STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(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 02/12/18 and concluded on 02/15/18.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/22/18

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

Electronically Signed | 03/08/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: MEAL SERVICE 1. Based on observation and resident and staff interview, the facility failed to provide care and services in an environment and manner that enhance dignity during 2 of 2 meals observed. Failure to serve each resident seated at the same table at the same time and provide adequate personal space for the resident does not preserve each resident's dignity or enhance their quality of life. Findings include: Upon arrival at the facility on 02/12/18 at 11:55 a.m., observation showed three residents seated at a table in the dining room. Staff served two of the residents their meal trays, but failed to serve the third resident until 12:05 p.m. (10 minutes later). Observation also showed two residents seated at a second table. Staff delivered one of the residents a meal tray, after the other resident had finished her meal and was attempting to leave the dining room. - Observation on 02/13/18 at 12:08 p.m., showed the following * Two residents seated at table #2, one resident	F 550	F550 Residents Rights 1. Residents will be provided with adequate space when dining. Residents #52 and #27 have been specifically addressed to provide adequate space when dining. Residents who are seated at a table will all be served together in a timely manner. Staff will knock on doors prior to entering residents #40, #11 and all other resident□s rooms. 2. Dining services evaluated seating arrangements to assure adequate spacing for each resident at the table. Dining staff and nursing staff monitor residents entering the dining room to be certain that all seated are served timely. All residents residing and receiving care have the potential to be affected. 3. Dietary manager or designee has assigned seating arrangements that provides adequate space for all existing residents and all new admissions or when a resident request a different seating arrangement. Dietary staff and certified nursing assistance will take orders and serve all residents seated at table together. All staff will knock doors to resident□s room and announce who they	

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F 550	Continued From page 2 had received their meal while the other resident waited until 12:18 p.m. (10 minutes later) to be served. * Four residents seated at table #3, three resident's had received their meals while one resident waited until until 12:14 p.m. (6 minutes later) to be served. * Three residents seated at table #4, two resident's had received their meals while one resident waited until 12:19 p.m. (11 minutes later) to be served. * Three residents seated at table #5, two residents had received their meals while one resident waited until 12:21 p.m. (13 minutes later) to be served. - The Resident Council meeting minutes, dated 01/02/18, stated, ". . . Wait times before meals are long . . ." During a group interview on 02/13/18 at 1:00 p.m., the following comments were made by residents regarding meal service: *Resident E: not everyone at the same (dining room) table gets served their meals at once *Resident G: staff take his order, but then he may wait up to 45 minutes to get served *Resident H: staff "bounce around from table to table," and don't necessarily take everyone at the table's order at once *Resident I (sits at a table with two other tablemates): staff may bring her food but not her tablemates' trays, even though they are all there at the same time. During an interview on 02/15/18 at 08:20 a.m. a dietary manager (#4) stated, all residents at the table should be served at the same time.	F 550	are. Both written and verbal education have been provided to staff on 3-8-18. 4. The DON or designee will be responsible for monitoring of dining services at all meals 3 x per week for 1 month, 2 x per week for 1 month, then monthly for 2 months. The DON or designee will also monitor knocking on resident□s doors prior to entering on 6 residents daily 3 days per week for 1 month, 6 residents daily 2 days per week for 1 month and 6 residents monthly x 2 months. Audit results will be discussed at monthly QAPI meeting. 5. Date of substantial compliance is March 22, 2018	

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F 550	Continued From page 3 - Observation of meal time on 02/12/18 and 02/13/18 showed Resident #52 seated at her table. Resident #27 positioned himself at the corner of the table next to and almost touching Resident #52. During an interview on 02/14/18 at 5:44 p.m., Resident #52 stated, Resident #27 always has to sit at the corner of the table and "almost sits on top of me." FAILURE TO KNOCK 2. Based on observation, review of facility policy, and resident interview, the facility failed to provide care in a manner and environment that maintained or enhanced, and respected each resident's dignity and privacy for 3 of 19 sampled residents (Resident A, Resident #40 and #11) and 2 random residents. Failure to knock on doors/announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Standards of Care" occurred on 02/15/18. This policy, dated October 2016, stated, Purpose: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. . . . Dignity: 2. Knock on the door prior to entering the resident's room. . . ." - Observation on 02/12/18 at 2:00 p.m. and 2:05	F 550		

