA's (#25 and #32) assisted Resident #4 with personal cares. A staff member (#14) knocked and entered Resident #4's room without waiting for a response or announcing herself. - Observation on 09/21/16 at 10:30 a.m. showed a certified medication assistant (CMA) (#7) assisted Resident #7 with a nebulizer (breathing medication) treatment. During this treatment, an activity aide (#21) and a CNA (#22) opened the closed privacy curtain without announcing themselves, looked inside, talked with the CMA (#7) and then exited the resident's room. During an interview on 09/22/16 at 10:30 a.m., an administrative nurse (#2) stated the CNA should have removed the clothing protector after breakfast and confirmed staff should not call a resident Poo Bear and the CNA should have covered up the resident prior to leaving the room.	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		10/31/16

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F 246	Continued From page 6 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, resident interview, group interview, information from the complainant, review of facility shift responsibilities, staff interview, and review of the Resident Council Meeting minutes, the facility failed to provide reasonable accommodations of individual needs in regard to call lights for 9 of 9 confidential interviewable residents (Resident A, B, C, D, E, F, G, H, & I) and 1 of 10 sampled resident (Resident #4) observed unable to reach the call light. Failure to respond to call lights in a timely manner, ensure call lights were in reach, ensure staff provide the necessary care and services in response to call lights, and ensure call lights were functioning properly, may result in the loss of dignity and poor quality of care (i.e. [for example] falls and incontinence episodes) for all the residents who reside in the facility. Findings include: Information received from the complainant identified concerns with call lights not within the resident's reach, the call light unplugged from the wall (i.e., nonfunctioning), and waiting 20-40 minutes for staff to respond to call lights. Review of the facility checklists regarding shift	F 246	It has always been the practice and policy at Wedgewood Manor to provide reasonable accommodation of needs/preferences. The facility has taken the following actions concerning deficiencies cited: 1a. For resident #4, staff was educated 9/28/16 on the importance of ensuring that call light is within resident□'s reach and accessible to her at all times. b. For resident G, all staff was educated on the importance of paying attention to call light and answering it accordingly on 9/28/16. c. Simplex was contacted on 10/7/16 for repairs of call light display box. 2. Potential exist for other residents to be at risk of not being provided reasonable accommodation. a detailed in-service shall be provided for all staff on the call light system on 10/20/16. 3. To ensure proper practices continue, audit shall be carried out by the DON/Designee. The audit will include routine rounds and feedback from at least three (3) residents daily X 3 months and weekly X 1 year.	

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F 246	Continued From page 7 responsibility occurred on 09/22/16. These checklists stated, ". . . Make sure Call Lights are plugged into the wall & [and] working . . . Standards of Care: All Staff . . . Call light within reach [of resident] . . ." GROUP INTERVIEW AND RESIDENT COUNCIL MEETING MINUTES - Upon surveyor request, an activities staff member (#31) invited interviewable residents to attend the group interview. On 09/19/16 at 3:30 p.m., 7 of 11 residents in the group voiced concerns about the call lights not being answered in a timely manner or not being within reach. Residents' confidential comments included the following: * Resident A - "I can wait 20 minutes" * Resident B - "I can wait 20 minutes" * Resident C - "It can be 20-30 minutes for staff to answer" * Resident D - "I can wait 30 minutes" * Resident E - "I can wait 30 minutes" * Resident F - "At night is horrible, can wait one hour" * Resident I - "I am without my call light within reach many times" Review of the Resident Council Meeting minutes occurred on 09/19/16, and identified the following Requests/Concerns from residents: * 05/02/16, ". . .There are still issues with staffing during meals, etc. [and so forth]. [Resident name] waited one time this past weekend for 45 minutes with her call light on. . . ." * 06/06/16, ". . . Please have all CNA's [certified nursing assistant's] remember to put the	F 246	4. Outcomes shall be reported to monthly QA committee for review and follow up.	

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F 246	Continued From page 8 call light in reach before leaving the room. . . ." * 09/12/16, ". . . [Resident name] states it takes a long time for lights to be answered. . . ." RESIDENT INTERVIEWS - During the initial tour on the afternoon of 09/19/16, Resident A stated sometimes he/she has had to wait "20 minutes for the call light to be answered." - During the initial tour on the afternoon of 09/19/16, Resident G stated he/she waits 45 minutes "most of the time" for staff to answer the call light and approximately a month ago he/she waited for an "hour." - During a confidential interview on the morning of 09/20/16, Resident H stated, "The call light some times takes 15 minutes" before it is answered. - During a confidential interview on the morning of 09/22/16, Resident D stated he/she recently waited 15-20 minutes for a staff member to answer his/her call light. Resident D indicated when the staff member (a nurse) entered his/her room, she turned off the call light. Then this staff member told the resident to turn his/her call light back on, and left his/her room without providing any assistance with toileting. Resident D stated he/she turned the call light on again, and waited approximately another 15 minutes before another staff member came to assist him/her. Review of Resident D's medical record occurred on September 21-22, 2016. The current Minimum Data Set (MDS) for Resident D identified intact	F 246		

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F 246	Continued From page 9	F 246		

cognition, clear speech, and able to make self understood.

OBSERVATIONS

- Observation on 09/20/16 at 9:20 a.m., showed Resident #4 laying in bed, call light clipped to the top edge of her pillow case, out of visual site and inaccessible to the resident. Resident #4 stated "I need to go to the bathroom and I don't want to eat in bed." When asked by surveyor if he/she could reach the call light, Resident #4 stated "I can't reach my call light, I don't know where it is."

- Observation on 09/21/16 showed Resident G's call light on from 8:35 a.m. to 8:51 a.m. (16 minutes). Observation during this time period showed two unidentified staff members in the resident corridor talking to each other and going into other resident rooms. Observation also showed an unidentified staff member walked past Resident G's room while the call light was on.

During an interview on the afternoon of 09/22/16, an administrative staff member (#1) stated her expectation was for all staff to answer call lights within five minutes.

CALL LIGHT SYSTEM

- Observations on September 19-22, 2016 showed the facility had a call light system that included a small display box attached to the wall, in each of the three corridors (Corridors A, B, and C) where the residents reside. When a resident's call light is activated in another corridor, the display box will digitally show staff members the room number for that resident.

