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 10/11/2017

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 and complaint survey started on October 9, 2017 and completed on October 11, 2017, 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 four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		11/15/17

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

Electronically Signed | 11/06/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: MEDICARE BILLING 1. Based on review of Medicare Part A notices/files, the facility failed to provide adequate written notices for 3 of 3 residents (Resident #1, #13, and #14) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the	F 156	F-156: The facility has taken the following action concerning the deficiency identified on the CMS-2567 to ensure Notice of Rights, Rules, Services, and Charges. 1. i. Resident #1 expired ii. For resident #13 and #14, the SNF	

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F 156	Continued From page 6 contact information for the intermediary review agency limits the residents' ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare billing records occurred on the morning of 10/11/17. The facility provided Resident #1, #13, and #14 with a demand bill form. These forms lacked the contact information for the intermediary review agency. POSTING OF INFORMATION 2. Based on observation, the facility failed to post E-mail addresses of all pertinent State advocacy groups including the State Survey Agency, State licensure office, State Ombudsman program, protection and advocacy agency, and the Medicaid Fraud Control Unit on 3 of 3 days of survey (October 09-11, 2017). Failure to provide this information has the potential to limit all residents and their families access to these agencies. Findings include: Observations on October 09-11, 2017, showed a listing of the State advocacy groups contact information displayed on a wall near the front entrance. The facility failed to post the E-mail addresses for any of the State Advocacy groups on the list.	F 156	Determination on continued stay and SNF Determination on Admission form has been updated to include contact information for the intermediary review agency. iii. The facility has updated information of the pertinent state advocacy groups including the State Survey Agency, State Licensure Office, State Ombudsman Program, Protection and Advocacy Agency and Medical Fraud Control Unit with e-mail addresses. 2. i. The SNF Determination on Continued Stay and SNF Determination on Admission bill forms were updated to include contact information for the intermediary review agency contact information. ii. Update information of all pertinent state advocacy groups with email addresses have been posted where it is easily accessible to all. 3. i. To ensure proper practice, education was provided to staff in charge of updating information on October 12, 2017. Nursing staff were notified on November 1, 2017 of form change. Staff that were unable to be at the prior meeting will receive training by November 15th, 2017. ii. Routine posting audits shall be done by Administrator/Designee to assure compliance weekly x 1 month, monthly x3 months and quarterly thereafter for one year. 4. Result of audit will be reported to monthly QA committee for review and follow up. Any issues identified will be	

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F 156	Continued From page 7	F 156	immediately corrected.	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure residents could safely self-administer medications (SAM) for 1 of 1 sampled resident (Resident #10) observed with medication in his room. Failure to determine if SAM is a safe practice for each resident has the potential to result in a medication error and/or harm to residents. Findings include: Review of the facility policy titled "Medication Administration guidelines" occurred on 10/11/17. This policy, revised March 2002, stated, ". . . 9. . . . Remain to witness act of swallowing medication unless plan of care includes a self administration program. . . ." Review of the facility policy titled "Self Administration of Medications-Residents" occurred on 10/11/17. The policy, revised December 1998, stated, "PROCEDURE: 1. Residents will not be permitted to administer or retain medications in their room unless so ordered by the attending physician . . . and approved by the care planning team. . . ."	F 176	F-176: RESIDENT SELF ADMINISTER DRUGS IF DEEMED SAFE To ensure that residents of Wedgewood Manor are properly assessed to determine that they are safe to self-administer medications. 1. For resident #10, nursing and med tech staff were educated on November 1, 2017 on policy and procedure for self-administration of medications. Any nursing or med tech staff not in attendance will have this review completed by November 15, 2017. 2. Potential exists for other residents to be affected by cited deficiency. i. A list of residents who are able to self- administer meds has been printed and also documented on each resident□s MAR. ii. Nursing staff was educated on November 1, 2017 concerning the importance to follow the self-administration policy and guidelines. 3. DON/ Designee shall do a weekly audit x 1 month, weekly x 3 months, and	11/15/17