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F 550	Continued From page 4 p.m. showed an unidentified Certified Nursing Assistant (CNA) entered two resident's rooms without knocking. - During a resident interview on 02/12/18 at 3:25 p.m., an interviewable resident (Resident A) stated staff do not always knock before entering the room and "will walk right into my bathroom when I am using the toilet." - On 02/13/18 at 10:20 a.m. during a resident interview, a bath CNA walked into Resident #40's room without knocking. - Observation on the afternoon of 02/13/18 showed Resident #11 seated in a wheelchair in his room. An unidentified CNA entered the resident's room without knocking/identifying himself.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 19 sampled residents (Resident #44). Failure to place Resident #44's call light within reach may result in an inability to call for help, increased falls, and/or incontinence.	F 558	F558-Reasonable accommodations 1. Resident #44 will be provided with call light that is within reach. 2. All residents residing and receiving care have the potential to be affected. Nursing and non-nursing staff are to make sure call lights are within reach of	3/22/18

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F 558	Continued From page 5 Findings include: Review of Resident #44's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis following a stroke and a history of falls. Resident #44's current care plan stated, ". . . ACTUAL FALLS R/T [related to] HX [history of] falls, poor balance and gait, right sided hemi-paresis secondary to CVA [cerebrovascular accident]. Frequently attempts to transfer self . . . Interventions . . . At times resident transfers self, encouraged to wait for assistance. . . . Encourage her to call for assist. . . . TOILETING: Res. requires limited assist of 1. Assist with incontinent products. . . . ADL [activities of daily living]/MOBILITY DEFICITS AEB [as evidenced by] right sided hemiparesis secondary to CVA . . . TRANSFERS: Assist of 1 with gait belt. . . ." Observation on 02/13/18 at approximately 8:30 a.m. showed Resident #44 seated in her wheelchair with a room tray in front of her. Her call light was located between the bed and the wall across the room from the resident. During a family interview on the morning of 02/13/18, observation showed Resident #44 seated in her recliner and the call light remained between the bed and the wall. A family member stated she has visited multiple times and found the resident's call light not within reach. The family member then took the call light and clipped it to the resident's recliner. Observation on the afternoon of 02/13/18 showed Resident #44 seated in her wheelchair	F 558	all residents. 3. Both written and verbal education have been provided to staff on 3-8-18. 4. The DON or designee will be responsible for monitoring of call light placement for 6 residents daily 3 days per week for 1 month, 6 residents daily 2 days per week for 1 month and 6 residents monthly for 2 months. Audit results will be discussed at monthly QAPI meeting. 5. Date of substantial compliance is March 22, 2018	

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F 558	Continued From page 6 by the TV, and the call light still clipped to her recliner, not within reach. Observation on 02/14/18 at 10:48 a.m. showed Resident #44 seated in her recliner and the call light lying on the bed, not within reach. During an interview on 02/15/18 at 11:12 a.m., an administrative nurse (#1) stated it is a standard of care that every resident has their call light within reach.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		3/22/18

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F 657	Continued From page 7 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS CONDUCTED ON 02/18/16 AND 02/16/17. Based on record review, facility policy review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 1 of 4 sampled residents (Resident #46) residing on the Memory Care Unit (MCU). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 02/15/18. This policy, dated September 2017, stated, "Purpose: To develop a person-centered care plan in conjunction with the Interdisciplinary team and resident/resident representative that reflects the actual care, condition, and preferences of each resident. . . . care plans will be updated and changes will be made as they occur to ensure the most current care plan for the resident. . . ." Review of Resident #46's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease. Medications included Aricept 5 milligrams (mg) daily. Resident #46's progress notes contained the following: *11/25/17 at 9:00 p.m.: "Resident yelling at staff,	F 657	F657-Care plan timing and revision 1. Resident #46 care plan was revised with specific behaviors and interventions. 2. All residents in memory care with behaviors and receiving care have the potential to be affected. Both written and verbal education have been provided to nursing staff on 3-8-18 regarding resident specific care planning. 3. DON will be responsible for directing staff in revising behavior care plans for residents in the memory care with behaviors. 4. The DON or designee will be responsible for reviewing and revising of behavior care plans in the memory care unit. MCU residents with behavior care plans will be monitored 1 per week for 1 month, biweekly for 2 months, 1x monthly for 2 months. Audit results will be discussed at monthly QAPI meeting. 5. Date of substantial compliance is March 22, 2018	

