STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING--------- B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

{X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 07/22/13 and completed on 07/24/13, the sample included two (2) residents for complete review, seven (7) 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	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 225 SS=D	483.13{c)(1)(ii)-(iii), {c)(2)- (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F225: 1.) The State Health Department was notified of the accident at the time of the 2013 Survey. Bruce Pritschettt was notified of the incident on 8-26-13.He was informed of the investigation results on 8-29-13 2.) All residents could be at risk. 3.) A new incident tracking log will be implemented and will ask in each situation if this is reportable. We will review every incident each morning M-F at our daily stand up meetings. On weekends, incidents will be logged by the charge nurse and if the reportable box is checked, it will prompt staff to call the Administrator, DON, or the LSW. Mandatory reporting laws, elder justice act, and resident rights were education topics at our all staff meeting that was held 8/7/2013. The nursing monthly staff meeting (8/6/2013) included discussion and review of the attached ND Health Department Memos on: Reporting Allegations of Mistreatment, Neglect, and Abuse, including Injuries of Unknown Source and Misappropriation of Resident Property. The Procedure for Incident Reporting was reviewed and revised to include the fact that incidents will be reported to the health dept according to their guidelines. 4.) Nicole Johnson LSW will monitor this log daily and the log will reviewed at QA meetings 1 time per month for 1 year beginning 9/24/2013. 5.) Completion date: August 28, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	administrator	9/09/13

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

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to report 1 of 1 alleged incident of neglect (involving Resident #3) immediately to the state survey and certification agency and failed to report the results of the investigation within five working days of the incident. Failure to report and thoroughly investigate all alleged violations involving neglect has the potential to place all residents at risk of possible neglect. Findings include: Review of the facility policy titled "Recognizing Signs and Symptoms of Abuse/Neglect" occurred on 07/24/13. This policy, dated April 2011, stated, "...'Neglect' is defined as failure to provide goods and services as necessary to avoid physical harm ...The following are some examples of ...signs and symptoms of ... neglect that should be promptly reported ... Fractures ...of questionable origin ..." Review of the facility policy titled "Reporting Abuse to State Agencies and Other Entities/Individuals" occurred on 07/24/13. This	F 225		

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F 225	Continued From page 2 undated policy, stated,"... Should a suspected . . . incident of ... neglect ... be reported, the facility Administrator, or his/her designee, will promptly notify ... [the] State licensing/certification agency responsible for surveying/licensing the facility ...within twenty-four ... hours of the occurrence of such incident ... [and] will provide the appropriate agencies ...with a written report of the findings of the investigation within five ...working days of the occurrence of the incident." Resident #3's medical record, reviewed July 22-24, 2013, identified diagnoses including cerebral palsy, contractures, osteoporosis, and history of A fall with a fracture of the humerus. The resident's care plan, dated 07/19/12, identified, "Problem Potential for falls ... Approaches Sit-to-stand lift ..." During an interview on 07/24/13 at 2:30p.m., the administrative nurse (#2) stated, "Our policy is to use an assist of two with lifts. We require an assist of two with any lift." The incident details report, dated 10/15/12 at 5:20 a.m., identified, "... Slipped or Fell ... Staff Assisted Transfer from toilet to chair. Number of Staff Assisting 1 ... Contributing Factors [as reported by the Certified Nurse Assistant (CNA) present at the time of the fall] Was equipment involved in the incident? ... sit-to-stand [lift] Comments Went to take [the resident] off of [the] toilet. She pulled her bad leg up and would not put it down. I was at the chair and could not get her leg down and it was preventing her to sit over [sic] [the] seat of [the] chair. I tried to put her back on [the] toilet [and] could not get her on it either. She kept slipping further, so for her safety, I had	F 225		