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F 176	Continued From page 8 Observation during initial tour of the facility on 10/09/17 at 1:35 p.m. showed a medication cup on Resident #10's bedside table contained one unidentified orange and white capsule. Review of Resident #10's medical record occurred on 10/11/17. The quarterly Minimum Data Set, dated 07/17/17, identified intact cognition. The record lacked evidence of a physician order and/or a care plan to self administer medications. A "NEW ADMISSION CHECKLIST" dated 01/18/17, stated, ". . . N/A [not applicable] . . ." next to ". . . self admin [administration] assessment if apporp [appropriate] . . ." The facility's failure to ensure Resident #10 received all of his medication and failure to determine if the resident is capable of SAM has the potential to result in a medication error and/or harm to residents.	F 176	quarterly x 1 year thereafter to ensure compliance. QA will include resident # 10 and a random sample of residents. 4. Outcomes shall be discussed in the monthly QA for review and follow up. Any issues identified will be immediately corrected.	
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 203		11/15/17

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F 203	Continued From page 9 (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 203		

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F 203	Continued From page 10 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in	F 203		

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F 203	Continued From page 11 the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident and/or family member, and Office of the State Long-term Care Ombudsman, in writing, of a transfer outside of the facility, including the destination and the reason for the transfer, and the resident's right to appeal the action for 1 of 3 sampled residents (Resident #1) transferred to the hospital. Failure to provide a notice of transfer does not allow the resident or guardian the right to make an informed choice regarding the resident's rights. Findings include: Review of the facility policy "Guidelines for Completing Transfer and Discharge Forms" occurred on 10/11//17. The undated policy stated: ". . . The purpose of these forms is to address the various types of transfer or discharge a nursing facility or swing bed unit	F 203	F-203: NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE To ensure Wedgewood Manor notifies residents and the residents and the residents□ representatives of transfers or discharges, the reasons for the move in writing and in a language or manner they understand. 1. Resident #1 expired 2. Education was provided to all nursing staff on November 1, 2017 on the importance of providing residents and/or representatives a written notice of transfer. Any Nurses not at the Nov. 1st, 2017 meeting will receive training by November 15th, 2017. Orientation for new nurses will include training on notice requirements before transfer/discharge. Checklists for hospitalization/discharge include completion of notice requirements	

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F 203	Continued From page 12 conducts: 1. Transfer for hospitalization. . . . Notice of Transfer . . . Under this section you need to complete the following for either an emergency medical transfer or non-emergency transfer . . ." Review of Resident #1's medical record occurred on all days of survey. The progress notes identified the facility transferred the resident to the hospital on 06/16/17. The record lacked evidence the facility provided the resident and/or the resident's family member/legal guardian a written notice of transfer. During an interview on 10/10/17 at 2:25 p.m., and administrative nurse (#1) confirmed the facility failed to provide the resident and/or family member a written notice of transfer.	F 203	for transfer/discharge. 3. Business Office Manager/ designee shall do an audit on all transfers and discharges weekly x1 month, monthly x 3 months, and quarterly thereafter for one year. 4. Outcomes shall be discussed in the monthly QA for review and follow up. Any issues identified will be corrected immediately.	
F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 205		11/15/17

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F 205	Continued From page 13 bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide a written bed-hold notice upon transfer for 1 of 3 sampled residents (Resident #1) transferred for hospitalization. Failure to provide a written bed-hold notice does not allow the resident to make an informed choice regarding their rights. Findings include: Review of the policy, "Bed Hold Policy" occurred on 10/11/17. This undated policy stated, ". . . Written information (including the facility's bed-hold policy) will be provided to the resident and family when a resident requires a hospitalization or therapeutic leave. A copy of this will be retained for the resident's medical record. . . ." The Bed Hold Policy has a place on the bottom of the form for the Resident or Family Member/Legal Representative to sign and date. Review of Resident #1's medical record occurred	F 205	F-205: NOTICE OF BED HOLD POLICY BEFORE/UPON TRANSFER To ensure Wedgewood Manor provides to the resident and resident representative written notice which specifies duration of bed hold policy at time of transfer of a resident to hospital or therapeutic leave. 1. Resident #1 expired 2. Education was provided to all nursing staff on November 1, 2017 on the importance of providing residents and/ or their representatives a written bed hold notice. This was also added to the new orientation checklist to be completed as part of orientation to new nursing/agency staff. Training on bed hold policy was added to the new Nurse□s Orientation Checklist. Any nursing staff not at the November 1, 2017 meeting will have training completed by November 15, 2017. Completion of bed hold was added	

