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 _____	02/18/2016

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 02/16/16 and completed on 02/18/16, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
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		3/24/16

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

Electronically Signed | 03/11/2016

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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 investigate an injury of unknown origin for 1 of 3 residents (Resident #17) discharged from the facility. Failure to investigate an injury of unknown origin placed Resident #17 and other residents at risk for further injury, and did not enable the facility to determine causative factors for the injury and/or implement corrective action. Findings include: Review of the facility policy titled "Accident and Incident Reports" occurred on 02/18/16. This policy, dated 01/19/15, stated, ". . . Assessment of . . . pain . . . swelling, or abnormalities should be included with initial assessment. . . . Notify the resident's physician . . . Notify the family according to family's request . . . Complete the Incident Report . . . Note the . . . exact circumstances of the incident. . . . Obtain a descriptive statement for Incident Form from the resident involved. . . ."	F 225	1. Resident #17 with a burn was discharged on November 30, 2015. 2. All residents with burns or injury have the potential to be affected. 3. Nursing staff have been educated on the need to notify nurse of resident injuries, complete an incident report, and complete an appropriate assessment. Nursing staff will report appropriately, monitor, investigate and notify physician and families as identified. Significant change assessments, including updating care plans will be completed as needed. Education on these interventions as well as supporting documentation to changes to care plan will be completed with nurses by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of resident injuries, assessment and nursing documentation	

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F 225	Continued From page 2 Review of Resident #17's medical record occurred on February 17-18, 2016. Diagnoses included cerebral infarction (stroke) and history of transient ischemic attacks (TIAs), aphasia, hemiplegia, and pain. The quarterly Minimum Data Set (MDS), dated 09/16/15, identified problems with short term memory, moderate independence with daily decisions, and extensive assist of one or more persons required for all activities of daily living (ADLs) except eating. The medical record indicated Resident #17 was "able to make simple decisions regarding her daily routine, but [had] a guardian in place for important health and financial decisions." The progress notes identified the following: * 11/02/15, "Bath done today. Has red burn like area to chest and right breast. When asked if resident was drinking something HOT - she agreed. Will continue to monitor area." * 11/04/15, "FOLLOW up: Res [resident] reddened area to chest has significantly improved in past 2 days. It is more of a pink area and the surface area has lessened also. Res denies pain. Will continue to monitor for improvement." * 11/09/15, "Bath done today. Burn to chest is significantly smaller. Now the size of 2-3 cm [centimeter] diameter. Left area OTA [open to air]. No other concerns." * 11/16/16, "Bath and body audit done today bruise to right shin. No other skin concerns noted." The progress notes failed to identify if/when Resident #17's physician and/or family were notified of the burn. The November 2015 "Treatment Administration	F 225	to ensure resident care is complete through monitoring and communication will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 225	Continued From page 3 Record" (TAR) both identified, "Reddened area to chest and right breast [Burn] Monitor daily until healed, every evening shift for SKIN CARE." The TAR indicated the monitoring began on 11/03/15, and ended on 11/21/15. The medical record indicated nursing staff continued to monitor Resident #17's chest/right breast for an additional five days following the bath and body audit which identified "no other skin concerns." Resident #17's most recent care plan failed to address the burn staff identified on 11/02/15. The medical record lacked evidence of an assessment (description/size of wound and pain level), an investigation including the exact circumstances of the incident/possible causative factors for the burn to Resident #17's chest/right breast, and/or any corrective actions the facility implemented. The facility failed to provide the incident report and/or skin assessments related to Resident #17's burn as requested by this surveyor. During interviews on 02/18/16 at 12:30 p.m., 1:16 p.m. and 1:29 p.m., when asked if any other residents in the facility experienced a burn, an administrative staff member (#2) stated, "Not that I can recall." She then added, "I don't remember [Resident #17's] burn either." The administrative staff member (#2) confirmed the facility failed to investigate the causative factors of Resident #17's burn, stating, "Her skin was red, and she said 'Yes' to a spill." She also confirmed the facility failed to complete an incident report and update the resident's care plan.	F 225		
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS	F 274		3/24/16

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F 274 SS=D	Continued From page 4 AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 2 of 14 sampled residents (Resident #4 and #13) within 14 days after a significant change occurred in the residents' physical or mental condition. Failure to complete a SCSA in response to the resident's improvement or decline limited the facility's ability to accurately assess each resident's status, identify, and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility Resident	F 274	1. Residents #4 and #13 have been assessed for significant changes in status and have been addressed. Resident #13 did not require a significant change in status MDS related to her diagnosis of Alzheimer's disease and due to her fluctuation in amount of ADL assistance and incontinence. Resident #4 did not require a significant change due to incorrect charting. 2. All residents with a change in status have the potential to be affected. 3. All residents triggering a significant change in condition will be reviewed at IDT (Interdisciplinary Team Meeting) and significant change in status assessment	