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F 2251	Continued From page 3 to lower her out of the sit-to-stand [lift].... Incident Details [as reported by the nurse on duty at the time of the fall] Part of Body Allegedly Injured Shoulder L [left] ...Type of Alleged Injury ... Pain, but no visible injury; states location of pain (L) shoulder ...Comments Res is unable to use (L) arm to grip handles in sit-to-stand lift which is what caused her to slip down in sling... " The general radiology report, dated 10/15/12, stated, "... There appears to be a spiral type fracture [a fracture caused by the forceful twisting] ... of the humerus ..." The incident details report, dated 10/15/12 at 5:20 a.m., also identified,"... Investigation [as reported by the Director of Nursing following the fall] ... Summarize factors that may have contributed to this incident Res unable to grip handles on sit to stand lift [with] (L) hand and is not able to position self properly on the lift. Also 2 assist is needed when using lifts.... Description of Corrective Actions taken to prevent recurrence of this incident Employee education ... Resident education ... Staff member involved in incident had ...written council/corrective action ... Investigation Results Reported to State/Agency ... N/A [inapplicable] ..."The investigation failed to identify why the CNA transferred Resident #3 with a sit-to-stand lift when she was unable to support the majority of her own weight and/or use both hands, whether the CNA applied the calf strap, if the CNA properly applied the front safety strap, and/or why the CNA failed to follow the facility's policy of using an assist of two with all lifts. The facility also failed to promptly notify the State licensing/certification agency within twenty-four hours of the incident and failed to provide the	F 225		

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F 225	Continued From page 4 agency a written report of the findings of the investigation within five working days of the incident. During an interview on 07/24/13 at 2:30p.m., when asked if the CNA's failure to follow the facility's policy/resident's care plan and/or her failure to follow the manufacturer's recommendations for the sit-to-stand lift met the definition of neglect, the administrative nurse (#2) stated, "Yeah, I guess she didn't do what she should have. [It] could be considered neglect." Failure to report and thoroughly investigate an alleged violation involving neglect limited the facility's ability to ensure the safety of Resident #3 and placed all residents at risk of possible neglect.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of policies/procedures, and staff interview, the facility failed to ensure 1 of 2 licensed staff members (#8) initialed the medication administration record (MAR) after medications were administered to 5 of 8 residents and 1 of 1 supplemental resident (Resident #12). Failure to not initial the MAR has the potential to cause a medication error. Findings include:	F 281	F281: 1.) Nursing staff member #8 was individually counseled and re-trained to follow the facility policy of signing medications after administration. Also, a nursing staff meeting was held on 8/6/2013 and the medication administration policy was reviewed. Staff were re-educated on the appropriate documentation methods for medication administration and training took place on how to complete a medication audit report on the new Point Click Care System that went live with electronic MARS and TARS on 8/1/2013. 2.) Without doing the above actions, all residents could be at risk.	

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F 281	Continued From page 5 Review of the facility policy titled "Administering Medications" occurred on 07/24/13. This policy, revised December 2009, stated,"... 12. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones." During random observations on 07/23/13 from 8:00a.m. to 11:30 a.m., a nursing staff member (#8) initialed the MAR before administering medications to five residents. During an interview on 07/24/13 at 3:30p.m., an administrative nurse (#2) agreed the nurse should have initialed the MAR after the medications were given to the residents. - Random observation of the MARs occurred on all days of survey and revealed numerous residents with days from 07/01/13 through 07/24/13 where medications were not initialed as administered. On 07/24/13 at 3:30p.m., Resident #12's MAR was shown as an example to an administrative nurse (#2). Resident #12's MAR had no medications initialed as administered on 07/03/13. Some of the medications included Celexa (depression), diltiazem (cardiac), Folic Acid (vitamin), Lasix (fluid/edema), and Melatonin (sleep aid). The administrative nurse stated staff nurses should have initialed all medications administered, circled the space if medications were not administered, and documented the reason not given on the back of the MAR. 483.25(h) FREE OF ACCIDENT		
F 323		F 323 3.) The SYSTEM CHANGE is the electronic EMAR implementation that took place 8/1/2013 with our Point Click Care System. This EMAR system enables the nursing staff to run shift audits that will confirm if there are any medications or treatments that were missed or not documented. This system also places any late medications in a pink status if not given in the correct administration time frame. Medication Administration Policy Reviewed. 4.) Completion Date: August 28, 2013. 5.) Two audits will be implemented and completed by the DON or designee. a. The first audit for this tag will be used to observe random nursing staff pass medication once a week x 1 month, then monthly (at random times) every month there after x 1 year to ensure staff is documenting the medication administration after the medication has been given and not before. (See attached audit.) b. The second audit for this tag will be used to check the medication administration report of 5 random residents/week x 1 month, then 5 monthly (at random times) every month there after x 1 year to ensure complete and accurate documentation of medications administered. (See attached audit.) Audits to be implemented 8/28/2013. Results of the audits will be reported and discussed at the monthly QA meetings for further recommendations.	