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F 657	Continued From page 8	F 657		

next door neighbor, people walking in the hall. Yelling that 'the lady needs to get the hell out!' . . ."
*12/03/17 at 8:30 a.m.: "Resident sat in hallway yelling at writer stating 'I am not ever taking a bath here again if you can't finish what you started' . . . Resident then refused all AM [morning] medication yelling at writer stating 'you couldn't do a bath right' . . ."
*12/03/17 at 9:00 a.m.: Late Entry: "Dining room staff and CNA [Certified Nurse Assistant] reported to writer that resident was upset in the dining room and that she was spitting food on the floor. Resident was asked to please stop and that her action [sic] were inappropriate. Resident continued to become more upset and spit. . . ."
*12/03/17 at 10:55 a.m.: "Resident did refuse AM medications but did then return to cart demanding them, only to refuse them once again. . . ."
*12/03/17 at 1:26 p.m. "Resident did take CNA's pen off of bucket and was slashing at people with pen. Staff did attempt to retrieve pen from resident and resident did come very close to biting CNA's arm. Pen was retrieved from resident but res [resident] did write on CNA's garbage bucket and on staff. . . ."
*12/06/17 at 6:54 p.m.: "Resident refused meds during shift. Also, assistance from staff at times. Resident stated, 'I don't want help from those dirty sneaks. I don't trust them.' . . ."
*12/11/17 at 4:04 p.m.: "Resident is having behaviors telling staff that her neighbor is a 'son of a bitch' d/t [due to] bathroom door being locked while neighbor was using bathroom. Resident is yelling in room and staff intervention has seemed to make the problem worse. . . ."
*12/16/17 at 5:37 p.m.: "Resident is packing up

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F 657	Continued From page 9	F 657		

her room, moving all the furniture, stripping the bed, is going home, not going to stay here, this started right after supper. . . . Resident swearing, calling staff liars, continues to pack room . . ."
*12/22/17 at 7:00 p.m.: "Refused supper, HS [bedtime] cares done and went to bed at 1800 [6 p.m.]. At 1900 [7 p.m.] up and dressed, propelling wheelchair within MC [Memory Care Unit] demanding that it is time to get up and go to breakfast, asking everyone what time is it, and gets angry when staff tell her that it is night time. . . ."
*01/14/18 at 5:47 p.m.: ". . . Wheelchair up against door at 1800 [6 p.m.], states, 'its staying there, I don't want any men in here' . . . "
*01/23/18 at 7:06 p.m.: "Starting at 635 [6:35 a.m.], Resident hollering and swearing at staff, to get [daughter's name] right now or I'm calling the sheriff, going up and down the hallway hollering for [daughter's name], attempted to get into the MCU kitchen, hit staff . . ."
*01/24/18 at 5:31 p.m.: "Starting at 1630 [4:30 p.m.] Hollering/swearing/demanding that the nurse needs to call her doctor, . . . refused to go to dining room for supper, or to have supper brought to her . . . Resident continued to holler and cry to get her doctor and get [daughter's name] until 1745 [5:45 p.m]. . . ."
*01/29/18 at 4:48 p.m.: "Resident approached by staff to come for supper. Resident slammed door in staffs face yelling 'I've already had supper and damn if I'm going to tell you where.' . . ."
*02/03/18 at 1:06 p.m.: "Resident refused to eat lunch, she was too upset about her daughter. . . ."
*02/07/18 at 8:42 a.m.: "Resident approached to take medications with AM meal. After taking Tylenol, Aricept and Norvasc resident stated

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F 657	Continued From page 10 'that's too many pills, my doctor told me I didn't need so many pills. I'm not taking any more.' Attempted to redirect with breakfast . . . Resident continued to refuse meds. . . ." *02/07/18 at 4:40 p.m.: "Resident yelling at all staff that they 'stole her cookies.' Resident also telling all staff that she called the sheriff on them. When writer approached resident multiple times resident continued to yell at all staff members. Resident then kicked writer in the leg while saying 'You sold the cookies to that girl and they sold them.' . . ." *02/09/18 at 3:26 p.m.: "Resident going up to staff demanding to know the way out, needs to get out and go home right now, calling staff names and swearing . . ." Resident #46's current care plan stated, "Focus: BEHAVIOR/WANDERING: Resident has been noted to refuse bathing. Resident does wander into other resident rooms at times . . . Follow resident's preferred, consistent routine as able. Mood and behavior monitoring per facility policy. Provide 1:1 visits for conflict resolution/problem solving/redirection as needed. Report changes in mood to practitioner and family. Signs placed on neighbor and residents door to orient her to her own room. RISK FOR ELOPEMENTS: elopement r/t [related to] confusion. No actual elopement attempts since admit. . . . apply alarm system, such as Wander-guard to reduce risk of elopement, . . . THOUGHT PROCESS: Resident is alert and oriented to person and place. She is confused and may not use call light appropriately. Resident scored 3 on the BIMS [Brief Interview for Mental Status] exam indicating severe cognitive impairment. Administer medication as ordered and monitor effectiveness	F 657		