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F 274	Continued From page 5 Assessment Instrument 3.0" User's Manual, October 2015, pages 2-20 and 2-23 states, ". . . A 'significant change' is a decline or improvement in a resident's status that . . . Will not normally resolve itself without intervention . . . (for declines only) . . . Impacts more than one area of the resident's health status . . . Requires interdisciplinary review and/or revision of the care plan. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, hypertension, edema, shortness of breath, osteoarthritis, and pain. Resident #4's annual Minimum Data Set (MDS), dated 10/06/15, identified independent for locomotion on the unit and supervision required for locomotion off the unit. The quarterly MDS, dated 01/06/16, indicated a decline in these areas; with extensive assistance of two or more persons required for locomotion on/off the unit. The record lacked evidence staff completed a SCSA following Resident #4's decline in two areas of functional status. - Review of Resident #13's medical record occurred on February 17-18, 2016. Diagnoses included Alzheimer's disease, osteoarthritis, osteoporosis, and edema.	F 274	MDS completed in 14 days. Appropriate follow-up within 14 days of significant physical or mental change to be documented as a progress note and changes made to care plan as needed. This will be completed by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of residents with significant change in condition, assessment and nursing documentation and monitoring for SCSA MDS completion will be monitored and completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 274	Continued From page 6 Resident #13's quarterly Minimum Data Set (MDS), dated 10/15/15, identified extensive assistance of two or more persons required for dressing and personal hygiene. The annual MDS, dated 01/15/16, indicated an improvement in these areas; with supervision required for dressing and personal hygiene. The record lacked evidence staff completed a SCSA following Resident #13's improvement in two areas of functional status. During interview on 02/18/16 at 1:16 p.m., an administrative staff member (#2) confirmed staff failed to complete SCSAs on Resident #4 and #13.	F 274		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		3/24/16

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 5 of 14 sampled residents (Resident #4, #6, #7, #8, and #14). Failure to ensure the care plans reflected the residents' current status limits staff's ability to ensure continuity of care. Findings include: Review of the facility policy titled "Care Plans" occurred on 02/18/16. The policy, revised 05/20/13, stated, "Purpose: To develop a care plan as a workable tool that reflects the actual care and condition of each resident. Policy: . . . The Master Care Plan (MCP) will be completed by the 14th day after admission and will be reviewed and updated monthly and as needed. . . ." - The medical record for Resident #7, reviewed on all days of survey, identified diagnoses including insomnia. The record showed staff administered Ambien (a hypnotic to aid sleep) 2.5 milligrams nearly daily from 11/20/15 until 12/07/15, when the physician discontinued the medication. The resident's current care plan, dated 11/20/15, stated, "The resident is on hypnotic therapy r/t [related to] insomnia. . . ." Staff failed to update the resident's care plan when the physician discontinued the hypnotic medication.	F 280	1. Residents #4, #6, #7, #8, and #14 care plans were assessed for accuracy and updated. 2. All residents have the potential to be affected. Care plans are reviewed to ensure accuracy and updated as needed. Changes to the care plans are made when the need is identified. 3. Care Plans are reviewed and revised on admission, quarterly, annually as well as on every change of condition for each resident. Changes to the care plan will to be communicated to the appropriate staff and implemented immediately. Staff will ensure the care plan accurately reflects the resident□s current condition. Education will be completed for Nurses, CNA□s by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of Care Plan Process to accurately reflect the current condition of the residents will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to	

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F 280	Continued From page 8 - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, osteoarthritis, and pain. Resident #4's current care plan identified, ". . . NUTRITION . . . 2 eggs daily at breakfast. . . ." A progress note, dated 06/10/15, identified, ". . . Res [Resident] does not receive eggs d/t [due to] allergy. . . ." Resident #4's current care plan failed to reflect her egg allergy as identified on 06/10/15. During interview on 02/18/16 at 1:16 p.m., an administrative staff member (#2) confirmed staff failed to update Resident #4's care plan. - Review of Resident #6's medical record occurred on February 16-17, 2016. The current care plan stated, ". . . Nectar thick liquids with all medication passes, Date Initiated 09/04/2014 . . . 09/19/2014 Release signed by family for res. to have thin liquids . . . Family visits often (. . . brother is also a resident here) . . ." The resident's current certified nursing assistant [CNA] care card (used by CNAs to direct resident care) stated, ". . . 09/19/2014 Release signed by family for res. to have thin liquids . . . Nectar thick liquids with all medication passes . . ." Review of the physician's orders, dated 10/21/14, stated, "Regular diet, Thin consistency . . ." During an interview on 02/17/16 at 9:35 a.m., a nurse (#15) stated Resident #6 drinks thin	F 280	monitor the correction.	