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F 323 SS=G	Continued From page 6 HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, review of manufacturer's recommendations, and staff interview, the facility failed to ensure safe transfers with an assistive device for 1 of 1 sampled resident (Resident #3) with a history of falling from a sit-to-stand lift. Failure to ensure proper use of the assistive device (sit-to-stand lift) resulted in Resident #3 experiencing a fall and a fracture.

Findings include:

Review of the undated "Employee Annual Review/New Employee Orientation" checklist occurred on 07/24/13. The check list stated, "... Prior to utilizing the Sit-to-Stand lift, ensure: The resident can bear weight on at least one leg. The resident has some upper body strength, the abilit to use both hands and the ability to follow simple commands ...."

Review of the "Invacare Owner's Operator and Maintenance Manual: Patient Slings" occurred on 07/24/13. The manual stated,"...WARNING Individuals that use the Standing Sling MUST be able to support the majority of their own weight,

F323:

1.) A Hoyer lift was implemented for Resident #3 on 7/25/2013 for all transfers.

2.) All residents that require a mechanical sit-to-stand may be at risk.

3.) Current resident lift concerns and safe use of mechanical lifts were discussed at the CNA meeting 8/27/2013 and the Physical Therapy Department will do lift evaluations on those of concern and we will evaluate changes on a case by case basis. The facility will continue with annual lift training of staff and new sling options are being researched for our sit-to-stand lift. The facility policy remains that two people are required in operation of all lift transfers. (See attached sling possibility). The Mechanical Lift policy was reviewed with C.N.A.'s and nurses.

4.) Annual lift training must be completed by 8/28/2013 to continue working on the floor with the lifts. Audit to monitor if the lift transfers are being done using the assist of 2 trained staff. 5 lift transfers a month will be done for one year. This is completed and tracked by Melissa Hallgren PTA and communicated to the DON and Staff Scheduling Coordinator. QA implementation will begin 8/24/2013 and will be reviewed at QA meetings 1 x per month for a period of 1 year.

5.) Completion date: August 28, 2103.

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F 323	Continued From page 7 otherwise injury can occur.... Before lifting the patient, make sure the bottom edge of the standing sling is positioned on the lower back of the patient and the patient's arms are outside the standing sling....WARNING The belt MUST be snug ... otherwise the patient can slide out of the sling during transfer, possibly causing injury...." Review of the "Steady-Aid 2500X/3500X User's Manual" occurred on 07/24/13. The manual stated, "... WARNING ...The front safety strap should be below the sternum level. Tighten the safety strap ... so that the harness is adjusted to a point where it fits snugly around the chest. NOTE: The safety strap is designed as a safety feature to prevent injury to the patient should a sudden loss of muscle control occur during the lift....The back of the patient's heels must rest against the raised lip of the footplate and the bottom of both feet must rest firmly on the surface of the foot plate....Model 3500X lifts include a calf strap that can be used to prevent patients legs from sliding out of the knee pad ... NOTE: ...Also make sure ...that the patient's arms are on the OUTSIDE of the harness.... re-tighten the safety strap on the harness if any noticeable slackening has occurred...." Resident #3's medical record, reviewed July 22-25, 2013, identified diagnoses including cerebral palsy, contractures, and history of fall with a fracture of the humerus [upper arm/shoulder]. The resident's annual Minimum Data Set (MDS), dated 04/11/13, identified intact cognition and extensive assistance of two persons for bed mobility, transfers, locomotion on/off the unit, and toilet use. The care plan, dated 07/19/12, identified,	F 323		