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F 205	Continued From page 14 on all days of survey. The facility transferred Resident #1 to the hospital on June 16, 2017. The resident's medical record lacked a completed bed-hold notice. During an interview on 10/10/17 at 2:25 p.m., an administrative nurse (#1) stated the facility should have completed a written bed-hold notice.	F 205	to hospitalization/therapeutic leave checklist. 3. Business Office Manager/Designee shall do an audit on all hospitalizations or therapeutic leave weekly x 1 month, monthly x 3 months, quarterly thereafter for one year. 4. Outcomes shall be discussed in the monthly QA for review and follow up. Any issues identified will be corrected immediately.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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	F 278		11/15/17

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F 278	Continued From page 15 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a 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 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 4 of 10 sampled residents (Resident #3, #5, #6, and #8). Failure to accurately complete Section C (Cognitive Patterns), Section E (Behaviors) and Section M (Skin Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings Include: COGNITIVE PATTERNS: The Long-Term Care Facility RAI Manual, revised October 2017, Page C-1, stated, ". . . C0100: Should Brief Interview for Mental Status (BIMS) be conducted? Attempt to conduct interview with all residents. . . . most residents are able to attempt the BIMS. A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.	F 278	F-278: ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Wedgewood Manor will ensure that every assessment accurately reflects each resident□s status and that it is coordinated by a registered nurse. 1. i For resident #3 and # 8 a correction shall be made to the most recent MDS to reflect that interview was attempted and BIMS will be coded as 99. ii. For resident #6 a correction shall be made to the most recent MDS to reflect resident #6 did not wander in dangerous places and that her wandering did not affect others. iii. Corrections shall be made to resident #5 to show resident did not experience delusions during the assessment period. iv. Corrections shall be made to resident #6 the most recent MDS coding of skin and ulcer treatment. 2. Potential exist for other residents to be affected by cited deficiency. i. A 100% audit of the most current	

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F 278	Continued From page 16 Without an attempted structured cognitive interview, a resident might be mislabeled . . . structured interviews will efficiently provide insight into the resident's current condition that will enhance good care. . . . Coding Instructions: Enter code 0, No: resident is rarely/never understood. Skip to C0700 and complete staff assessment for mental status. Enter code 1, Yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, . . . Proceed to C0200, Repetition of Three Words. . . ." - Review of Resident # 3's medical record occurred on all days of survey. The quarterly MDS, dated 09/12/17, showed sections B0700 and B0800 identified Resident #3 as usually makes self understood and sometimes has the ability to understand others. Facility staff coded section C0100 a 0, No: resident is rarely/never understood and the BIMS interview was not completed. - Review of Resident # 8's medical record occurred on 10/11/17. The significant change MDS, dated 08/02/17, showed sections B0700 and B0800 identified Resident #8 as makes self understood and sometimes has the ability to understand others. Facility staff coded C0100 a 0, No: resident is rarely/never understood and the BIMS interview was not completed. During an interview on 10/11/17 at 10:35 a.m., an administrative nurse (#4) confirmed staff failed to attempt a cognitive interview resulting in an inaccurate coding of section C0100. Staff failure to attempt to conduct a BIMS interview when the resident had been identified as interviewable	F 278	MDS for each resident will be done. Corrections to the most recent MDS shall be made if there are any discrepancies. ii. MDS Coordinator was educated on October 27, 2017 on MDS definitions, assessment accuracy, coding MDS accurately and documentations regarding in the medical records to justify coding as MDS during the look back period. 3. Monitoring of MDSs for resident #3,5, 6, 8 and a random sample of residents will be completed by the Administrator/Designee to ensure accuracy in coded MDS prior to submissions weekly x 1 month, monthly x three months, then quarterly thereafter for 1 year. 4. Outcomes shall be discussed in the monthly QA for review and follow up. Any issues identified will be corrected immediately.	