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F 280	Continued From page 9	F 280		

liquids, including with medications.

Review of Resident #6's brother's closed medical record identified the resident discharged from the facility on 02/03/16.

The facility failed to update the care plan when Resident #6's fluids changed to thin consistency and when the resident's brother was discharged from the facility.

- Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, ". . . Chronic clinical condition . . . 1200 ml [milliliter] fluid restriction, Date Initiated: 10/23/2015 . . . Nutrition: Res has dx [diagnosis] anemia, CKD [chronic kidney disease], constipation, unstageable to [left] lateral foot . . . Goal: Res will maintain adequate nutritional status as evidenced by showing no s/s [signs or symptoms] of malnutrition and consuming 50% or [greater] of meals through next review . . . Interventions . . . Fiber Juice 4 oz [ounces] daily . . . Med Pass 2.0 4 oz TID [three times daily] between meals . . . Regular diet with 1500 cc [cubic centimeter] Fluid Restriction, Date Initiated: 10/28/2015 . . ." The CNA ADL care plan stated, ". . . 1200 ml fluid restriction . . . Fiber Juice 4 oz daily . . . Med Pass 2.0 4 oz TID between meals . . . Regular diet with 1500 cc Fluid Restriction . . ."

Review of the physician's orders identified the following:
*10/20/15, "Clarification on fluids, 1200 ml fluid restriction."
*10/27/15, "Increase fluid restrictions to 1500 cc."
*11/02/2015, "Protein powder 1 scoop BID [twice

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F 280	Continued From page 10 daily] with meals." *02/03/2016, "Arginaid 8 oz daily with noon meal." Review of Resident #8's weights identified the resident lost 21 pounds since admission (13.4% in approximately 3.5 months). The facility failed to identify the resident's severe weight loss and include the dietary interventions of Arginaid daily and protein powder twice a day on the resident's care plan. The facility failed to remove the 1200 ml fluid restriction order after adding the new order to increase fluid restrictions to 1500 mls daily. - Review of Resident #14's medical record occurred on February 18, 2016. The current care plan stated, ". . . Greek yogurt daily at breakfast, Date Initiated 09/09/2015 . . ." The current CNA ADL care plan stated, ". . . Greek yogurt daily at breakfast . . ." A dietary progress note, dated 09/21/15, stated, "Res dislikes Greek yogurt. Will d/c [discontinue]." The facility failed to remove Greek yogurt from Resident #14's care plan.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		3/24/16

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F 281	Continued From page 11 Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure administration of insulin occurred within the ordered/recommended times for 1 of 2 sampled residents (Resident #19) observed during insulin administration. Failure to administer Humalog (a rapid-acting insulin) at the correct time may result in low blood sugar levels (hypoglycemia) for all diabetic residents residing at the facility. Findings include: "Nursing 2015 Drug Handbook," 35th edition, Wolters Kluwer, Philadelphia, pages 759-762, stated the following, ". . . NovoLog . . . Give NovoLog 5 to 10 minutes before start of meal. . . ." Review of the facility policy titled "Injections/Insulin" occurred on 02/18/16. This undated policy, stated, ". . . Novolog (sic)- Give 5-10 minutes before eating. . . ." Observation of medication pass on 02/17/16 at 4:45 p.m., showed a nurse (#4) administered three units of NovoLog insulin to Resident #19. The resident received her meal at 5:55 p.m. (65 minutes after the insulin administration). Facility staff failed to ensure Resident #19 received a nourishment (carbohydrate) or meal within 5-10 minutes of rapid-acting insulin administration. This may result in unstable blood sugar levels for Resident #19 and other insulin dependent residents in the facility.	F 281	1. Resident #19 will be administered Insulin according to ordered/recommended times. 2. All residents with orders for Insulin have the potential to be affected. 3. Nursing staff have been educated on administering insulin at prescribed/recommended times or providing appropriate nutrition. Education completed by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of Insulin administration will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		3/24/16