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F 246	Continued From page 10 During the following observations, the call light display box did not function properly: * 09/20/16 at 8:30 a.m. - Corridor A - Digital words did not illuminate (not readable). * 09/20/16 at 8:30 a.m. - Corridor C - Digital words partially illuminated (difficult to read). * 09/21/16 at 8:20 a.m. - Corridor A - Digital words did not illuminate. * 09/21/16 at 8:20 a.m. - Corridor C - Digital words partially illuminated. * 09/21/16 at 9:45 a.m. - Corridor A - Digital words did not illuminate. * 09/21/16 at 9:45 a.m. - Corridor C - Digital words partially illuminated. On 09/21/16 at 9:45 a.m., a nurse (#13) was asked to read the digital words on the call light display box in Corridor C. She stated, "I really can't read it." On 09/22/16 at 9:45 a.m., a staff member from maintenance (#20) verified the digital words on the call light display box in Corridor A were not readable, and the system needed to be repaired.	F 246		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	F 272		10/31/16

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 272	Continued From page 11 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, facility staff failed to identify the date of the Care Area Assessment (CAA) documentation on Section V of the Minimum Data Set (MDS) for 10 of 10 sampled resident records reviewed (Resident #1, #2, #3,	F 272	It is the policy and practice of Wedgewood Manor to follow the RAI guidelines. The facility has taken the following actions concerning deficiencies cited: 1i. For residents #1,2,4,6, admission MDS dated 11/27/15, 08/16/16, 03/07/16,	

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	355087	A. BUILDING _____ B. WING _____	C 09/26/2016

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(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 272	Continued From page 12 #4, #5, #6, #7, #8, #9, and #10). Failure to identify the date of the CAA documentation limits the ability of professional staff, including consultants, to locate this assessment data. Findings include: The Long-Term Care Facility RAI User's Manual, Version 1.13, dated October 2015, page V-5, stated, ". . . For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column . . ." Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10's medical records occurred between September 19-22, 2016. The CAA Summary identified the location of CAA documentation (for example, see CAA summary) however failed to identify the dates of the CAA information on the "Location and Date of CAA Information" column. The following CAA summaries lacked dates for all the Care Areas triggered: * Resident #1 - admission MDS dated 11/27/15 * Resident #2 - admission MDS dated 08/16/16 * Resident #3 - significant change MDS dated 05/11/16 * Resident #4 - admission MDS dated 03/07/16 * Resident #5 - significant change MDS dated 09/12/16 * Resident #6 - admission MDS dated 07/05/16 * Resident #7 - significant change MDS dated 02/23/16 * Resident #8 - significant change MDS dated 07/29/16	F 272	07/05/16 respectively shall have CAA summaries dated on the location and date of CAA information column on section V of the MDS. ii. For residents #3,5,7,8,10 significant change MDS dated 05/11/16, 09/12/16, 02/23/16, 07/29/16, 04/27/16 respectively shall have CAA summaries dated on the location and date of CAA information column on section V of the MDS. iii. For resident #9, annual MDS dated 04/27/16 shall have CAA summaries dated on the location and date of CAA information column on section V of the MDS. 2. The facility has identified other residents similar to those identified on CMS 2567, corrections on current MDS section V shall be made to reflect dated CAA summaries. 3i. To ensure proper practice continues, education was provided to the MDS coordinators 9/28/16. Additional education shall be provided 10/20/16 on comprehensive assessments and periodic in-services shall be provided on comprehensive assessments. ii. Routine MDS audits shall be done jointly by MDS coordinators, Administrator/Designee to assure compliance weekly X 6 months. 4. Results of audit will be reported to monthly QA committee for review and follow up.	

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F 272	Continued From page 13 * Resident #9 - annual MDS dated 07/01/16 * Resident #10 - significant change MDS dated 04/27/16 During an interview on 09/20/15 at 1:35 p.m., a nurse (#4) confirmed the CAA summaries failed to identify the dates on the "Location and Date of CAA Information" column on Section V of the MDS.	F 272		
F 278 SS=D	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	F 278		10/31/16

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F 278	Continued From page 14 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.3), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 10 sampled residents (Resident #4). Failure to accurately code a current urinary toileting program does not allow the residents' assessments to reflect her current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and the care provided to this resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 2, page 2-1 states, ". . . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident . . ." Chapter 3, page H-5 states, ". . . Look for documentation in the medical record showing that the following three requirements have been met: * implementation of of an individualized, resident specific toileting program that was based on an assessment of the resident's unique voiding pattern * evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report	F 278	1. For resident #4, a correction has been made to the most recent MDS to reflect resident□s toileting schedule. 2. Potential exist for other residents to be affected by cited deficiency. i. A 100% audit of all residents' chart will be done and corrections to current MDS shall be made if there are any discrepancies. ii. Staff was educated 10/14/16 on MDS definitions, toileting program, coding the MDS accurately, documentations required in the medical records to justify coding on the MDS. More detailed education shall be provided on 10/20/16. 3. Development and implementation of a process through joint audit by MDS coordinator, Administrator/Designee to ensure accuracy in coded MDS prior to submission weekly X 6 months. 4. Outcomes shall be discussed in the in monthly QA for review and follow up.	

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F 278	Continued From page 15 * notations of the resident's response to the toileting program and subsequent evaluations, as needed." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . ." - The generic toileting schedule, established for Resident #4, failed to meet the criteria for coding a urinary toileting program (item H0200C) on the MDS. Review of Resident #4's medical record occurred on September 19-22, 2016. The current quarterly MDS, dated 09/02/16, identified the resident as rarely/never understood (in Section C), had short and long-term memory loss, required extensive assistance of one staff member for toileting, frequently incontinent of urine, and on a urinary toileting program. Resident #4's current care plan stated, "Approaches . . . Voiding-incontinent of bladder at [sic] frequently, wears briefs . . . toilet immediately after evening activities to prevent self transfers." Review of the Bowel and Bladder Toileting Record from September 1-21, 2016 showed a generic toileting schedule of toilet every two hours, beginning at 6:30 a.m. and ending at 4:30 p.m. During an interview, on the morning of 09/22/16, a nurse (#5) verified the facility staff failed to accurately complete item H0200C on the MDS.	F 278		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		10/31/16

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F 280 SS=D	Continued From page 16 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged 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 CONDUCTED ON 09/10/15. Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the care plan for 2 of 10 sampled residents (Resident #3 and #6). Failure to ensure care plans reflected the resident's current status and needs limited the staff's ability to ensure consistency and continuity of care. Findings include:	F 280	It is the practice and policy at Wedgewood Manor to ensure that residents have the right to participate in planning care. The facility has taken the following actions concerning deficiencies cited; 1a. For resident #6, care plan has been reviewed and updated to reflect actual care provided. b. For resident #3, care plan has been updated to reflect accurate assessment of	

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F 280	Continued From page 17 Review of the facility policy titled "CARE PLANS" occurred on 09/22/16. This policy, dated August 2000, stated, " Purpose: to assure that resident care plans accurately reflect actual or potential problems and interventions used. . ." - Review of Resident #6's medical record occurred on September 19-22, 2016. Diagnoses included amputation (loss of limb). The admission Minimum Data Set (MDS), dated 07/05/16, identified extensive assistance with two persons for transfers. The current care plan stated, " Impaired mobility . . . Use hoyer lift for transfers . . .". Observation on 09/20/16 at 10:27 a.m., showed a therapy staff member (#12) transfer Resident #6 from the bed to the wheelchair utilizing a sliding board. During an interview on 09/22/16 at 10:20 a.m., a nurse (#13) stated Resident #6 does not use a Hoyer lift. The care plan had not been revised to include Resident #6's transfer needs. - Review of Resident #3's medical record occurred on September 19 -22, 2016. Diagnoses included cerebral vascular accident (CVA), hemiplegia (weakness on one side of the body), falls with fractures and Parkinson's. The resident's quarterly MDS, dated 08/02/16, identified extensive assist of one person for transfers and moderately impaired cognition.	F 280	resident□'s need. Resident is care planned to have wheel chair alarm. 2i. There shall be review of communication between therapy and nursing department in other to alleviate potential existence of other residents being affected 10/20/16. ii. Review of all care plans to ensure consistency with actual care provided. 3. DON/Designee shall carry out a daily audit X 3 months, weekly X 6 months to ensure that care plans match actual care provided. 4. Outcomes shall be discussed in monthly QA.	