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F 278	Continued From page 17 hinders the facility's ability to accurately identify the residents cognitive status. Section E: Behavior The Long-Term Care Facility RAI Manual, revised October 2016, Chapter 3, page E-19, stated, "E1000: Wandering - Impact . . . Coding Instructions for E1000A. Does the Wandering Place the Resident at Significant Risk of Getting to a Potentially Dangerous Place? *Code 0, no: if wandering does not place the resident at significant risk. Code 1, yes: if the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside of the facility where there is heavy traffic) or encountering a dangerous situation (e.g., wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders)." Page E-20, stated, ". . . Coding Instructions for E1000B. Does the Wandering Significantly Intrude on the Privacy or Activities of Others? *Code 0, no: if the wandering does not intrude on the privacy or activity of others. *Code 1, yes: if the wandering intrudes on the privacy or captivities of others . . ." - Review of Resident #6's medical record occurred on all days of survey. The significant change MDS, dated 04/24/17, identified Resident #6 wandered in dangerous places and her wandering affected others. The medical record lacked evidence to support the coding of Resident #6's wandering. The Long-Term Care Facility RAI Manual, revised October 2016, Chapter 3, page E-1, stated,	F 278		

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F 278	Continued From page 18 "E0100: DELUSION A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . Page E-2 stated, Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis." - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 08/14/17, identified the resident experienced delusions during the assessment period. The resident's medical record lacked evidence to support the coding of delusions on the MDS. Section M: Skin Conditions The Long-Term Care Facility RAI Manual, revised October 2016, Chapter 3, page M-39 and M-40, stated, "M1200: Skin and Ulcer Treatments . . . Coding Instructions: Check all that apply in the last 7 days. . . . M1200H, Application of ointments/medications other than to feet . . ." - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 07/24/17, identified application of ointments/medications other than to feet occurred during the look-back period. The medical record lacked evidence to support the skin and ulcer treatment coding. During an interview on 10/11/17 at 10:21 a.m., an administrative nurse (#4) confirmed the incorrect coding of the MDS.	F 278		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		11/15/17

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F 281	Continued From page 19 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: INSULIN ADMINISTRATION 1. Based on observation, and review of facility policy, the facility failed to provide services to meet professional standards of practice for 2 of 2 residents (Resident #5 and #15) during observation of insulin administration. Failure to follow the facility policy for insulin preparation and administration with an insulin FlexPen may result in an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Administration-Pen" occurred on 10/11/17. This policy, revised April 2014, stated, ". . . Remove the cap from the pen and wipe the rubber stopper with an alcohol wipe . . . Perform an air shot . . . Turn dose selector to '2' units. Holding pen with the needle pointing up . . . Press the injection button all the way in until the dose selector is back to '0' . . ." - Observation on 10/10/17 at 8:46 a.m. showed a nurse (#3) primed one unit of Resident #5's Lantus FlexPen insulin with the needle pointing downward. The nurse failed to prime the FlexPen in an upward position with two units. - Observation on 10/10/17 at 11:14 a.m. showed	F 281	F-281: SERVICES PROVIDED MEET PROFESSIONAL STANDARDS To ensure that the services provided by Wedgewood Manor or arranged by the facility as outlined by the comprehensive care plan meet professional standards of quality. 1. i. For resident #5, staff #3 and other nurses and med techs were re-educated on how to use insulin pens properly and insulin administration per facility policy on November 1, 2017. ii. For resident #15, staff #5 and other nurses and med techs were re-educated on insulin administration per facility policy during the meeting on November 1, 2017. iii. For resident #15, Physician order of artificial tears has been changed from 1-2 gtts to both eyes daily and PRN to 1 gtts to both eyes daily and PM. iv. Resident #1 expired. v. Resident #7 ibuprofen 200mg tablet order was changed to 600mg every 6 hours as needed for pain. vi. Resident #8□s Systane eye drops order was changed to 1 gtts to the left eye daily.	