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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 309	Continued From page 12 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure staff followed physician's orders for 1 of 2 sampled residents (Resident #8) on a fluid restriction. Failure to follow fluid restriction orders may result in an exacerbation of residents' symptoms. Findings include: Review of Resident #8's medical record occurred on all days of survey and diagnoses included chronic kidney disease, hypo-osmolality (low levels of electrolytes, proteins and nutrients in the blood) and hyponatremia (low sodium in the blood). The current care plan stated, ". . . Chronic clinical condition/hypo-osmolality and hyponatremia . . . 1200 ml [milliliter] fluid restriction (incorrect - refer to F280), Date Initiated: 10/23/2015 . . . Nutrition: Res [resident] has dx [diagnosis] anemia, CKD [chronic kidney disease] . . . Regular diet with 1500 cc [cubic centimeter] Fluid Restriction, Date Initiated: 10/28/2015 . . ." The certified nursing assistant (CNA) activities of daily living (ADL) care plan stated, ". . . 1200 ml fluid restriction	F 309	1. Resident #8, physicians order for changes in fluid restrictions were reviewed and care plan was updated. 2. All residents with Physicians orders for fluid restrictions have the potential to be affected. 3. Nursing staff have been educated on the need to follow physician orders and make changes to care plans as orders change and with documentation of fluid intake reflecting changes. Education on these interventions as well as supporting documentation will be completed with nurses by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of physician orders for fluid restrictions and nursing documentation to ensure physician orders are followed and communicated through changes in Care Plans will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months, 4 times/month for 3 months	

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	355069	A. BUILDING _____ B. WING _____	02/18/2016

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F 309	Continued From page 13 (incorrect - refer to F280) . . . Regular diet with 1500 cc Fluid Restriction . . ." Review of the physician's orders identified the following: *10/20/15, "Clarification on fluids, 1200 ml fluid restriction." *10/27/15, "Increase fluid restrictions to 1500 cc." *10/27/15, "Fluid Restriction: Nursing to give 120 ml with each medication administration et [and] dietary to give 370 ml with each meal. Three times a day." Review of Resident #8's October 2015 through February 2016 Medication Administration Records (MARs) identified nursing staff documented the amount of fluid given to the resident with his medications. Documentation identified the resident received 120 mls of fluids three times daily with most medication passes. Review of fluid intake reports from October 2015 through February 2016 identified the resident received more than 1500 mls of fluids on 14 days, ranging from 1540 to 2200 mls per day. During an interview on 02/18/16 at 12:22 p.m., when asked if the nurses enter the amount of fluid given to Resident #8 during medication pass into the separate fluid intake section of the electronic medical record, an administrative nurse (#2) stated she "thinks everyone is doing it differently." She stated some nurses just chart the fluid intake during medication administration on the MAR while others chart it in the fluid intake section of the electronic medical record, as well.	F 309	and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		3/24/16

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F 312 SS=D	Continued From page 14 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interview, the facility failed to provide the necessary assistance for 3 of 14 sampled residents (Resident #6, #8, and #11) to maintain grooming and nutrition. Failure to provide assistance as needed resulted in Resident #11 eating with his fingers and Resident #6 and #8 to be un-groomed. Findings include: Review of Resident #11's medical record occurred on February 17-18, 2016. Diagnoses included Alzheimer's disease. The care plan stated, "ADL [activities of daily living] . . . EATING: Independent with set up to supervision . . . " Observation on 02/16/16 from 4:55 to 5:35 p.m. showed Resident #11 seated in the dining room for his evening meal. The resident held silverware wrapped in a napkin in his left hand and ate his meal with his right hand. The meal included pureed pizza, pureed chocolate cake, and a broccoli/cauliflower salad (regular consistency). Facility staff failed to assist Resident #11 with his silverware.	F 312	1. Residents #11, #6, and #8, will be provided with assistance with ADLs, grooming and with meals. 2. All residents requiring assistance with ADLs have the potential to be affected. 3. All CNA□s & Nurses will be re-educated on the need to provide grooming, personal hygiene care, dining assistance, and overall cleanliness. Education will be completed by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of proper ADL care related to grooming, personal hygiene and assistance with meals for residents will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 312	Continued From page 15 Observation on 02/17/16 at 5:10 p.m. showed Resident #11 seated in the dining room and eating his evening meal with his fingers. The meal included a pureed biscuit, turkey gravy, and chocolate peanut butter pudding. Facility staff failed to assist Resident #11 and encourage the use of silverware. - Observation during the week of survey showed excessive facial hair on Resident #6's face and neck. Review of Resident #6's current care plan stated, ". . . Personal hygiene: Extensive assist of 1. Will participate with washing hands and face and upper body with cuing and encouragement . . ." During an interview on 02/18/16 at 10:00 a.m., Resident #6 stated he prefers to be clean shaven but it is difficult for him to shave himself. - Observation during the week of survey showed excessive facial hair on Resident #8's face and neck. Review of Resident #8's current care plan stated, ". . . Personal hygiene: Extensive assist of one. Encourage resident to wash own face and hands . . ." During an interview on 02/17/16 at 5:15 p.m., a family member of Resident #8's stated staff do not shave Resident #8 very often and identified he is use to being clean shaven. During an interview on 02/18/16 at 10:20 a.m., an administrative nurse (#3) stated she expected	F 312		