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F 280	Continued From page 18 The current care plan for Resident #3 stated, "Problem Onset . . . Schedule Care Tasks CNA . . . Approaches . . . chair alarm in recliner . . . Safety will get [sic] without asking for assistance. falls . . . fx [fracture] humerous [sic] . . . healing left hip fracture . . . Approaches . . . Re-orient to surroundings as needed . . . pt [patient] self transfers and bruises shins on recliner footrest . . ." Observations on 09/20/16 and 09/21/16 showed a Resident #3 in wheelchair with a chair alarm. During an interview on 09/22/16 at 10:30 a.m., an administrative nurse (#2) confirmed Resident #3's care plan lacked the use of a chair alarm on resident's wheel chair.	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: 1. Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #9) and 1 of 1 supplemental resident (Resident #16) observed during insulin administration. Failure to prime insulin pens according to manufacturer's directions may result in an incorrect dose of insulin. Findings include:	F 281	Wedgewood Manor always strives to ensure that services provided meet professional standards. The facility has taken the following actions concerning deficiencies cited; 1ai. For resident #9, CMA has been educated on 9/28/16 to prime insulin before administration. ii. For resident #16, CMA has been educated on 9/28/16 to prime insulin before administration.	10/31/16

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F 281	Continued From page 19 Review of the manufacturer's instructions for NovoLog FlexPen occurred on the afternoon of 09/20/16. The instructions stated, ". . . Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing upwards, press the push-button all the way. . . The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . . Selecting your dose. Check and make sure that the dose selector is set at 0. Turn the dose selector to the number of units you need to inject. . . ." - Observation on 09/20/16 at 11:10 a.m. showed a certified medication aide (CMA) (#7) obtained Resident #16's NovoLog FlexPen, dialed the FlexPen to 10 units as per physician's order, and administered the insulin to the resident. The CMA failed to prime the insulin pen with 2 units and give the airshot prior to dialing the insulin dosage. - Observation on 09/20/16 at 11:22 p.m. showed a CMA (#7) obtained Resident #9's NovoLog FlexPen, dialed the FlexPen to 10 units as per physician's order, and administered the insulin to the resident. The CMA failed to prime the insulin pen with 2 units and give the airshot prior to dialing the insulin dosage.	F 281	b. For resident #6, staff was educated 10/12/16 on the need to pay attention to detail and the risks associated with leaving medication in resident'□s room unattended. 2. Other residents stand the potential of being at risk for services not meeting professional standards. Medication administration in-service will be provided 10/20/16 and periodically with return demonstration. Medication administration education will also be included in the orientation of staff new to the responsibility. 3. Occasional unscheduled monitoring and observation of medication administration by the DON/Designee weekly X 3 months. 4. Outcomes shall be reported to the monthly QA committee for review and follow up.	

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F 281	Continued From page 20 During an interview on the afternoon of 09/20/16, an administrative nurse (#2) confirmed staff should follow the manufacturer's instructions when using the insulin flexpen. 2. Based on observation, review of facility policy, record review, and staff interview, the facility failed to ensure medications were stored properly for 1 of 1 sampled resident (#6) observed with a medication left in his room by a staff member. Failure to remove a Lantus insulin pen (diabetic medicine injection) and an administration needle from this resident's room has the potential to result in unauthorized administration of medication which could lead to adverse effects and/or cause injury. Findings include: Review of the facility policy titled "Self Administration of Medications-Residents" occurred on 09/22/16. This policy, revised December 1998, stated, " . . . Residents will not be permitted to administer or retain medications in their rooms unless so ordered by the attending physician . . . and approved by the care planning team . . ." Review of Resident #6's medical record occurred on September 19-22, 2016. Diagnoses included diabetes. The current care plan stated, ". . . Have no injury related to medication usage . . . Maintain resident environment free of . . . safety hazards. . .". The current physician orders, dated 06/28/16, stated, "Lantus . . . every HS (at bedtime) . . .". The medical record lacked a self administration assessment.	F 281		

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F 281	Continued From page 21 During initial tour on 09/19/16 at 1:58 p.m. an observation showed an unattended Lantus pen and administration needle while Resident #6 was present in the room. During an interview on the morning of 09/22/16 at 12:00 p.m., an administrative staff nurse (#2) stated Resident #6 does not self administer his own medications and she would not expect the Lantus pen to be left in his room.	F 281		
F 286 SS=F	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to maintain all resident assessments in the resident's active record, in a centralized location, accessible to all professional staff members, including consultants. This occurred for 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). Failure to maintain resident assessments in the resident's active record, accessible to all professional staff members, including consultants, can result in a lack of continuity of care for the residents. Findings include:	F 286	The facility always maintains 15 months of resident information and the following actions have been taken concerning deficiencies cited; 1i. For resident #1-10, information and documentations are now available and readily accessible to staff, consultants, state agencies (including surveyors), CMS and others who are authorized by law. ii. Cabinet containing resident information has been unlocked and moved to a central location (nurses station) where it is easily and readily accessible to staff, consultants, state agencies (including	10/31/16

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F 286	Continued From page 22 The Long-Term Care Facility RAI User's Manual, page 1-5 - 1-6 stated, ". . . The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. . . . Page 2-7 stated, ". . . Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g. a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS [Centers for Medicare and Medicaid Services] and others who are authorized by law and need to review the information in order to provide care to the resident. Nursing homes that are not capable of maintaining MDSs electronically must adhere to the current requirement that either (not both) a hand written or a computer-generated copy be maintained in the clinical record. Either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period . . . ." During the entrance conference on 09/22/16 at	F 286	surveyors), CMS and others who are authorized by law. 2. Facility will ensure that all charts are reviewed on a regular basis. All persons authorized to access records will be educated on how to access documents. A copy of CAA summary will also be placed in every resident□'s chart. 3. Random audits to ensure authorized personnel know where to look; in order to be able to access resident information shall be carried out weekly X 3 months by MDS coordinator/Designee. 4. Outcomes shall be reported to the QA committee for review.	

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F 286	Continued From page 23 1:20 p.m., administrative staff members identified some of the facility's clinical records are electronic and some are hard copy. Review of the clinical records for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 occurred between September 19-22, 2016. Electronic clinical record review showed the MDSs (excluding the CAAs) stored in the electronic clinical record. Review of the hard copy of the clinical record identified no CAAs present. During an interview on 09/21/16 at 10:45 a.m., staff members #5, #8, #13 and #27 explained the storage and access to the the resident assessments as follows: * The MDSs (excluding the CAAs) are stored in the electronic clinical record. * A printed version of the MDSs (including the CAAs) are stored in a locked file cabinet located in a room with the copy machine. When asked, staff members #5, #8, and #13 were not aware who had a key to the file cabinet. Staff member #27 identified access to the key for the locked file cabinet would generally be during normal business hours. * Some CAAs, not all, were stored electronically in a folder in the facility's G: drive. Per request, the facility Information Technology (IT) department identified, in writing, a total of four professional staff members (#2, #4, #5 and #28) and two IT staff members (#29 and #30) having access to this folder containing some of the CAAs. The facility's system for storage of the CAAs failed to allow professional staff (including consultants), State agencies (including	F 286		