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F 657	Continued From page 11 and side effects. Update practitioner as needed. Allow resident time to communicate. Anticipate and meet needs prn [as needed] . . . Consistent routine, caregivers, and environment as able. Keep call light within reach at all times when in room. Observe for changes in cognition. Assess physical/mental status for contributing factors. . . ." The plan of care was not revised to include additional approaches/interventions to respond to Resident #46's physical/verbal aggression. During an interview on 02/15/18 at 12:45 p.m., an administrative nurse (#1) stated she would expect staff to update the resident care plan to reflect current conditions. Lack of a consistent approach for staff to utilize to prevent the behavior from occurring and interventions to consistently implement when/if the behavior occurred placed both staff and residents at ongoing risk of being subjected to the behavior.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans 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: Based on observation, review of professional reference, and staff interview, the facility failed to ensure staff followed professional standards of practice during 1 of 1 observation of administration of rapid-acting insulin (Resident #50). Failure to administer rapid-acting insulin	F 658	F658-Services provided meet professional standards. 1. Resident #50 insulin regimen reviewed with nursing staff and a snack has been provided for resident after insulin administration.	3/22/18

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	355069	A. BUILDING _____ B. WING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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F 658	Continued From page 12 within 5-10 minutes of a meal may result in the resident experiencing hypoglycemia (low blood glucose). Findings include: Prescribing information for NovoLog insulin, found at www.novo-pi.com/novolog.pdf, stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm. . . ." Observation of insulin administration for Resident #50 occurred on 02/14/18 at 11:00 a.m. and showed a licensed nurse (#2) drew up 5 units Humalog insulin for Resident #50 and administered the insulin at 11:05 a.m. After receiving the insulin, Resident #50 propelled her wheel chair to a common area and sat watching the birds in the aviary. At 11:15 a.m., a staff member (#3) arrived and transported Resident #50 to her table in the dining room. Observation at 11:42 a.m. showed Resident #50 had not received any food and was dozing on and off at the table. At 11:44 a.m. an unidentified staff member asked the resident what she wanted to eat and at 11:50 a.m. staff brought her tray (45 minutes after she received the rapid-acting insulin). An interview with an administrative nurse (#1) occurred on 02/14/18 at 2:20 p.m. The staff member stated Resident #50 should have received food within 15 minutes of the insulin	F 658	2. All residents on rapid acting insulin have the potential to be affected. All residents on insulin were assessed. All residents on rapid acting insulin will be provided with a snack after insulin administration. 3. Graham crackers or juice are to be kept on treatment carts. Charge nurses are to provide snack after administration of rapid acting insulin. Written and verbal education provided to nursing staff on 2/22/18. 4. The DON of designee will be responsible for monitoring administration of fast acting insulin on 3 residents daily 3 per week for 1 month, 3 residents daily 2 per week for 1 month, 3 residents daily 1 per week for 1 month and 3 residents monthly for 2 months. Audit results will be discussed at monthly QAPI. 5. Date of substantial compliance is March 22, 2018	

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F 658	Continued From page 13 administration. This conflicts with the professional reference information which states ". . . within 5-10 minutes before a meal . . ."	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, information provided by the complainant, review of facility procedure, review of a professional reference, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 11 sampled residents (Resident #2, #35, and #36) observed during transfers and repositioning. Failure to use a gaitbelt and/or mechanical lift during transfers and repositioning placed Resident #2, #35, and #36 at risk of accidents and injury. Findings include: Information provided by the complainant indicated staff do not always use a gait belt during transfers. Review of the facility policy titled "Standards of Care" occurred on 02/15/18. This policy, dated October 2016, stated, . . . Safety: A gait belt will be used for assisted transfers and ambulation . . .	F 689	F689-Free of Accident Hazards/Supervision/Devices 1. Resident #2, #36 staff are to use gait belt with transfers. Resident #35 staff are to use the lift when repositioning. 2. All residents who need assistance with transfers/positioning have the potential to be affected. 3. 3/8/18 education for Nursing will include appropriate use of gait belts. Care Plans will be reviewed by nursing staff for residents who are lifts which need to be repositioned with lifts. 4. The DON or designee will be responsible for monitoring of proper gait belts use and repositioning for 6 residents daily 3 days per week for 1 month, 6 residents daily 2 days per week for 1 month and 6 residents monthly for 2 months. Audit results will be discussed at monthly QAPI meeting 5. Date of substantial compliance is	3/22/18

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F 689	Continued From page 14 "	F 689	March 22, 2018	

Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Inc., New Jersey, page 1054, stated, "Assisting a Client to Ambulate . . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ."