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F 323	Continued From page 8 "Problem Potential for falls r/t [related to] cerebral palsy and history of falls manifested by contractures and potential for poor positioning ... Approaches Sit-to-stand lift ...Total lift to reposition adequately in bed per her request, likes it at NOC [night] ..." During an interview on 07/24/13 at 2:30p.m., the administrative nurse (#2) stated, "Our policy is to use an assist of two with lifts. We require an assist of two with any lift." The incident details report, dated 10/15/12 at 5:20 a.m., identified, "... Slipped or Fell ... Staff Assisted Transfer from toilet to chair. Number of Staff Assisting 1 ... Contributing Factors [as reported by the Certified Nurse Assistant (CNA) present at the time of the fall] Was equipment involved in the incident? ... sit-to-stand [lift] Comments Went to take [the resident] off of [the] toilet. She pulled her bad leg up and would not put it down. I was at the chair and could not get her leg down and it was preventing her to sit over [sic] [the] seat of [the] chair. I tried to put her back on [the] toilet [and] could not get her on it either. She kept slipping further, so for her safety, I had to lower her out of the sit-to-stand [lift].... Incident Details [as reported by the nurse on duty at the time of the fall] Part of Body Allegedly Injured Shoulder L [left] ...Type of Alleged Injury ... Pain, but no visible injury; states location of pain (L) shoulder ... Comments Res is unable to use (L) arm to grip handles in sit-to-stand lift which is what caused her to slip down in sling.... Investigation [as reported by the Director of Nursing following the fall] ... Summarize factors that may have contributed to this incident Res unable to grip handles on sit to stand lift [with] (L) hand and is not able to position self properly on	F 323		

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F 323	Continued From page 9	F 323		

the lift. Also 2 assist is needed when using lifts... . Description of Corrective Actions taken to prevent recurrence of this incident Employee education ... Resident education ... Staff member involved in incident had ... written council/corrective action ... Investigation Results Reported to State/Agency ... N/A [nonapplicable] ..."The investigation failed to identify why the CNA transferred Resident #3 with a sit-to-stand lift when she was unable to support the majority of her own weight and/or use both hands, whether the CNA applied the calf strap, if the CNA properly applied the front safety strap, and why the CNA failed to follow the facility's policy of using an assist of two with all lifts.

The first interdisciplinary progress note relating to this incident or any injuries, dated 10/15/12 at 2:00p.m., identified "Resident c/o [complained of] pain to (L) shoulder- medicated [with] Tylenol #3 [Tylenol with Codeine] [at] 10:40 a.m.- To clinic for xray [with] van driver [and]2 assist from PT [physical therapy]- Tolerated procedure fair- [Physician] called to say he thinks the (L) clavicle is Fx [fractured] ..."

The general radiology report, dated 10/15/12, stated,"...There appears to be a spiral type fracture [a fracture caused by the forceful twisting] ... of the humerus ..."

The orthopaedic clinic report, dated 10/16/12, stated, "... This patient is seen in consultation for a left shoulder injury. It was a slip at the nursing home, I believe, on October 15th. She is an 86 year old woman ... with some discomfort in her proximal shoulder.... Xray findings ... showed a proximal humeral fracture and severe osteoarthrosis. She is tender in the area of the

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F 323	Continued From page 10 shoulder ... Fracture starts below the anatomic neck and extends longitudinally down the shaft ... At this time, I would suggest we maintain a sling for the next 3 weeks and reassess her ... she is not an operative candidate. My suggestion would be to keep her comfortable, immobilizer her as well as possible ..." The interdisciplinary progress notes identified the following: * 10/16/12 at 3:00a.m.,"... PRN [as needed] Hydro[codone]/APAP [a pain medication] q [every] HS [hour of sleep] for (L) shoulder pain [with] good relief. Hoyer lift [with] 2 assist used for toileting [and] transfers. Sling in place for (L) arm support." *10/17/12 at4:00 a.m.,"...Res[resident] having behaviors q HS, yelling [at] staff, holding call light button down. Did calm down after talking [with] res for awhile and comforting res. Rested [sic] quietly in bed currently. PRN Hydro/APAP q HS [with] relief of shoulder pain." *10/18/13 at 10:00 a.m.,"...(L) arm in sling as ordered," and at 11:30 a.m.,"...Medicated [with] PRN Hydrocodone for c/o (L) arm pain...." The therapy documentation note, dated 01/08/13, stated,"... Recommend Rts [restorative therapists] to 'practice' sit-[to]-stand lifts, build up to 2 min [minutes] in upright [position] while sustaining proper alignment of trunk [and] LEs [lower extremities]. Once she accomplishes this, CNA may begin sit-[to]-stand lift, but must cant [continue] [with] 2 persons when moving [Resident#3]." The interdisciplinary progress note, dated 03/27/13 at 12:30 a.m., identified, "D/C [discontinue] ... arm sling."	F 323		