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(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 286	Continued From page 24 surveyors), CMS, and others who are authorized by law easy and quick access to these resident assessments at all times.	F 286		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR 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 information received from the complainant, observation, record review, and resident and staff interview, the facility failed to provide activities of daily living (ADL) assistance to 2 of 10 sampled residents (Resident #2, and #4) and 1 supplemental resident (Resident #16) who required staff assistance with personal hygiene and grooming. Failure to ensure residents receive regular baths and assistance with grooming may result in poor hygiene and negatively impact their self-esteem. Findings include: Information from the complainant identified observations of a resident with greasy hair, matted eyes, and a dirty face/neck. The complainant identified concerns with residents not receiving personal hygiene assistance. - Review of Resident #2's medical record occurred on September 19-22, 2016. The resident's current Minimum Data Set (MDS),	F 312	It the policy and practice of Wedgewood Manor to provide care for dependent residents that would promote good nutrition, grooming, personal and oral hygiene. 1a. For resident #2, bath aide has been educated 10/10/16 on the importance of ensuring resident takes at least a bed bath if actual bath is refused. Nursing staff was educated 10/10/16 to identify reasons for refusal and ways to re-approach resident in order to encourage ADLs. b. For resident #4, facial hair has been trimmed and education provided to bath aide on 10/10/16 to offer baths at least once a week. c. For resident #16, facial hair has been trimmed. 2. Facility has identified residents who may be at risk for deficiency cited. In-service shall be provided to nursing	10/31/16

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 312	Continued From page 25 dated 08/16/16, identified total assistance from one person for bathing. Resident #2's current care plan stated, ". . . Scheduled Care Tasks CNA [certified nursing assistant] . . . Shower Day - Friday: Day Shift . . ." Review of the facility's "Bath Report Roster" identified Resident #2 did not receive a shower from her admission day (08/09/16) until 08/18/16 (nine days later). An entry on the roster, dated 08/11/16 at 4:23 a.m., stated, "Condition prevents completion of task- Nurse Notified." The medical record contained no further information regarding this entry. During an interview on 09/21/16 at 3:42 p.m., two nursing staff members (#13 and #18) identified if staff do not complete a scheduled task, nursing staff are expected to write a note as to what task staff did not complete and why. Review of the facility's bath schedule for 08/11/16 failed to identify Resident #2's name on the bath list. The roster also identified Resident #2 last received a shower on 09/13/16. Observations throughout the survey until the morning of 09/22/16 (nine days after the resident's last documented shower) showed Resident #2's hair looked greasy and unkempt. - Review of Resident #4's medical record occurred on September 19-22, 2016. A current quarterly MDS, dated 04/02/16, identified extensive assist of one person for personal hygiene and bathing. Resident #4's current care plan stated, "Problem Onset: Scheduled Care Tasks CNA . . . Approaches . . . Shower Day - Thursday: Day Shift . . ." Review of facility's "Bath Report Roster"	F 312	staff on the importance of maintaining good hygiene for all residents on 10/20/16. 3. DON/Designee will review bath sheet and personal care assignment weekly X 3 months. 4. Outcomes shall be discussed in monthly QA.	

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F 312	Continued From page 26 identified Resident #4 failed to receive a shower from 08/06/16 until 08/19/16 (14 days). Observations on 09/19/16 throughout the morning of 09/21/16 showed Resident #4's hair greasy and unkempt. Observations on 09/19/16, 09/20/16, and 09/21/16 throughout the day showed Resident #4 with unshaven black and white facial hair on her chin and above her upper lip. - Review of Resident #16's medical record occurred on September 21-22, 2016. The resident's quarterly MDS, dated 07/23/16, identified the resident required extensive assistance from one staff member with personal hygiene. Observation on 09/19/16 at 3:30 p.m. and on 09/20/16 at 2:00 p.m. showed Resident #16 in the activity room, with multiple unshaven white hairs on her chin. Observation on 09/21/16 at 11:22 a.m. showed the resident in the therapy room, with long black hairs on her chin. During an interview on 09/22/16 at 10:30 a.m., an administrative staff nurse (#2) stated, she expected facility staff to shave the facial hairs and document when each resident received their shower/bath.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		10/31/16

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F 314	Continued From page 27 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development and/or deterioration of pressure ulcers for 1 of 1 sampled resident (Resident #2) identified with a pressure ulcer. Failure to routinely assess/monitor pressure ulcers, ensure consistent implementation of interventions and treatment, may have resulted in the development of new pressure ulcers and the deterioration of existing pressure ulcers. Findings include: Review of the facility policy titled "Skin Care Protocol/Prevention" occurred on 09/22/16. This policy, revised December 2013, stated, ". . . Resident assistant will do a thorough skin inspection of all residents at risk on a daily basis . . . Any resident who is at risk of developing pressure ulcers will have a written positioning schedule and will be repositioned at least every 2 hours and as needed. . . . Immobile residents should have a care plan that includes the use of devices that totally relieve the pressure on the heels. Do not use donut devices. Place a pillow or support under the lower leg totally suspending	F 314	Wedgewood Manor has always practiced measures, treatments and services that prevents or heals pressure sores. The facility has taken the following actions concerning deficiencies cited. 1. For resident #2, care plan has been updated to include dates of implementation. CNA charting document has also been updated to reflect side to side repositioning. All interventions to promote healing of pressure ulcer have been implemented. 2. Potential exist for residents to be at risk for pressure sores. In-service on proper skin assessment shall be provided 10/20/16 on admission and weekly for any resident at risk of breakdown. In-service will also include treatment, monitoring current pressure ulcer, pressure relief interventions, reporting changes in skin condition, proper wound dressing and promptly initiating treatment. In-service shall be provided 10/20/16 to CNAs on follow up identification of red area, reporting and documentation, daily skin assessment, proper positioning,	

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F 314	Continued From page 28 the heels off the bed is recommended. . . . Notify physician of pressure ulcer. . . . Obtain physician order in treatment of ulcer. . . . Wound documentation will be a 1x [once] per week and PRN [as needed] . . ." Upon entrance to the facility, staff completed a form titled "Additional Resident Information Sheet." This form identified Resident #2 had an unstageable right heel pressure ulcer and Stage I pressure ulcers to her left heel and coccyx region. Review of Resident #2's medical record occurred on September 19-22, 2016. The admission Minimum Data Set, dated 08/16/16, identified severely impaired cognition, extensive assistance from two or more people for bed mobility, total dependence on two or more people for transfers, and no pressure ulcers. Resident #2's current care plan identified, "Problem Onset: SKIN . . . Approaches . . . systemic skin checks weekly . . . Reposition every 2 hours - side to side only, prefers to lie on back, may wiggle self on back at times. . . . prevalon boots at all times . . . refer to wound clinic . . ." The care plan failed to identify Resident #2's current pressure ulcers and lacked dates indicating the implementation of the interventions. A certified nursing assistant (CNA) charting book contained the following information regarding Resident #2: "Turn and reposition every 2 hours and prn. Side to side only. Prevalon boots to both heels at all times." The charting book also contained a turning and repositioning record which included "back" as part of the schedule, although the resident's care plan identified "side	F 314	ensuring that positioning match documentation and proper placement of provolone boots to avoid shearing of heels. 3. DON/Designee shall review charts (Braden assessment, daily/weekly skin assessment et al) weekly X 1 year to assure compliance. 4. Outcomes shall be discussed by DON/Designee in the monthly QA meeting.	