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F 312	Continued From page 16 certified nursing assistants to check daily if residents need assistance with shaving.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary treatment and services to prevent pressure ulcers for 1 of 6 sampled residents (Resident #9) with current/healed pressure ulcers. Failure to implement preventative measures may result in the reoccurrence or deterioration of pressure ulcers. Findings include: Review of Resident #9's medical record occurred on all days of survey. Diagnoses included a history of pressure ulcers to both heels and buttocks. Resident #9's current care plan stated, ". . . Prevalon boots [a type of pressure-relieving boot] to be worn when in bed . . . Reposition every 2 hours . . ." Current physician's orders included:	F 314	1. Resident #9 will be evaluated for the proper application of boots, turning and repositioning program to prevent new development of pressure ulcers and the reoccurrence of healed pressure ulcers. 2. All residents at risk for skin breakdown have the potential to be affected. 3. All residents at risk for skin breakdown will be evaluated for the need of a turning and repositioning program. Individualized programs will be implemented as needed. Education on prevention and treatment of pressure sores will be completed with nursing staff by March 24, 2016. 4. Date if correction is March 24, 2016. 5. Auditing of resident application of	3/24/16

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F 314	Continued From page 17 *(Start date 01/05/16): "Apply A&D ointment [a skin protectant cream] to buttocks with pericares [perineal care] and prn [as needed]. Every morning and at bedtime for excoriation. *(Start date 09/02/15): "Prevalon boot to bilateral feet at all times. Every shift for pressure ulcer." (This order conflicts with the care plan which states Prevalon boots when in bed.) Observation on 02/17/16 at 9:13 a.m. showed Resident #9 in bed with Prevalon boots on both feet. Two certified nursing assistants (CNAs) (#5 and #9) removed Resident #9's boots and assisted her with morning cares. Observation showed the CNAs failed to apply A&D ointment with perineal cares and failed to reapply or offer the Prevalon boots to Resident #9. The CNA (#9) transferred Resident #9 to her wheelchair, where she remained until a CNA (#9) assisted her to lie down at 2:08 p.m. (approximately four and a half to five hours later). Staff failed to offer repositioning every two hours as care planned. Observation on 02/18/16 at 8:50 a.m. showed Resident #9 in bed with Prevalon boots on both feet. A CNA (#9) removed the boots and assisted Resident #9 with morning cares. Observation showed the CNA failed to apply A&D ointment with perineal cares and failed to reapply or offer the Prevalon boots to Resident #9. During an interview on 02/17/16 at 1:37 p.m., a nursing staff member (#4) identified the CNAs are responsible for applying the A&D ointment and stated the staff apply it in the morning and evening "after the resident has been washed up." Review of Resident #9's treatment administration	F 314	boots, turning and repositioning programs being followed will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 314	Continued From page 18 record (TAR) for February 2016 identified the following treatments: *Apply A&D ointment to buttocks with pericares and prn *Prevalon boot to bilateral feet at all times Review of the TAR identified nursing staff members signed off the TAR for the above interventions on the morning/afternoon of 02/17/16, although observation showed staff failed to provide these interventions. Failure to consistently implement pressure ulcer prevention measures as ordered/care planned for Resident #9 may result in the reoccurrence or new development of pressure ulcers.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/25/15. Based on observation and record review, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #5) observed during PAL lift (a sit-to-stand mechanical lift) transfers.	F 323	1. Butt sling will be used with all transfers when using a PAL lift for resident #5. 2. All residents requiring assistance with transfers using a PAL lift have the potential to be affected. 3. Education for nursing staff on the use	3/24/16

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F 323	Continued From page 19 Failure to ensure proper use of the PAL lift may result in avoidable accidents, falls, and injuries. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 12/03/15, identified extensive assistance from one person for transfers. Resident #5's current care plan and certified nursing assistant (CNA) care card (used by CNAs to direct resident care) identified, "Pal lift with butt sling and 1 assist for transfer." Observations during the survey showed the following: *02/16/16 at 5:15 p.m.: Two CNAs (#10 and #11) transferred Resident #5 from her bed, to the toilet, and the to her wheelchair using a PAL lift without the butt sling in place. Observation showed the resident's knees bent and shoulders shrugged upward. *02/17/16 at 9:58 a.m.: A CNA (#12) transferred Resident #5 from her bed, to the toilet, and then to her wheelchair using a PAL lift without the butt sling in place. Observation showed the resident's knees bent and shoulders shrugged upward. *02/17/16 at 4:45 p.m.: A CNA (#9) transferred Resident #5 from her bed, to the toilet, and then to her wheelchair using a PAL lift without the butt sling in place. Observation showed the resident's knees bent and shoulders shrugged upward. Failure to transfer Resident #5 according to her care plan may result in an avoidable fall and/or injury.	F 323	of a butt sling for the PAL lift with transfers will be completed by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of butt sling usage with PAL lift for resident transfers will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		3/24/16