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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 323	Continued From page 11	F 323		

Observation of staff transferring Resident #3 utilizing the sit-to-stand lift showed the following:
* 07/23/13 at 11:10 a.m., two CNAs (#11 and #13) transferred Resident #3 from the toilet to her wheelchair utilizing the sit-to-stand lift. Although the resident held onto the right hand grip, her left arm hung at her side throughout the transfer.
* 07/23/13 at 2:22 p.m. two CNAs (#11 and #13) transferred Resident #3 from her wheelchair to the toilet utilizing the sit-to-stand lift. The resident held onto the right hand grip. Her left arm hung at her side.
* 07/23/13 at4:13 p.m., two CNAs (#9 and #10) transferred Resident #3 from her wheelchair to the toilet utilizing the sit-to-stand lift. The resident held onto the right hand grip. Her left arm hung at her side.
* 07/23/13 at 11:10 a.m., two CNAs (#9 and #10) transferred Resident #3 from the toilet to her wheelchair utilizing the sit-to-stand lift. Although the resident held onto the right hand grip, her left arm hung at her side throughout the transfer.
During each of the observations listed above, the resident did not bear weight and was in a seated position as she hung from the harness.
Staff failed to ensure the resident was able to bear weight, and pulled down on and/or failed to support her left arm during the transfer.

During an interview on 07/24/13 at 11:45 a.m. with the physical therapy staff member (#14), when asked if she would recommend the sit-to-stand lift for a resident who is unable to support the majority of her own weight and/or use both hands, this staff member (#14) stated, "I don't know if I would use the [sit-to-stand] lift if they [the resident] are not able to stand and are i a seated position." When asked what she would

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F 323	Continued From page 12 expect staff to do if the resident was unable to use both hands, the physical therapy staff member (#14) stated, "Make sure their arm is supported during the transfer." Following a description of the observations made on 07/23/13, she further stated, "They could have reinjured her [Resident #3's] arm." Failure to assess Resident #3's ability to use the sit-to-stand lift when she was unable to support the majority of her own weight and/or use both hands, failure of the CNA to follow the facility's policy of using an assist of two with all lifts, and failure of the CNA to properly apply the front safety strap and/or the calf strap resulted in Resident #3's sustaining a left arm spiral fracture. Failure to re-assess Resident #3's ability to use the sit-to-stand lift when she is unable to support the majority of her own weight and/or use both hands resulted in her being in a seated position in the sit-to-stand lift and in her arm being unsupported during transfers which may result in Resident #3 falling and sustaining another injury.	F 323		
F 327 SS=D	483.250) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policies/procedures, and staff interview, the facility failed to ensure 3 of 3 sampled residents (Resident #3, #6, and #8) with a history of urinary tract infections (UTI) were offered fluids during	F 327		