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F 314	Continued From page 29 to side." Current physician's orders included the following: *08/09/16 - Weekly skin checks *09/01/16 - 1 Packet Arginaid daily to promote skin healing *09/01/16 - 1 ounce extra meat daily *09/01/16 - 1 tablespoon Beneprotein daily Resident #2's Treatment Administration Record (TAR) identified an intervention of "Weekly skin checks." The TARs showed the following: *08/12/16: check mark *08/19/16: "N" (indicating not done) *08/26/16: "N" *09/02/16: "N" *09/09/16: check mark *09/16/16: no documentation (i.e. blank) *The medical record lacked further information regarding these weekly skin checks. During an interview on 09/21/16 at 3:29 p.m., a supervisory nurse (#2) stated staff are supposed to write a note to correspond with the check mark on the TAR. On 09/22/16 at 9:28 a.m., a supervisory nurse confirmed staff failed to document weekly skin checks three weeks in a row (08/19/16, 08/26/16, and 09/02/16). The documentation showed staff failed to perform weekly skin checks two weeks prior to first identifying a pressure ulcer on 09/01/16. This may have resulted in delayed identification of the pressure ulcer and delayed implementation of interventions. Nurses' notes identified the following: *09/01/16 at 1:17 p.m.: ". . . has red area on left	F 314		

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F 314	Continued From page 30 lateral heel 3x3 cm [centimeters], dark bluish/purple area inside that is 1x1 cm. Non blanchable - unstageable. Prevalon boot applied. . . ." *09/10/16 at 3:42 p.m.: ". . . Resident has red area with dark purple center on left heel. She also has what looks like a probable blister to the right heel. She is on Arginaid, MVT [multivitamin], & using prevalon boots bilaterally. MD [physician] updated by written message . . ." *09/13/16 at 11:44 a.m.: ". . . The following is a late entry from 9/12/2016: Resident is noted to have a discoloration of right heel. The entire heel is noted to be spongy and fluid filled. Skin is noted to be intact at this point. The affected area measures 6.5x5.3 cm. The affected area is covered with an allevyn [dressing] for protection and boot is placed for offloading. The left heel is noted to have a stage 1 ulcer which is noted to be superficial in nature. Resident is noted to have a dime sized superficial ulceration of the lower back/coccyx region. The surrounding skin is noted to be reddened but blanchable. Affected area is covered with an allevyn adhesive which covers entire coccyx/buttocks region. . . ." *09/14/16 at 3:40 p.m.: ". . . Late entry from 9/12/2015 [sic]: [MD] office was called regarding newly found ulcerated region to lower back/coccyx region. She is also notified of ulcerated region to right heel. No answer, generic message left. This writer will write a status update sheet requesting dressings to be placed to affected areas. . . ." *09/20/16 at 8:39 p.m.: ". . . Res [resident] seen by [MD] today with orders to refer Res to wound clinic b/4 [before] next [rounds]. . . ." When asked for clarification regarding the above	F 314		

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F 314	Continued From page 31 nurse's notes, the facility provided no further information. During a phone interview on the morning of 09/23/16, a facility provider stated she did not recall receiving a facility request for staff to place dressings on 09/12/16. The record lacked evidence of further assessment/monitoring of the ulcerated area to Resident #2's back/coccyx after its discovery on 09/12/16, and lacked any measurements of the area. The facility's "Wound Assessment Reports" (computerized assessments) identified the following: *09/01/16: unstageable, nonblanchable red area with a dark center to Resident #2's left heel measuring 3 cm by 3 cm with a dark 1 cm by 1cm area in the center *09/10/16: unstageable, nonblanchable red area with a dark center to Resident #2's left heel measuring 3 cm by 3 cm with a dark 1 cm by 1cm area in the center *09/10/16: unstageable, spongy light purple area to Resident #2's right heel measuring 7 cm by 7 cm. The facility's "Wound Records" (hand written assessments) identified the following: *09/01/16: left heel, unstageable, 1 cm by 1 cm, dark red appearance *09/07/16: left heel, stage I, 1 cm by 1 cm, dark red appearance *09/12/16: left heel, stage I, outer area unstageable, 1 cm by 1 cm, dark red appearance with a scabbed area to the outer edge *09/12/16: right heel, stage II, 6.5 cm by 5.3 cm, purple and boggy in appearance	F 314		

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F 314	Continued From page 32 *The medical record lacked evidence of more recent wound assessments as of the morning of 09/21/16. On 09/21/16 at 11:40 a.m., when asked about monitoring of pressure ulcers, a supervisory nurse (#2) stated she expected staff to complete a weekly assessment of pressure ulcers. Record review on the afternoon of 09/21/16 identified a nurse's note, dated 09/21/16 at 12:13 p.m., which stated, "Refer to wound module [wound assessment report] for update." The "Wound Assessment Report," dated 09/21/16 (nine days after the previous assessment), identified the area to Resident #2's left heel as nonblanchable, red with a dark center, unstageable, and measuring 1.5 cm by 3 cm with dried rough skin and a dark area in the center. The assessment also identified the area to Resident #2's right heel as unstageable, spongy, light purple, 6 cm by 7 cm, and included the note: "blister has broken outer skin still covering wound bed underneath." This wound assessment failed to include an assessment of the resident's current Stage I coccyx ulcer. Observation on 09/20/16 at 8:11 a.m. showed Resident #2 positioned supine in bed with the head of the bed elevated, receiving a nebulizer treatment. Observation showed bilateral Prevalon boots in place; however, the resident's heels protruded from the boots and rested directly on the bed. Observation showed Resident #2 remained this way until 10:11 a.m. when staff repositioned her on her right side. At 12:02 p.m., a CNA (#22) assisted Resident #2 to eat lunch in bed. At 1:46 p.m., observation showed Resident	F 314		

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F 314	Continued From page 33 #2 seated in her recliner until 3:20 p.m., when staff assisted her to lie down and positioned her on her left side. These observations conflict with documentation on Resident #2's turning and repositioning schedule, which identified the following for 09/20/16: *7:00 a.m.: Left *8:00 a.m.: No documentation; however, observation showed Resident #2 on her back. *9:00 a.m.: Back *11:00 a.m.: Chair (observation showed Resident #2 on her right side) *12:00 p.m.: Back *2:00 p.m.: Left (observation showed Resident #2 in her recliner) Observation on 09/21/16 at 8:16 a.m. showed Resident #2 supine in bed with the head of the bed elevated and both heels resting directly on the bed. At 9:28 a.m., a CNA (#22) assisted Resident #2 to eat in bed. Observation showed Resident #2's right heel was covered with a paper towel, which contained a moderate amount of serous drainage. The CNA identified she was unaware the resident's heel was open or covered with a paper towel. At 10:20 a.m., observation showed Resident #2 positioned in bed as before, supine with her heels protruding from the Prevalon boots and resting directly on the bed. The paper towel with serous drainage remained on the resident's right heel. The CNAs (#14 and #22) repositioned the resident on her left side. During an interview on 09/21/16 at 4:49 p.m., a staff nurse (#13) (who completed the Wound Assessment Report dated 09/21/16) stated she	F 314		