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F 325 SS=D	Continued From page 20 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure adequate interventions to prevent weight loss and maintain an acceptable nutritional status for 2 of 2 sampled residents (Resident #1 and #5) identified with severe weight loss. Failure to initiate timely and effective interventions, re-evaluate and modify the interventions as needed, and consistently implement existing interventions resulted in severe weight loss for Resident #1 and #5. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The current Minimum Data Set (MDS), dated 12/03/16, identified severe cognitive impairment and extensive assistance from one person for eating.	F 325	1. Residents #1 and #5 identified with weight loss have been reassessed, weekly weights monitored and care plans have been reviewed and updated as appropriate. 2. All residents who have experienced weight loss have the potential to be affected. 3. Weights, supplement intake and refusals will be monitored weekly. Education to be provided to all nursing and dietary staff regarding following the tray card, assuring appropriate foods and supplements are provided as ordered, weekly weights are monitored and care plan changes made as necessary by March 24, 2016. 4. Date of correction is March 24, 2016.	

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F 325	Continued From page 21 Current physician's orders identified the following: *(Start date 12/09/15): "Benecalorie 1.5 oz [ounces] daily at breakfast" *(Start date 01/04/16): ". . . diet . . . Continue to encourage peanut butter bread." Resident #5's weights showed the following: *02/03/16 (most recent weight obtained): 115 pounds (lbs) *01/13/16: 120 lbs *12/16/15: 126 lbs *11/11/15: 130 lbs *10/12/15: 126 lbs *09/14/15: 128.5 lbs *08/03/15: 134 lbs *This represents a 14 pound weight loss in 6 months (10.5 percent (%)), i.e. a severe weight loss. Nutrition notes stated the following: *02/17/16 at 2:10 p.m.: "Most recent weight 115# [pounds] (2/3/16). Res [resident] needs recent weight. . . ." *02/08/16 at 11:52 a.m.: ". . . Weight 115# (2/3/16). . . . Weight has dropped over the past month which could be r/t [related to] increase of Synthroid [a medication for hypothyroidism]. She continues to receive Carnation Instant Breakfast with meals, Ice Cream with noon and supper meals as well as PM [afternoon] snack, Boost Glucose Control 4 oz BID [twice a day] between meals, Benecalorie 1.5 oz daily at breakfast, and peanut butter and jelly sandwich daily with noon and supper meals. Will continue to offer and encourage high calorie foods/fluids and encourage intakes. . . ." *02/03/16 at 3:28 p.m.: ". . . Most recent weight	F 325	5. Auditing of resident weights and nutritional intake with appropriate documentation and changes to care plan will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 325	Continued From page 22 120# (1/13/16). Meal intakes averaged 12% over the past week. Res needs a recent weight. . . ." *01/22/16 at 12:33 a.m.: ". . . Encourage use of peanut butter as resident does not eat many meats or veggies. . . ." *12/09/15 at 3:03 p.m.: ". . . Weight 121.5# (12/2/15). Meal intakes over the past week averaged 19%. . . . Will offer Benecalorie 1.5 oz daily at breakfast d/t [due to] weight loss. . . ." *10/28/15 at 2:29 p.m.: ". . . Weight 124# (10/26/15). Meal intakes 33% over the past week. Will re-start Boost Glucose Control 4 oz BID and monitor for acceptance. . . ." *09/02/15 at 2:36 p.m.: ". . . Weight 129# (8/21/15). . . . She enjoys ice cream with chocolate syrup. Suggest to offer her ice cream with noon and supper meals. . . . ." *08/12/15 at 2:34 p.m.: ". . . Weight 134# (8/10/15). Res has been typically refusing Boost supplement. Will d/c [discontinue] at this time and monitor weights. . . ." Review of Resident #5's care plan identified "Weekly weights," "Boost Glucose Control 4 oz BID," "Carnation Instant Breakfast with meals," and "Offer peanut butter and peanut butter sandwiches," but did not include a care plan specific to weight loss and failed to identify specific weight loss interventions of ice cream with the noon and evening meals and afternoon snack, Benecalorie at breakfast, and peanut butter and jelly sandwiches with the noon and evening meals. Observation on 02/16/16 at 8:13 a.m. showed Resident #5 asleep in bed. A nursing staff member (#4) entered the resident's room to check her blood glucose level. The staff member	F 325		

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F 325	Continued From page 23	F 325		

asked, "Are you ready to get up for breakfast?" Resident #5 replied, "Yes, I am," and "I'm hungry." Observation showed Resident #5 remained in bed until 9:58 a.m. (almost two hours later), when a certified nursing assistant (CNA) (#12) assisted her with morning cares. The CNA asked, "Are you hungry?" and the resident replied, "Ya. I didn't get nothing to eat today." The CNA finished morning cares and took the resident to the dining room. Observation showed staff served the resident bread with jelly on it, but failed to offer Resident #5 peanut butter.