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F 281	Continued From page 20 a nurse (#5) prepared Resident #15's Humalog FlexPen insulin. The nurse (#5) applied the needle to the FlexPen and failed to cleanse the tip of the FlexPen with an alcohol swab prior. The nurse (#5) primed the FlexPen in a downward position, not in an upward position. Physician Orders 2. Based on observation, record review, and review of professional literature, the facility failed to provide services to meet professional standards of practice for 3 of 10 sampled residents (Resident #1, #7, and #8) records reviewed and observation during medication administration of 1 supplemental resident (Resident #15). Failure to clarify physician orders to ensure the correct medication dosage is administered may result in medication errors and adverse effects. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice" 10th ed., Pearson Education, Inc., New Jersey, pages 760-761 state, ". . . Essential parts of a Medication Order . . . The dosage of the drug includes the amount, the times or frequency of administration, and in many instances the strength. . . ." - Observation during medication administration on 10/10/17 at 10:36 a.m. showed a licensed nurse (#5) administered Resident #15's artificial tear eye drops. The physician order stated, "ARTIFICIAL TEARS-Give 1-2 gtts [drops] to both eyes daily and prn [as needed] for dry eyes." The	F 281	2. Other residents stand the potential of being at risk for services not meeting professional standards. Medication administration in-service was provided November 1, 2017. Medication Administration in-service include the appropriate techniques to prime insulin and prepare insulin pens for insulin administration. Medication administration training included instruction to nurses to be specific with dosage directions when receiving orders from physicians to help decrease risk of medication error. Any nurse or med tech not at the meeting will receive education by November 15th, 2017. Medication administration education will also be included in the orientation of staff new to the responsibility and agency nurses by November 15th, 2017. 3. Monitoring and observation of insulin administration and/or medication orders for Resident #5,7, 8, and 15 and random sample of residents will be completed by the DON/Designee weekly x 1 month, monthly x three months, and quarterly thereafter x 1 year. 4. Outcomes shall be reported to the monthly QA committee for review and follow-up. Any issues identified will be corrected immediately.	

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F 281	Continued From page 21 nurse (#5) administered one drop of the artificial tears in both eyes. The October 2017 Medication Administration Record (MAR) failed to indicate the actual number of drops administered. - Review of Resident #1's medical record showed a physician's order which stated, "Ultram 50 mg [milligram] tablet: take 1-2 tabs [tablets] every 6 hours as needed for pain. Max [maximum] of 400mg / 24 hours. Review of Resident #1's MAR failed to identify the number of Ultram tablets given. - Review of Resident #7's medical record occurred on all days of survey. A physician's order, dated 07/12/17, stated, Ibuprofen 200 mg tablet - Give 600-800 mg (milligrams) every 6 hours as needed for pain. Review of Resident #7's MAR for the months of July, August, September and October 2017 identified Ibuprofen administered on 14 of 22 occasions with no indication as to the actual dose administered. - Review of Resident #8's medical record showed a physician order, dated 05/04/16 included Systane eye drops - Give 1-2 gtts to the left eye daily. Review of Resident #8's MAR failed to identify the number of eye drops administered.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		11/15/17

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F 309	Continued From page 22 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of the hospice contract, and staff interview, the facility failed to provide the necessary care and services for 1 of	F 309	F-309: PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Wedgewood Manor will ensure that each	

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F 309	Continued From page 23 1 resident (Resident #1) receiving hospice services. Failure to provide access to the residents' hospice plan of care to all practitioners and staff involved in the residents' care limited coordination of care and services for the residents. Findings include: Review of the facility services agreement between the facility and the hospice agency occurred on 10/11/17. This agreement, dated 03/08/06 stated, ". . . A. Hospice Plan of Care: [name of facility] Hospice shall develop, at the time an legible resident is admitted into [name of facility] Hospice program, a Hospice Plan of Care for the management and palliation of the resident's terminal illness. The Hospice Plan of Care is a written document which will include a detailed description of the scope and frequency of hospice services and supplies needed to meet the resident's needs. The Hospice Plan of Care will specify which services and supplies are related to the patient's terminal illness . . . Hospice shall furnish a copy of such Plan of Care for such resident to Wedgewood Manor at the time of the resident's admission into [name of Hospice facility] Hospice Program. . . ." Review of Resident #1's medical record occurred on all days of survey. The record identified an admission to hospice services on 10/05/17. The record failed to contain a copy of the hospice care plan. During an interview on 10/10/17 at 3:30 p.m., an administrative nurse (#1), confirmed Resident #1's medical record does not contain a hospice	F 309	resident receives and that the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, consistent with the resident□s comprehensive assessment and plan of care. 1. Resident #1 expired 2. Hospice shall be responsible for determining, and modifying as necessary, the appropriate hospice plan of care as specified in 42 C.F.R.§418.112(d). The hospice plan of care shall encompass all issues related to the Resident's terminal illness and related conditions. Additionally, the hospice plan of care shall specifically identify which provider is responsible for performing the respective functions that have been agreed upon and include in the hospice plan of care. Hospice shall communicate with the resident, family members, facility staff, and the attending physician in the development and updates to the content of the hospice plan of care. Hospice shall provide the facility with the following information immediately upon the information becoming available to Hospice: (i)the most recent hospice plan of care specific to each Resident under Hospice's care. A telephone meeting was conducted with Hospice on 11/15/17 to ensure entities involved are aware of care plan requirements. 3. The DON/Designee shall conduct an audit on each resident that is admitted into hospice, to ensure that care plan and every other documentation needed to	