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F 314	Continued From page 34 thought she recalled the night shift nurse telling her the resident's blister broke. She stated she was under the impression the night shift nurse would apply a dressing. She stated the director of nursing asked her to assess the wound earlier that day. The nurse stated a paper towel was not an appropriate dressing, and identified Resident #2 now had a dressing in place. Facility staff failed to consistently implement pressure relief interventions (elevating heels off the bed, repositioning schedule), monitor current pressure ulcers weekly and promptly inititate treatment. This may have resulted in the development/deterioration of Resident #2's pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to implement a toileting program for 1 of 3 sampled residents (Resident #3) on a toileting program. Failure to implement a toileting program, at times consistent with the residents'	F 315	Wedgewood manor collaborates with Health Research and Education Trust together with Agency for Health Research and Quality on infection control and UTI. It is our practice to put measures in place	10/31/16

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F 315	Continued From page 35 bowel and bladder toileting schedule, placed residents at risk for increased episodes of urinary incontinence, skin breakdown, constipation, and may compromise the residents' dignity. Findings include: Review of Resident #3's medical record occurred on September 19-22, 2016. Diagnoses included urinary tract infection (UTI), constipation, and benign neoplasm of the prostate. The Quarterly Minimum Data Set (MDS), dated 08/02/16, identified frequently incontinent of bladder, continent of bowel, and requires extensive assistance of one staff for toileting. Resident #3's current plan of care stated; "Approaches . . . TIOLETING [sic]: A01 [assist of one], PROMPTED TOILETING SCHEDULE. WEARS BRIEF FOR URINARY INCONTINENCE . . . Problem Onset: TOILETING . . . Constipation . . . Approaches . . . ASSIST OF 1 FOR TOILETING. Prompted toileting plan . . . Problem Onset: SAFETY will get [sic] without asking for assistance . . . Approaches . . . Assist with toileting." Review of Resident #3's "Bowel and Bladder Toileting Record" identified staff are expected to toilet Resident #3 nine times in a 24 hour period. The record identified the following: *09/09/16 - toileted 5 times in a 24 hour period. *09/10/16 - toileted 4 times in a 24 hour period. *09/11/16 - toileted 5 times in a 24 hour period. *09/12/16 - toileted 4 times in a 24 hour period. *09/13/16 - toileted 5 times in a 24 hour period. *09/14/16 - toileted 5 times in a 24 hour period. *09/15/16 - toileted 8 times in a 24 hour period.	F 315	to prevent UTI and restore bladder. The facility has taken the following measures concerning deficiencies cited. 1. For resident #3, toileting schedule was re-evaluated for effectiveness and care plan was updated. Resident'□s toileting schedule now includes prompted toileting every 3 hours. 2. Potential exist for other residents to be at risk for deficiency cited. Facility shall ensure that current toileting schedule for other residents are implemented on a consistent basis and re-evaluated for effectiveness. Education will be provided 10/20/16 to all staff on the importance of being consistent with resident toileting schedule. In-service will also include education on what a toileting program is. 3. DON/Designee will do a daily chart audit and monitoring of actual toileting pattern for a month and weekly X 6 months. 4. Outcomes shall be discussed in monthly QA.	

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(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 315	Continued From page 36 *09/16/16 - toileted 7 times in a 24 hour period. *09/17/16 - documentation showed facility staff failed to toilet resident in a 24 hour period. *09/18/16 - toileted 5 times in a 24 hour period. *09/19/16 - toileted 4 times in a 24 hour period. *09/20/16 - toileted 6 times in a 24 hour period. *09/21/16 - toileted 3 times in a 24 hour period. Observations of Resident #3 and staff interview identified the following: *09/20/16 at 11:00 a.m. - attempted to be toileted, resident refused. *09/20/16 at 1:30 p.m. - Certified Nurse Assistant (CNA) (#23) stated, "took resident to bathroom 20 minutes ago and he voided. Also stated, "Resident voided at 10:00 a.m. in the bathroom." *09/20/16 at 3:50 p.m. - took resident to bathroom and didn't void. *09/21/16 at 10:15 a.m. - CNA (#25) stated "[Resident #4] had been taken to the bathroom. The resident's brief was wet and he voided on the toilet." The facility failed to implement the current toileting schedule on a consistent basis and/or evaluate the schedule for effectiveness to ensure Resident #3 remained continent.	F 315		
F 323 SS=E	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.	F 323		10/31/16

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 _____	C 09/26/2016

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F 323	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 2 sampled residents (Resident #3 and #4) and 2 supplemental residents (Resident #17 and #18) observed during cares. Failure to ensure the use of wheelchair foot rests (Resident #3, #4, #17 and #18), failure to use chair alarm as care-planned (Resident #3), and failure to ensure the bed is in the low position (Resident #4) placed residents at risk for falls and injuries. Findings include: Review of facility policy titled "Fall Reduction/Safety Policy" occurred on 09/22/16. This policy, dated 05/31/07, stated, "Procedures: . . . Fall prevention strategies will be used . . . sensor pads will be applied . . . These alarm systems are used to help alert staff when a resident who is at high risk for falls is attempting to self-transfer/ambulate . . ." -Review of Resident #3's medical record occurred on September 19 -22, 2016. Diagnoses included cerebral vascular accident (CVA), hemiplegia (weakness on one side of the body), falls with fractures and Parkinson's. The resident's quarterly Minimum Data Set (MDS), dated 08/02/16, identified extensive assistance of one person for transfers, limited assistance of one person for locomotion, moderately impaired cognition, and a history of falls.	F 323	1. For resident #3, care plan has been reviewed and updated to reflect actual care. Care plan has now been updated to indicate resident only has an alarm on his wheel chair. Foot rest has also been put in place. For resident #4, staff has been educated to lower bed and ensure resident call light is within reach. Foot rest is also in place. Foot rest has been put in place for resident #17. Foot rest is in place for resident #18. 2. There is potential of having other residents at risk for accident hazards. In-service shall be provided 10/20/16 to all staff concerning resident safety and the implications of wheeling residents without foot pedals, not leaving beds in low position and not having alarms in place for residents who are care planned to have one. Foot rest has also been put in place for all residents in a wheelchair. 3. Daily audit by DON/Designee will be carried out to ensure all residents in a wheelchair have their foot pedals in place, alarms in place for residents care planned to have one and bed in low position daily X 6months. 4. Outcomes shall be reported to QA committee for follow up.	

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F 323	Continued From page 38	F 323		

Resident #3's current care plan stated, ". . . Locomotion: Assist of one at times. Use W/C [wheelchair] for long distances. . . . Schedule Care Tasks CNA [certified nursing assistant] . . . Approaches . . . chair alarm in recliner . . . Safety will get [sic] without asking for assistance . . . falls . . . fx [fracture] humerous [sic] . . . healing left hip fracture . . . Approaches . . . Re-orient to surroundings as needed . . . pt [patient] self transfers and bruises shins on recliner footrest . . ."

Observation on 09/20/16 at 9:15 a.m., showed Resident #3 sitting in the recliner without the chair alarm on. Facility staff failed to place a chair alarm on the recliner.

Observation on 09/21/16 at 10:15 a.m., showed a CNA (#25) transferred Resident #3 from the wheelchair to the recliner. The CNA (#25) failed to place a chair alarm on the recliner.

Observation on 09/20/16 at 3:29 p.m. showed an unidentified staff member transported Resident #3 in his wheelchair from the dining room to the nurses' station without foot rests in place. During the transport, the resident's feet brushed along the floor, making an audible noise.