Resident #5's Treatment Administration Record (TAR) for February 2016 included the intervention of "Boost Glucose Control two times a day 4 oz." The TAR lacked a place to document how much of the supplement Resident #5 consumed each day. On 02/18/16 at 12:23 p.m., a nursing staff member (#4) stated the universal worker passes the Boost to Resident #5 twice a day, and then lets nursing staff know how much she drank.

On the afternoon of 02/17/16, a universal worker (#13) identified she offered the Boost to Resident #5 but she refused to drink any of it. Review of Resident #5's TAR identified nursing staff documented a "check mark" for the Boost at 3:00 p.m. The staff failed to identify Resident #5's refusal, and the TAR lacked documentation of the amount of supplement consumed by Resident #5. Failure to correctly document resident supplement intakes and/or refusals of supplements may result in an inaccurate description of Resident #5's intakes, and may delay initiation of additional weight loss interventions.

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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 325	Continued From page 24 Review of Resident #5's dietary tray card identified: "Peanut butter jelly bread dinner/supper." Observation on 02/17/16 at 5:47 p.m. showed Resident #5 in the dining room and assisted by staff to eat. Resident #5's meal did not include a peanut butter and jelly sandwich. Observation on 02/18/16 at 12:17 p.m. showed Resident #5 in the dining room and assisted by staff to eat. Resident #5's meal did not include a peanut butter and jelly sandwich. Failure to offer Resident #5 something to eat when she stated she was hungry, ensure staff weigh Resident #5 weekly, consistently implement existing weight loss interventions, and accurately document Resident #5's supplement intakes/refusals may lead to further weight loss and poor nutrition. Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1319-1320, stated, ". . . Pitting edema is edema that leaves a small depression or pit after finger pressure is applied to the swollen area. . . . Evaluation of edema . . . 2mm [milimeter] [depression or indentation] [equals] 1+ Barely detectable 2 to 4mm [equals] 2+ 5 to 7 mm [equals] 3+ . . ." - Review of Resident #1's medical record occurred on all days of survey and identified admission to the facility on 09/21/15. Diagnosis	F 325		

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	355069	A. BUILDING _____ B. WING _____	02/18/2016

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F 325	Continued From page 25	F 325		

included dementia and hypertension (high blood pressure). Physician's orders included Lasix (a diuretic) 40 milligrams (mg) for edema related to hypertension (initiated on admission) and "edema checks to bilateral extremities daily," (initiated on 10/02/15).

Review of Resident #1's weight from 09/21/15 to 02/15/16 showed the following:
*09/21/15 (admitted to the facility) - 164.5 lbs
*10/21/15 - 150.5 lb (1lb weight loss in 30 days)
*11/04/15 - 147 lbs
*12/21/15 - 144 lbs (20lb weight loss in 3 months)
*01/26/16 - 143 lbs
*02/15/16 - 142 lbs (22.5 lb weight loss since admission)

Resident #1's daily edema checks from 10/02/15 to 01/31/16 showed the following:
*October:
Left leg: 1+ edema 18 days; 2+ edema 9 days; and 3+ edema 3 days
Right leg: 1+ edema 14 days; and 2+ edema 16 days
*November:
Left leg: 1+ edema 29 days a trace of edema 1 day
Right leg: 1+ edema 19 days; 2+ edema 10 days, and a trace of edema 1 day
*December:
Left and right leg: a trace of edema 31 days
*January:
Left and right leg: a trace of edema 26 days and no edema 2 days

Resident #1's nutrition progress notes stated the following:
*09/30/15 - "New Admit Nutrition Assessment: . . .

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F 325	Continued From page 26 Weight 164.5lb . . . Will offer fortified milk for additional protein . . ." *10/19/15 - "Weight 150lb . . . Meal intakes typically 76-100%. Weight loss since admit is likely r/t decreased edema. . . . Will continue to monitor." *10/21/15 - "Res does not want milk to drink. Will d/c milk per res request." *12/30/15 - "Weight 144 lb . . . Meal intakes typically 76-100%. Meal intakes are typically 76-100%. Res has lost weight since admit which was likely r/t decreased edema. Will offer super cereal (calorie enhanced) at breakfast and continue to monitor weights." *01/18/16 - "Weight 146 lb . . . Meal intakes are typically 76-100%. Res does not want super cereal. Will d/c." *02/10/16 - "Weight 140 lb . . . Meal intake averaged 78% over the past week. Will continue to monitor." *02/17/16 - "Weight back up to 142 lb . . . Meal intakes 76-100% over the past week. Will continue to monitor." Resident #1's edema records showed a trace of edema in December and January however, the dietary note, dated 12/30/15, identified continued weight loss related to edema and initiated super cereal. Resident #1 refused the super cereal and the facility discontinued it in January but failed to initiate other interventions to prevent further weight loss. During an interview on 02/18/16 at 10:25 a.m., the resident care manager (# 14) stated Resident #1's weight loss was "probably not all edema" related.	F 325		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		3/24/16