- Observation on 02/13/18 at 9:48 a.m. showed two Certified Nurse Assistant's (CNAs) (#7 and #8) assist Resident #2 with toileting. When Resident #2 was ready to stand, both CNA's (#7 and #8) reached under her arms and lifted her to a standing postition. The CNA's (#7 and #8) failed to use a gait belt during the transfer.

- Observation on 02/13/18 at 10:01 a.m. showed two CNAs (#7 and #8) assist Resident #36 with toileting. When Resident #36 was ready to stand, both CNA's (#7 and #8) reached under her arms and lifted her to a standing position. The CNA's (#7 and #8) failed to use a gait belt during the transfer.

During an interview on 02/15/18 at 12:45 p.m., an administrative nurse (#1) stated she would expect staff to use a gait belt during transfers.

- Observation on 02/14/18 at 5:16 p.m. showed two CNAs (#5 and #6) used a full body mechanical lift to transfer Resident #35 from the bed to the wheelchair. The resident requested to be repositioned in the wheelchair. Both CNAs (#5

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F 689	Continued From page 15 and #6) reached under her arms and lifted her to reposition her in the chair. The CNA's (#5 and #6) failed to use the full body mechanical lift to reposition Resident #35. During an interview on 02/15/18 at 12:24 p.m., an administrative nurse (#1) stated she expected staff to use the lift to reposition Resident #35 in her wheelchair.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 02/16/17. Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to provide respiratory care consistent with standards of practice and physician's orders for 2 of 7 sampled residents receiving oxygen (Resident #24 and #44). Failure to ensure oxygen is administered as ordered and change oxygen tubing per policy may complicate a resident's respiratory status. Findings include:	F 695	F695-Respiratory/Tracheostomy Care and Suctioning 1. Resident #24 and #44 nursing order was implemented in treatment record to change oxygen tubing weekly. Resident #24 education to nursing staff resident is on continuous oxygen. 2. All resident who use oxygen have the potential to be affected. All resident who are on oxygen were assessed. 3. Residents who are prescribed oxygen will have nursing orders to change oxygen tubing in treatment record weekly. Dating of oxygen tubing to be implemented. Written and verbal	3/22/18

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F 695	Continued From page 16 Review of the facility policy titled "Oxygen Use & Storage" occurred on 02/15/18. This policy, revised February 2018, stated, ". . . Oxygen will be administered per practitioner orders via an oxygen concentrator, portable marathon unit, or wall oxygen. . . . Cleaning of Concentrator . . . The tubing is changed weekly by the MA/TMA [medication aide/certified medication aide] or nurse. . . . Marathon Portable Units/Liquid Oxygen . . . Hold the strap on the back of the portable unit and push the bottom back side until it is vertical. The green indicator should fill the window, indicating the fill level. . . . Set the order liter flow. . . . The tubing is changed weekly by the MA/TMA or nurse. . . ." - Review of Resident #44's medical record occurred on all days of survey. Diagnoses included lung cancer. Current physician's orders included continuous oxygen at 3 liters per minute (lpm) via nasal cannula. Observation on 02/13/18 at 9:09 a.m. showed Resident #44 seated in her wheelchair and wearing oxygen via nasal cannula. The portable oxygen tank was set to a demand flow (not continuous) of 3 liters per minute (lpm). During a family interview on the morning of 02/13/18, a family member identified the oxygen flow is supposed to be set a 3 lpm continuous, and she has found Resident #44's portable oxygen tank empty 3-4 times. The family also expressed concerns that staff did not change her oxygen tubing regularly. Observation showed the oxygen tubing was not dated, and review of Resident #44's medical record lacked evidence of oxygen tubing changes.	F 695	education provided to all nursing staff on 3/8/18. 4. The DON or designee will be responsible for monitoring of oxygen tubing being dated and liter flow for 6 residents daily 3 days per week for 1 month, 6 residents daily 2 days per week for 1 month and 6 residents monthly x 2 months. Audit results will be discussed at monthly QAPI meeting 5. Date of substantial compliance is March 22, 2018	