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F 327	Continued From page 13 nursing cares. Failure to offer adequate fluids may increase the risk of UTis and dehydration. Findings include: Review of the facility policy titled "Hydration Implementation Suggestions" occurred on 07/24/13. This policy, undated, stated,"... Nursing assistants/nursing staff could offer fluids to residents upon awakening, during care and upon repositioning of the resident. ... Offer hydration between meals since excess fluids at meals may lead to decreased food intake and weight loss." - Review of Resident #6's medical record occurred on all days of survey. This resident had UTis treated with antibiotics on 03/08/13, 03/16/13, 05/15/13, and 05/31/13. The Minimum Data Set (MDS), dated 04/18/13, identified short and long-term memory problems, moderately impaired daily decision making skills, extensive assist of one for transfers, and limited assist of one for eating. The care plan, dated 04/25/13, noted a problem for potential skin breakdown related to poor nutrition with an approach stating, "Offer fluids frequently and encourage resident to drink." Another problem stated, "Altered elimination related to aging process" with "occasional stress incontinence" with an approach to, "Monitor for s/s [sign/symptoms] of UTI." During an observation on 07/22/13 at 5:00p.m., two certified nursing assistants (CNAs) (#9 and #10) assisted Resident #6 to the bathroom. The CNAs did not offer the resident any water or fluids during or after cares. One CNA (#9) transported	F 327	F327: 1.) Residents #3, 6, and 8 have had their care plans updated to instruct offering fluids upon arising, during care, and upon repositioning (8/28/2013). 2.) All residents have the potential for risk of increase for UTI's and dehydration if fluids are not offered during the above times listed. 3.) Re-education of CNA staff was completed at the monthly meeting dated 8/27/2013 by Amy Larsen-Buck, DON and Judy Mckibben, RN Staff Development Nurse. Staff were directed to make sure every resident has a water pitcher and glass in their room and to make sure these are placed within reach of the residents. Offer fluids to residents when they wake up, during care, and upon repositioning. We do not include the specific times of days for drinks for our residents in our care plans. Each of the residents showed no signs of dehydration such as poor skin turgor or dry mouth or lips. 4.) An audit will be implemented by the Staff Development Nurse or designee to observe cares on 5 residents/week x 1 month, and then five residents/month x 1 year for every month thereafter. The audit will monitor at random times if fluids are being offered upon awakening, during cares, and upon repositioning. (See attached audit.) Audit to be implemented 8/28/2013. Results of the audits will be reported and discussed at the monthly QA meetings for further recommendations 5.) Completion date: August 28, 2013	

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F 327	Continued From page 14 the resident in his wheel chair to the facility's living room. During another observation on 07/23/13 at 11:30 a.m., a CNA (#11) assisted the resident into his wheelchair and transported him to the hallway bathroom near the dining room. That CNA (#11) did not offer the resident any water or fluids before leaving his room. - Review of Resident #8's medical record occurred on July 23-24, 2013. The record showed a history of UTis. The MDS, dated 04/19/13, identified short and long-term memory problems, moderately impaired daily decision making skills, extensive assist of two for transfers, and extensive assist of one for eating. The care plan, dated 04/25/13, noted potential problems for skin breakdown and altered elimination [constipation]. The approaches were to offer fluids frequently and encourage the resident to drink. During an observation on 07/23/13 at 5:00p.m., a CNA (#9) took the resident to the bathroom and then out to the facility's living room. The CNA did not offer the resident any water or fluids during or after cares. During an interview on 07/24/13 at 3:30p.m., an administrative nurse (#2) stated Resident #8 recently had a UTI. - Resident #3's medical record, reviewed July 22-25, 2013, identified diagnoses including cerebral palsy, contractures, history of a fractured humerus [upper arm/shoulder], and history of UTis treated with antibiotics on 11/22/12 and	F 327		