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F 309	Continued From page 24 care plan. During an interview on 10/10/17 at 4:10 p.m., an administrative staff member (#2) stated the nursing staff have the ability to access to the hospice care plan via the Epic computer system. During an interview on 10/10/17 at 4:14 p.m., a facility staff nurse (#3) stated the facility had not received a hospice care plan for Resident #1. She stated Hospice will fax the care plan to the facility when it is completed. When asked regarding the availability of the hospice care plan via the computer, the staff nurse stated she was unaware of any way to access the care plan in that manner.	F 309	provide care for resident is in place. Monitoring/QA will occur with each Hospice admission for 1 year. 4. Outcomes shall be discussed in monthly QA meeting. Any issues identified will be corrected immediately.	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 314		11/15/17

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F 314	Continued From page 25 Based on record review and review of facility policy, the facility failed to provide the necessary treatment and services to prevent the development and/or deterioration of a pressure ulcer for 1 of 1 closed record (Resident #11) identified with a pressure ulcer. Failure to routinely assess/monitor the resident's skin, implement interventions, and provide appropriate treatment may have resulted in delayed healing and further deterioration of Resident #11's existing pressure ulcer. Findings include: Review of the facility policy titled "Skin Care Protocol/Prevention" occurred on 10/11/17. This policy, revised December 2013, stated, "Purpose: Residents of Wedgewood Manor will be assessed upon admission and routinely thereafter for their level of risk for developing pressure ulcers. Early intervention/prevention is our primary focus. . . ." Review of Resident #11's medical record occurred on 10/11/17. Diagnoses included breast cancer, malignant bone cancer, osteoarthritis, and type 2 diabetes mellitus. Review of the departmental notes identified the following: * 04/12/17 at 3:55 p.m.: ". . .Skin check done then res [resident] [sic] skin good. Has a drsg [dressing] on coccyx which was there prior to admission. . . ." * 04/17/17 at 7:00 p.m.: ". . . Mepilex to coccyx remains clean dry and intact. . . ." * 04/18/17 at 3:31 p.m.: "Mepilex intact to coccyx at this time . . ."	F 314	F-314: TREATMENT TO PREVENT/HEAL PRESSURE SORES To ensure Wedgewood Manor routinely assesses/monitors the resident□s skin, implements interventions and provides appropriate treatment to promote healing of pressure ulcers, the facility has taken the following action concerning deficiencies cited. 1. Resident #11 expired. 2. For other residents at risk or potential to be affected: Wedgewood Manor will review all residents at risk for skin breakdown utilizing their most current Braden Risk Assessment Score. Any residents identified at risk, a CP review will be completed to ensure they have appropriate interventions and treatments in place. Nursing staff/CNAs received training on 11/01/17 on skin care policy which includes inspection of skin upon admission and hospital return. Dressings will be removed during skin inspections on new/return admissions unless resident has a physician order specifically stating to leave dressings in place i.e.: such as a surgical dressing. Any nursing staff/CNA's not at the 11/01/17 meeting will receive training by 11/15/17. Skin care policy will be part of the orientation for new CNAs/nurses and agency staff. 3. Monitoring/QA of residents with skin issues and a random sample of residents will be completed weekly x 1 month, monthly x three months, and quarterly thereafter x one year. Any issues identified will be corrected immediately.	