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F 695	Continued From page 17 During an interview on 02/14/18 at 4:29 p.m., an administrative nurse (#1) stated staff should document tubing changes on the treatment administration record (TAR). - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included heart disease, congestive heart failure, presence of cardiac pacemaker, and respiratory failure. Review of a physician order, dated, 02/09/17, identified continuous oxygen at 2 liters per nasal cannula. Review of Resident #24's January 2018 and February 2018 TAR lacked documentation of the oxygen tubing changes. During an interview on 02/15/18 at 12:45 p.m., an administrative nurse (#1) verified the TAR for Resident #24 did not include changing of the oxygen tubing weekly.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		3/22/18

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F 725	Continued From page 18 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, information provided by the complainant, resident, and family interview, the facility failed to ensure sufficient staff available to promptly respond to residents' call lights for 1 of 1 complaint resident (Resident C), 5 of 7 residents attending the group interview (Resident E, F, G, H, and I) and 2 of 6 resident interviews (Resident B and D) and 1 of 3 family interviews (Resident #44's family). Failure to promptly respond to resident calls for assistance may result in residents experiencing falls and/or incontinence. Findings include: - Information received from the complainant identified concerns with call lights not functioning and/or slow response from staff. The complainant indicated, on 08/05/17, Resident C's call light was not functioning. The complainant stated staff did come in the room and determined it wasn't working. The complainant stated the call light	F 725	F725-Sufficient Nursing Staff 1. Residents #44 call light was placed within her reach of her at all times. In an effort to assist nursing, all staff have been given the expectation that call lights are to be answered and resident□s expectations met. Maintenance has inspected all call lights and they are in working order. All residents who need assistance and able to use the call light have the potential to be affected. 2. Call lights will be left within reach of residents. There will be increased utilization of all non-nursing and nursing staff working are to answer call lights to address and/or communicate needs of residents. All staff were educated and provided with written expectations to leave call lights on until resident□s needs are met on 3-8-18. Staff will answer call lights and communicate with resident so they know what they can expect from	

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F 725	Continued From page 19 remained malfunctioning until the early afternoon of 08/09/17. That evening the complainant stated she waited 32 minutes for staff to answer and; on the morning of 08/10/17 waited 42 minutes and in the afternoon 26 minutes. On 08/13/17 (no time identified) she waited 34 minutes for staff to respond to the call light. - During an interview on 02/12/18 4:50 p.m., Resident B stated she has waited up to 30 minutes for staff to respond to her call light and was incontinent once due to waiting. She stated the facility is short staffed and wishes staff would be "more attentive." - During an interview on the morning of 02/13/18 Resident D stated he has waited up to one hour and 30 minutes for staff to respond to the call light. - During a group interview on 12/13/18 at 1:00 p.m., residents identified the following concerns regarding staffing/call lights: *Resident E: waits a half hour to over an hour at times for the call light to be answered, staff "have a habit of coming in and saying 'we'll be here in a minute' and shut it off, and then don't come back for an hour." The resident stated this happened again recently when he was in the bathroom. Resident E further identified if a resident calls during the supper hour nobody is around *Resident F: her call light has been on and staff just walk right by *Resident G: staff walk by and don't answer lights, he was left on toilet so long "my legs go numb," he also stated he has used his cell phone to call for help from the bathroom. *Resident H: Staff leave her in the bathroom	F 725	their nursing staff and when the staff will be back to meet their needs. 3. DON or designee will monitor call lights x 20 residents weekly for 1 month, 15 residents weekly for 1 month, and 10 residents weekly for 1 month. Audits to be discussed in monthly QAPI meeting. 4. Substantial compliance is March 22, 2018	

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F 725	Continued From page 20 even if her light is on, she frequently has to wait a half hour or more for help, her call light is on and staff just walk by *Resident I: Staff leave her in the bathroom, shut off her call light and say they will come back but they don't, she has had to wait 30-40 minutes. - During a family interview on the morning of 02/13/18, Resident #44's family member stated they have waited 35-40 minutes for call lights to be answered, and it happens mostly in the evening/late evening. The family member also stated she has visited on multiple occasions to find Resident #44 taking herself to the bathroom, even though her call light is on. The family member stated, "Sometimes you can't wait." The family member further stated staff will walk by the room and look at the call light, but do not answer it if they are not assigned to that resident.	F 725		