During an interview on 09/22/16 at 10:30 a.m., an administrative nurse (#2) stated, "they should have removed the alarm from the wheelchair and placed it on the recliner. I believe he has gotten out of that recliner one other time in the past. He likes to get up by himself."

- Review of Resident #4's medical record occurred on September 19-22, 2016. Diagnoses

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 _____	C 09/26/2016

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

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F 323	Continued From page 39	F 323		

include muscle weakness, dementia, Alzheimer's, seizure disorder, gait and mobility abnormalities, and history of falls. The current MDS, dated 09/02/16, identified long and short term memory problems, extensive assist from one person for bed mobility, transfers, and locomotion.

The current care plan for Resident #4 stated, ". . . Problem Onset: Scheduled Care Tasks CNA . . . transfers with assist of 1 . . . fall mat with low bed . . . bed alarm . . . Safety falls- prior to admission here memory deficit/confusion . . . Assist with toileting . . . Do not leave unattended with cares, toileting, or bathing . . . Unpredictable . . . Problem Onset: Psychotropic Drug use . . . Approaches . . . Keep call light within arm's length of resident and teach resident how to use call light to request assistance."

Observation on 09/20/16 at 9:20 a.m., showed Resident #4 laying in bed with the head of the bed at a 90 degree angle, and the call light clipped to the top edge of her pillow case, out of visual sight and inaccessible to the resident. The entire bed was in a high position with the resident's bedside table/breakfast tray in front of her. Resident #4 stated "I need to go to the bathroom and I don't want to eat in bed. The surveyor asked the Resident if she could reach the call light, Resident #4 stated "I can't reach my call light, I don't know where it is." A CNA (#23) entered the room at 9:23 a.m. and moved the bed side table away from the resident and bed. Resident #4 pulled back the covers and started to swing her legs off the bed. The CNA (#23) stated "I have to get rid of this tray first" and lifted Resident #4's legs back into bed. The CNA (#23)

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 _____	C 09/26/2016

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F 323	Continued From page 40	F 323		

picked up the breakfast tray and left the room. The bed remained in a high position. The CNA (#23) returned to Resident #4's room at 9:30 a.m. (5 minutes later).

Failure to lower the bed and ensure the resident could reach the call light placed the resident at risk for falls and/or injury.

Observation on 09/21/16 at 3:38 p.m. showed a staff member (#19) transported Resident #4 in her wheelchair from the activity room to the TV lounge without foot rests in place. During the transport, Resident #4's feet brushed along the floor, making an audible noise. The resident's feet caught on the floor, causing the wheelchair to stop abruptly. The staff member stated, "Lift your feet up," to which Resident #4 replied, "I'm so tired." The resident's feet again caught on the floor, causing the wheelchair to stop abruptly. The staff member stated, "Lift your feet up or I'll run them over."

During an interview on 09/22/16 at 10:30 a.m., an administrative nurse (#2) verified, the CNA should have lowered the bed before leaving the room and placed the call light so the resident could reach it.

- Review of Resident #17's medical record occurred on 09/22/16. The current care plan identified, ". . . Assist with W/C mobility as needed t/o [throughout] the day . . ."

Observation on 09/21/16 at 4:15 p.m. showed an unidentified CNA transported Resident #17 in his wheelchair to the dining room without foot rests in place. During the transport, the resident's feet

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 _____	C 09/26/2016

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WEDGEWOOD MANOR	**804 MAIN ST W CAVALIER, ND 58220**

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F 323	Continued From page 41 brushed along the floor, making an audible noise. - Review of Resident #18's medical record occurred on 09/22/16. The current care plan identified, ". . . ambulates independently [at] times, wheelchair as needed when tired, shuffling gait d/t [due to] dementia. . . ." Observation on 09/21/16 at 4:17 p.m. showed a certified nursing assistant (CNA) (#15) transported Resident #18 in his wheelchair to the dining room without foot rests in place. During the transport, the resident's feet brushed along the floor, making an audible noise. During an interview on 09/22/16 at 10:03 a.m., a supervisory nurse (#2) stated staff should use foot rests during wheelchair transport if the resident is unable to lift their feet.	F 323		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's dysphagia diet information, and staff interview, the facility failed to provide food in a form designed to meet the resident's needs for 2 of 2 sampled residents (Resident #1 and #7) on dysphagia (altered texture) diets. Failure to provide food to residents in the form ordered by the physician increases the risk of aspiration and pneumonia.	F 367	It is the policy and practice of Wedgewood Manor to follow therapeutic diets prescribed by physician. The facility has taken the following measures concerning deficiencies cited. 1a. For resident #1, a waiver was signed by the resident and he verbalized understanding of the risks associated with failure to comply with dietary orders.	10/31/16

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 _____	C 09/26/2016

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F 367	Continued From page 42 Findings include: - Review of Resident #1's medical record occurred on September 19-22, 2016. Physician's orders, dated 11/21/15 stated, "Mechanical Soft Dysphagia Level 2 Diet, No Straws." Resident #1's current care plan stated, "Problem/Need: Scheduled Care Tasks . . . Approaches: . . .Meals - . . . Soft mechanical diet with chopped food . . . Problem/Need: Nutrition . . . Approaches: . . . Often likes to eat pizza for meals/snacks . . . Likes sandwiches. Often likes to snack on chips, pop, and candy . . ." Review of Resident #1's dietary notes, dated 08/18/16, stated, ". . . Resident is on a regular diet, mechanical soft texture - level 2, regular liquids, . . . Snacks: resident often requests staff to order him a pizza or make a frozen pizza for snacks or if he does not like what is on the menu. He also likes items such as chips and candy. Resident does have chewing/swallowing problems and is on an altered diet for this. . . ." Observation of Resident #1 eating lunch on 09/20/16 at 12:45 p.m. showed the resident eating slices of pizza. Resident #1 stated staff buy the pizza at the store and they bake it in the oven for him. Upon request, an administrative dietary staff member (#8) provided the "Dysphagia Mechanically Altered (Level 2) or Mechanical Soft Diet" from the facility's diet and nutrition manual on the afternoon of 09/21/16. The "Foods to Avoid" for the dysphagia level 2 diet included: pizza, sandwiches, chewy candies, corn chips, and potato chips.	F 367	Speech therapist also approved the inclusion of pizza to resident's diet. b. Resident #7 is no longer on a therapeutic diet. 2. Potential exist for other residents to be at risk of not being offered diets prescribed by a physician. Education shall be provided to all staff 10/20/16 on therapeutic diets and what residents can or cannot have. 3. Routine audit of residents on therapeutic diet will be carried out by Dietary Manager/Designee to assure compliance □daily X 6 months. 4. Outcomes shall be reported to monthly QA for follow up.	