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F 314	Continued From page 26 * 04/25/17 at 9:04 a.m.: "Weekly skin checks . . . rash to the upper back is improving with the HCT [hydrocortisone] cream. Dressing in place to the left chest wound. . . . No other skin changes noted during assessment." * 04/26/17 at 4:31 p.m.: "Pressure ulcer/coccyx. Wound clinic called-orders to apply silvasorb gel into the wound bed and cover with allevyn or mepilex dressing. Change daily. If no improvements-set up a telemed [telemedicine] appt [appointment] with the wound clinic. . . ." * 04/26/17 at 4:53 p.m.: "2 pm [2:00 p.m.] -CNA [certified nurse assistant] reported that resident has a skin change to the coccyx. Dressing was noted on admit 4/11/17. A mepilex dressing was removed-stage 2 area noted to the coccyx that measures 3.5 cm [centimeters] x 3.5 cm. Wound bed is 100% [percent] slough/yellow. No odor or drainage noted. Periwound is red/blanchable and dry. . . . Mattress overlay applied. Gel wc [wheelchair] cushion added. . . ." The facility failed to investigate/address the mepilex dressing observed on Resident #11's coccyx on 04/12/17, and failed to remove the dressing to assess the area for 15 days. Failure to remove the dressing and assess the area on Resident #11's coccyx may have delayed healing and contributed to further deterioration.	F 314	4. Outcomes shall be discussed in the monthly QA for review and follow-up. Any issues identified will be corrected immediately.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		11/15/17

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F 329	Continued From page 27 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: AS NEEDED PSYCHOTROPIC MEDICATIONS Based on record review, review of facility policy, review of monthly medication administration	F 329	F-329: 483.45 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Wedgewood Manor will to ensure that each resident□s drug regimen is free	

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F 329	Continued From page 28 records (MAR) and behavior monitoring flow sheets, the facility failed to ensure a medication regimen free from unnecessary drugs for 2 of 3 sampled residents (Resident #3, and #8) who received as needed (PRN) psychotropic medications. Failure to provide non-pharmacological interventions prior to medication administration placed residents at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Psychotropic Monitoring" occurred on 10/11/17. This undated policy stated, " . . . psychotropic medications will not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances . . . goal is to maximize the resident's functional potential and well-being while minimizing the hazards associated with drug side effects. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and anxiety disorder. Current physician's order's included lorazepam (antianxiety) 0.5 milligrams (mg) every six hours PRN for anxiety. The current care plan stated, ". . . Behaviors; door seeking, wandering, hallucinates . . . take a short stroll outside with resident as able . . . distract with activities when trying to wander: coffee and a cookie or visiting one on one with staff . . . if wandering away from unit, instruct staff	F 329	from unnecessary drugs. 1. i. For resident #3, staff was educated on November 1st, 2017 to properly document all non-pharmacological interventions as per their individualized care plan prior to medication administration. ii. For resident #8, staff was educated on November 1, 2017 to properly document all non-pharmacological interventions as per their individualized care plan prior to medication administration. 2. Potential exist for other residents to be at risk of unnecessary medication administration. i. Detailed in-service was provided to all nursing staff on November 1, 2017 on the importance of properly documenting non pharmacological interventions prior to medication administration. Any CNA or nurse not at the meeting will receive education by 11/15/17. ii. Unnecessary medication training shall be added to the new employee orientation checklist for agency and new staff. 3. DON/Designee shall do an audit on PRN psychotropic medications to ensure that proper interventions and documentations are in place for resident #3, Resident #8, and a random sample of residents weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. 4. Outcomes shall be reported to	

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F 329	Continued From page 29 to stay with resident, converse with resident and gently persuade resident to propel W/C (wheelchair) back to designated area . . ." The Behavior Monitoring form included the following interventions: ". . . 1. redirect as able and provide distraction. 2. take to fenced in courtyard. 3. take to coffee time. 4. take on a quick stroll outside. 5. fold clothes. 6. offer audiobooks . . ." Review of Resident #3's PRN Medication Administration Records identified the following: * July 2017 - On seven occasions staff administered PRN lorazepam. The medical record lacked evidence of non-pharmacological interventions attempted prior to administering the lorazepam on three occasions, and one attempt of a non-pharmacological intervention prior to administering the lorazepam on two occasions. * August 2017 - On three occasions staff administered PRN lorazepam. The medical record lacked evidence of non-pharmacological interventions attempted prior to administering the lorazepam on one occasion, and one attempt of a non-pharmacological intervention prior to administering the lorazepam on one occasion. * September 2017 - On three occasions staff administered PRN lorazepam. The medical record lacked evidence of non-pharmacological interventions attempted prior to administering the lorazepam on one occasion, and one attempt of a non-pharmacological intervention prior to administering the lorazepam on one occasion. - Review of Resident #8's medical record occurred on 10/11/17. Diagnoses included dementia with behavioral disturbance and	F 329	monthly QA committee for review and follow up. Any issues identified will be corrected immediately.	