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F 327	Continued From page 15 12/15/12. The resident's annual MDS, dated 04/11/13, identified intact cognition, extensive assistance of two persons for transfers, and set-up assistance for eating. The care plan, dated 04/18/13, identified, "Problem Freq [frequent] UTI's .... Problem ... kidney stone ... Problem ...constipation ... Approaches Encourage fluids...." Observation revealed the following: *On 07/22/13 at4:00 p.m., two CNAs (#10 and #15) assisted Resident #3 to the bathroom. *On 07/23/13 at 11:10 a.m., two CNAs (#11 and #13) assisted Resident#3 to the bathroom. * On 07/23/13 at 4:13 p.m., CNAs (#9 and #10) assisted Resident #3 to the bathroom. During each observation, the CNAs failed to offer Resident #3 fluids following cares. During an interview on 07/24/13 at 3:30p.m., an administrative nurse (#2) stated CNAs would be expected to offer fluids to residents during cares.	F 327		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE- SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 16 by: Based on observation, review of the facility's policies and procedures, and staff interview, the facility failed to properly prepare the sanitization solution and sanitize food contact surfaces in the kitchen on 2 of 3 days (July 22-23, 2013) of survey. Without the correct concentration of sanitizing solution, the facility is unable to effectively disinfect food contact surfaces and food preparation equipment. This practice has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared and served in this area. Findings include: Review of the facility's policy titled "Kitchen General" occurred on 07/24/13. This undated policy, stated, "... 1. All food contact surfaces will be washed, rinsed and sanitized ..." Review of the facility's policy titled "Cleaning - Sanitation of Non-Food Contact Surfaces" occurred on 07/24/13. This undated policy, stated," ... 3. Sanitizing solutions much be checked with test strips for proper solution strength .... 14.... counter tops a. Clean and sanitize between uses and at the end of the day.. .. 16. Dining room tables a. Cleaned and sanitized prior to the breakfast meal and after each meal service...." Review of the facility's policy titled "Sanitizing Solutions" occurred on 07/24/13. This undated policy, stated, "... 1. Employees need to be properly trained in handling different cleaning agents. 2. Mix chemicals used in the recommended concentration of levels for maximum efficiency. (Higher concentrations can	F 371	F371: 1.) To reduce the risk of foodborne illness, directions for correct sanitation chemical mixing will be posted and a new dietary chemical sanitation log will be implemented. All dietary staff will be re-educated. 2.) Without doing the above actions, all residents could be at risk. 3.) A dietary meeting will be held August 19, 2013 with the Consulting Dietician present to re-educate the entire dietary staff on the sanitation policy and practices and instruct staff on the SYSTEM CHANGE which will be keeping a daily dietary chemical sanitation log that will require time, temperature, and ppm's to be logged and directions for mixing and testing the sanitation chemicals will be posted in the kitchen for further reference. (See attached instructions and log). These instructions and log were added to the Sanitizing Solutions Procedure. 4.) This dietary chemical sanitation log will be implemented on 8-26-13 and monitored by the Dietary manager Patti Johnson and reviewed at monthly QA meetings 1 time per month x 1 year. 5.) Date Completed: August 28, 2013	

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F 371	Continued From page 17 be unsafe and may leave an odor or bad taste on the objects and corrode metals.)...6. Check solution concentrations frequently with a test kit since they may ... bind with food .... 8. Staff may utilize Dietary Chemical Sanitizing Log to document the process as desired...." During the initial tour of the main kitchen on 07/22/13 at 12:00 p.m., observation showed, and the administrative dietary staff member (#6) confirmed a bucket containing chlorine sanitizer and water sitting on the counter. She stated, "It's cold from breakfast." Upon request, the administrative dietary staff member (#6) tested the chemical concentration of the sanitizer by immersing a chlorine test strip in the sanitizer for approximately 10 seconds with an immediate change in color (deep purple/black or greater than 200 parts per million (ppm)) identified on the strip. (The recommended Chlorine test strips register between 50-100 ppm following a 10 second contact time.) She immediately repeated the process, with the same results. Later in the tour, the administrative dietary staff member (#6) also stated she "rinses the three compartment sink with Dawn dish soap" prior to "washing [fresh] vegetables in the sink." Staff failed to properly prepare the sanitization solution and failed to sanitize the three compartment sink prior to preparing ready-to-eat food items. On 07/23/13 at 8:50a.m., observation showed and a dietary staff member (#5) confirmed a bucket containing chlorine sanitizer and water sitting on the counter. Upon request, she tested the chemical concentration of the sanitizer by immersing a chlorine test strip in the sanitizer for approximately 10 seconds with an immediate	F 371		

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F 371	Continued From page 18	F 371		

change in color (deep purple/black or greater than 200 ppm) identified on the strip. She stated, "This is old. I'll refill it." After refilling the bucket with chlorine sanitizer and water, the dietary staff member (#5) immediately repeated the process, with the same results. Staff failed to obtain the correct chlorine concentration when preparing the sanitization solution.

On 07/23/13 at 9:15a.m., upon request, a dietary staff member (#12) prepared sanitization solution in the kitchen sanitization bucket. She mixed Clorox bleach with Dawn dishwashing soap, stating, "I kinda eyeball it, so it covers the bottom, and usually fill it half way (with water)." Upon request, the dietary staff member (#12) tested the chemical concentration of the sanitizer by immersing a test strip in the sanitizer for approximately 10 seconds with an immediate change in color (deep purple/black or greater than 200 ppm) identified on the strip. She stated, "It should be 200 [ppm]," and confirmed the concentration of the solution was greater than 200 ppm. She stated, "We're killing 'em, nothing will live through that." Staff failed to follow manufacturer's mixing instructions for the preparation of a chlorine sanitization solution.