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	355087	A. BUILDING _____ B. WING _____	C 09/26/2016

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F 367	Continued From page 43 During an interview on the morning of 09/22/16, an administrative staff member (#1) provided an undated document from an administrative nursing staff member (#2) which stated, "Discussed dysphagia diet with resident and the risk for choking if solid, whole foods. For example, his pizza, potato chips, toast, and sandwiches. Resident verbalized understanding of chocking [sic] hazards. Resident would still like to eat food per his request." When asked about the date of the document, the administrative staff member (#1) stated it was written yesterday (09/21/16). The staff member stated they have discussed the risks of the diet with Resident #1, but did not document the discussion in the medical record. - Review of Resident #7's medical record occurred on September 20-22, 2016. Diagnoses included dysphagia (swallow disorder). The current care plan, dated 02/23/16, stated, " . . . Level 3 dysphagia soft diet . . . ". The dinner meal card, dated 09/20/16, stated, ". . . texture 3 dys (dysphagia) soft . . ." Review of facility's "Dysphagia Advanced (Level 3) or Mechanical (Dental) Soft Diet" occurred on 09/22/16. This document stated, "Foods Allowed . . . meats must be very tender, small pieces, thin slices, chopped or ground, and well moistened . . . Foods to Avoid . . . dry, tough meat, fish or poultry, any other whole pieces of meat . . ." An observation on 09/20/16 at 12:10 p.m. showed Resident #7 eating whole chicken on the bone.	F 367		

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 _____	C 09/26/2016

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 367	Continued From page 44 During an interview on 09/22/16 at 12:45 p.m., an administrative staff member (#8) confirmed Resident #7 should have small pieces of meat and should not have eaten chicken on the bone.	F 367		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		10/31/16

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 _____	C 09/26/2016

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 441	Continued From page 45 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, information received from the complainant, record review, and staff interview, the facility failed to follow standard infection control practices for 2 of 7 sampled residents observed during cares (Resident #2 and #5) and the cleaning of resident equipment for all residents. Failure to perform hand hygiene after perineal care, ensure oxygen tubing is free from potential contamination, and disinfect semi-critical items (i.e. bed pans, urinals, denture cups, and wash basins) according to manufacturer's guidelines may result in the transmission of infection within the facility. Findings include: Information received from the complainant identified a concern that staff placed a nasal cannula on a resident after it had been on the floor. - Review of Resident #2's medical record occurred on September 19-22, 2016. Diagnoses included a stage I pressure ulcer to the coccyx and a history of methicillin-resistant Staphylococcus aureus in the urine. Resident #2's current Minimum Data Set (MDS), dated 08/16/16, identified extensive assistance from one person for personal hygiene.	F 441	The facility shall put the following measures in place for deficiency cited as it is the practice of Wedgewood Manor to follow proper infection control and prevention techniques. 1a. For resident #2, staff has been educated on the importance of following proper hygiene protocol during cares. b. For resident #5, education will be provided 10/20/16 to all staff on observation of safe practices especially the proper use of oxygen tubing. c. Facility policy has been updated to include procedures specific to the use of Cavicide disinfectant consistent with manufacturer□'s instruction. 2. Potential exist for other residents to be at risk for deficiency cited. In-service shall be conducted 10/20/16 for all staff on appropriate instruction to provide care safe from contamination. Proper hand washing and glove use education shall be provided. Education will be provided to all housekeeping staff on proper use of disinfectants. 3. Audit of proper hand washing and glove use, proper disinfection procedure and observation of safe practices shall be conducted by Infection Control	

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 _____	C 09/26/2016

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 441	Continued From page 46 Observation on 09/20/16 at 10:11 a.m. showed two certified nursing asssistants (CNAs) (#14 and #22) checked and changed Resident #2's brief as she lie in bed. Observation showed a CNA (#14) donned gloves and performed perineal cares for Resident #2, who was incontinent of bowel movement (BM). Wearing the same soiled gloves, the CNA then removed a tube of calmoseptine (moisture barrier cream) from a drawer and applied it to the resident's buttocks/coccyx region. The CNA changed her gloves and, without performing hand hygiene, proceeded to place a new brief on Resident #2, reposition her in bed, and apply her oxygen via nasal cannula before washing her hands. Observation on 09/21/16 at 10:20 a.m. showed two CNAs (#14 and #22) checked and changed Resident #2's brief as she lie in bed. One CNA (#14) donned gloves and performed perineal care for Resident #2, who was incontinent of BM. Wearing the same soiled gloves, the CNA grabbed a tube of moisture barrier cream and applied it to the resident's buttocks/coccyx region. The CNA then changed her gloves and, without performing hand hygiene, placed a new brief on Resident #2 and repositioned her in bed before washing her hands. - Review of Resident #5's medical record occurred on September 19-22, 2016. Diagnoses included Alzheimer's disease, pneumonia, and congestive heart failure. Current physician's orders identified oxygen at three liters per minute via nasal cannula as needed for shortness of breath. Observation throughout the morning of 09/20/16	F 441	Nurse/Designee weekly X 6 months. 4. Results of audit shall be submitted to monthly QA committee for review and follow up.	

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 _____	C 09/26/2016

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 441	Continued From page 47	F 441		

showed Resident #5 seated in a recliner in her room and a portable oxygen tank on the back of her wheelchair with the cannula/tubing touching the floor. Prior to the noon meal, an unidentified staff member transferred Resident #5 to her wheelchair and brought her to the dining room, where another staff member placed the nasal cannula on Resident #5's face.

- Review of the manufacturer's instructions for CaviCide surface disinfectant identified, ". . . For use as a disinfectant on precleaned non-critical medical devices, instruments, and implements: Instruments must be thoroughly cleaned to remove excess organic debris, rinsed, and dried. . . . Using either a tray or ultrasonic unit, immerse instruments in CaviCide for 3 minutes at room temperature . . . Remove and rinse instruments. Wipe dry prior to use. Discard solution after each use. . . . *Non-critical medical devices are items that come in contact only with intact skin. . . ."

Review of the facility policy titled "Utensil Cleaning Procedure" occurred on 09/22/16. This undated policy stated, ". . . 2. In the large sink run fairly hot water, add virex cleaner/disinfectant (effective against MRSA, HIV, and more) use ratio of 1/2 oz [ounce] of virex to 1 gallon of water. 3. Starting with utensils that do not have visible contaminates on them soak for 5 minutes then wash, rinse and let air dry. 4. If cleaning a utensil that has visible contaminates (this includes bedpans and urinals) on it wash, rinse, drain sink, rinse sink thoroughly, refill sink with fairly hot water add virex cleaner/disinfectant, soak for 5 minutes, wash, rinse, let air dry. This needs to be done between each utensil that has visible contaminates on them. . . ."

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 _____	C 09/26/2016

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 441	Continued From page 48 During a confidential interview during the survey, staff members (#6, #10, and #26) expressed concerns with cleaning items such as bed pans, urinals, denture cups, and wash basins for use on multiple residents. When asked about the cleaning procedure, the staff members referred to the facility policy but stated they do not use virex anymore. The staff members identified they are instructed to use CaviCide disinfectant. The staff members identified they do not measure the CaviCide prior to adding it to the water. One staff member (#26) stated, "[I] just dump the chemical in." Another staff member (#6) added, "Sometimes I spray them [the bed pans, etc.] [with Cavicide spray] if they're really bad [soiled]." The facility lacked a procedure specific to the use of CaviCide disinfectant, and the facility's current process for use of CaviCide was inconsistent with the manufacturer's instructions. - During an interview on 09/22/16 at 11:00 a.m., an administrative staff member (#1) stated she was not aware of staff cleaning bed pans, urinals, denture cups, and wash basin for use on multiple residents and it was her understanding staff members provided residents with new items each week.	F 441		