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F 329	Continued From page 30	F 329		

Parkinsons disease. The record identified a physician's order dated 05/04/16, Ativan (antianxiety) 0.5 milligrams (mg) every eight hours PRN for anxiety.

The current care plan stated, ". . . Behaviors: Verbally abusive behavior, hollering or demanding wandering and care rejection. . . . likes to go to coffee time, likes to watch TV in b wing lounge, offer sports on TV or newspaper to read, assess for pain daily and offer tylenol, approach resident warmly and positively, . . . offer to call sister, move to recliner in b wing lounge, offer snack, try distraction, give ativan if these are not effective to quiet resident. . . ."

The Behavior Monitoring form included the following interventions: ". . . 1. remind resident he's ok. 2. call sister. 3. lay in recliner. 4 offer snack. 5. distraction. 6. notify nurse of any pain . . ."

Review of Resident #8's PRN MAR identified the following:
* August 2017 - On ten occasions staff administered PRN Ativan. The medical record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on two occasions, and one attempt of a non-pharmacological intervention prior to administering the Ativan on one occasion.
* September 2017 - On ten occasions staff administered PRN Ativan. The medical record lacked evidence of non-pharmacological interventions attempted prior to administering the Ativan on four occasions, and one attempt of a non-pharmacological intervention prior to administering the Ativan on two occasions.

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F 329	Continued From page 31 The medical records for Resident #3 and #8 lacked evidence of a non-pharmacological intervention to modify a resident's behavioral disturbance prior to administering a psychotropic medication as stated in the facility policy.	F 329		
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition for 2 of 2 suction machines (supply room and crash cart). Failure to ensure the suction machine remained functional in case of an emergency situation placed residents at risk for choking and aspiration. Findings include: Review of the facility policy titled "Suctioning" occurred on 10/11/17. This policy, undated, stated, ". . . Connect tubing to suction machine and check equipment for proper working order . . ." Observation of the suction machine stored in the supply room occurred on 10/11/17 at 10:46 a.m.	F 456	F-456: ESSENTIAL EQUIPMENT SAFE OPERATING CONDITION Wedgewood Manor will ensure that all mechanical, electrical and patient care equipment are maintained and in safe operating condition. The facility has taken the following actions concerning deficiencies cited. 1. The suction machine stored in the supply room that is non-operational has been discarded. 2. i. The nursing staff was re-educated on how to properly operate the suction machine and the location of the suction machine on November 1st, 2017. Return demonstrations were completed by nursing staff in attendance. Any nurses that were not in attendance will be educated by November 15th, 2017	11/15/17

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F 456	Continued From page 32 with a licensed nurse (#3). Observation showed the machine did not produce suction. The nurse checked all the connections numerous times and the machine still had no suction. At 10:54 a.m. another nurse (#4) attempted to obtain suction from the machine without success. The nurse (#4) obtained a suction machine from the crash cart. The nurse (#4) lacked the required knowledge to connect tubing to the suction machine and attempted a second time with success. The administrative nurse (#1) checked the first suction machine, confirmed it did not work, and removed it from the supply room.	F 456	and also complete a return demonstration. ii. Suction machine education shall be added to the new employee orientation checklist for new nursing staff and agency staff. iii. The entire nursing staff has been educated on where the suction machine is stored. Suction machine is set up on the crash cart and will be checked by the night nurse every night to ensure suction is set-up and readily available for emergency situations. 3. Audits on random nursing staff to ensure they possess the required knowledge needed to locate and set-up the suction machine shall be carried out by the DON/Designee weekly x 1 month, monthly x 3 months, and quarterly thereafter x 1 year. 4. Results of audit shall be submitted to monthly QA committee for review and follow up. Any issues identified will be corrected immediately.	
F9999	FINAL OBSERVATIONS A complaint investigation was conducted in conjunction with the standard Medicare/Medicaid recertification survey. The complaint issues regarding facility staff, resident safety, meals not being served on time, quality of life, and infection control could not be substantiated.	F9999		