During an interview on 07/24/13 at 10:20 a.m., the administrative dietary staff member (#6) stated, "We usually spray Control Plus after we wash items off. We've never had to have a log [document the results of the test strips]."

During an interview on 07/24/13 at 10:35 a.m. with the administrative dietary staff member (#6) and a dietary staff member (#5), the staff member (#5) read the directions printed on the Clorox bleach container regarding how to prepare

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F 371	Continued From page 19 sanitization solution. She then held up a small container of quaternary ammonia sanitizer test strips and stated, "I test it [the solution] with this. They've been sitting back there since I started." She also stated, "We don't have to write it [the concentration of the sanitizing solution] down." The administrative dietary staff member (#6) then confirmed staff members failed to demonstrate a consistent method of preparing the sanitization solution (at times mixing cleaning and sanitation products), failed to use the correct test strips for the products used, and failed to sanitize the three compartment sink prior to preparing fresh vegetables in the sink.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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F 431	Continued From page 20 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure Ativan, a Schedule IV controlled substance, ordered on an as needed (PRN) basis was accounted for periodically for 2 of 2 sampled residents (Resident #5, and #8) and 1 of 1 supplemental resident (Resident #13). Not periodically accounting for controlled substances has the potential for medication errors and/or drug diversion. Findings include: Observation of the medication cart occurred on 07/24/13 at 11:00 a.m. with a nursing staff member (#16) and revealed the following: * Review of Resident #5's July 2013 medication administration record (MAR) revealed an order for Ativan 0.5 milligrams (mg) PRN twice a day. The Ativan medication cassette had been filled by the pharmacy on 04/29/13 with sixty-four 0.5 mg tablets. Nineteen tablets had been taken from the cassette. Review of the MARs since 04/29/13 revealed sixteen PRN Ativan tablets were initialed	F 431	F431: 1.) For residents #5, #8, and #13, Pharmacy Consultant I.J. Jacobson was notified of discrepancies with amount dispensed and the amount on hand with the documented doses given. Medications are dispensed using the Opus system (single dose) compartments. 2.) Any resident with a prn order for a Scheduled III or higher may be affected by this. 3.) The SYSTEM CHANGE will consist of implementing a supplementary documentation box in our EMAR system of Point Click Care to initiate a count of remaining medication for every prn Scheduled III or higher after a dose is given. This will enable us to monitor the amount of prn dosages given vs. the amount dispensed and audit for discrepancies. Education was provided to the nurses at the nurses meeting on August 6th regarding the discrepancies noted. The Controlled Substances Policy was reviewed and revised. 4.) The DNS or designee will conduct audits. An audit will be used to observe cassettes and the counts in the EMAR. This will be done by choosing 5 residents with prn medications in this category/week x 1 month, then five residents per month x 1 year for every month thereafter. (See attached audit.) Audits will be reviewed at monthly QA meetings and will be implemented August 28, 2013. 5.) Completion date: August 28, 2013.	

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F 431	Continued From page 21 as administered. Three tablets were unaccounted for. * Review of Resident #8's July 2013 MAR revealed an order for Ativan 0.5 mg PRN twice daily. The Ativan medication cassette had been filled by the pharmacy on 06/29/13 with sixteen 0.5 mg tablets. Eight tablets had been taken from the cassette. Review of the MARs since 06/29/13 revealed three PRN Ativan tablets were initialed as administered. Five tablets were unaccounted for. * Review of Resident #13's July 2013 MAR revealed an order for Ativan 0.5 mg PRN twice daily. The Ativan medication cassette had been filled by the pharmacy on 06/10/13 with sixteen 0.5 mg tablets. Nine tablets had been taken from the cassette. Review of the MAR since 06/10/13 revealed six PRN Ativan tablets were initialed as administered. Three tablets were unaccounted for. During the above process, a nursing staff member (#16) stated nurses were not keeping any kind of count between the MAR and the PRN Ativan cassettes. During an interview on 07/24/13 at 3:30p.m., an administrative nurse (#2) stated the facility lacked a process to periodically account for the PRN Ativan.	F 431		