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F 328 SS=D	Continued From page 27 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, resident interview, and staff interview, the facility failed to ensure adequate treatment and services regarding oxygen therapy for 1 of 2 sampled residents (Resident #9) with orders for continuous oxygen. Failure to ensure oxygen is worn continuously as ordered may result in respiratory distress and low oxygen saturations. Findings include: Review of the facility policy titled "Oxygen Use & Storage" occurred on 02/18/16. This policy, revised May 2013, stated, ". . . Oxygen will be administered per practitioner orders via an oxygen concentrator, portable marathon unit, or wall oxygen. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease and anxiety. The	F 328	1. Resident #9 will have oxygen administered according to physician orders. 2. All residents requiring continuous oxygen therapy have the potential to be affected. 3. Nursing staff have been educated regarding oxygen use during transfers and ADLs. Education will be provided with all nursing staff by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of residents on oxygen therapy will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director	

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F 328	Continued From page 28 current Minimum Data Set (MDS), dated 12/02/15, identified intact cognition and oxygen use. Resident #9's care plan stated, ". . . O2 [oxygen] at 2 L/NC [liters per nasal cannula] to keep sats [saturations] above 90% . . ." Current physician's orders included: "Continuous Oxygen 2/L per NC every shift for atelectaisis [sic]." Observation on 02/17/16 at 9:13 a.m. showed Resident #9 in bed with oxygen via nasal cannula. Two certified nursing assistants (CNAs) (#5 and #9) removed the nasal cannula, assisted Resident #9 to ambulate from her bed to the bathroom using a front-wheeled walker, and performed morning cares. A CNA (#9) then transferred Resident #9 into her wheelchair and applied oxygen at 9:36 a.m. (23 minutes later). During an interview on 02/17/16 at 1:25 p.m., Resident #9 stated she gets "really short of breath" and "I need it [oxygen] all the time." Observation on 02/17/16 at 2:08 p.m. showed a CNA (#9) removed Resident #9's nasal cannula and assisted her into bed using a pivot transfer and her walker. Resident #9 stated, "I can't breathe." The CNA reapplied the nasal cannula at 2:13 p.m. (five minutes later), and asked, "Are you doing ok now?" The resident replied, "No, I'm not." The CNA then summoned a nursing staff member (#4) to check Resident #9's oxygen saturation, which was 90%. Observation on 02/18/16 at 8:50 a.m. showed Resident #9 in bed with oxygen via nasal cannula. A CNA (#9) removed the nasal cannula, assisted Resident #9 to ambulate to the bathroom with a front-wheeled walker, and	F 328	of Nursing (or designee) will be responsible to monitor the correction.	

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F 328	Continued From page 29 performed morning cares. At 9:16 a.m. (26 minutes later), the CNA reapplied the nasal cannula. During an interview on the morning of 02/18/16, a supervisory nurse (#2) stated "continuous oxygen" should include wearing the nasal cannula during transfers and personal care.	F 328		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure each resident received food in a form designed to meet the individual resident needs for 1 of 2 sampled residents (Resident #11) with physician's orders for a mechanically altered diet. Failure to prepare food at the right consistency may result in reduced meal intake and choking. Findings include: Review of the dietary guidelines titled "Consistency Alterations: Introduction" occurred on 02/17/16. These undated guidelines stated, ". . . Level 2 - Dysphagia Mechanically Altered: *Cohesive, moist, semi-solid *Requires some chewing ability *Ground or minced meats with fork-mashable fruits and vegetables . . . *The food forms easily into a cohesive bolus . . ."	F 365	1. Resident #11 will be provided a diet as ordered with appropriate textures. 2. All residents with special diets have the potential affected. 3. Education will be provided to nursing and dietary staff regarding special diet textures as ordered by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of residents on diets with orders for special textures will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to	3/24/16

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F 365	Continued From page 30 Review of Resident #11's medical record occurred on February 17-18, 2016. Diagnoses included Alzheimer's disease. Physician's orders included a dysphagia mechanical soft texture diet. Resident #11's care plan stated, "NUTRITION: . . . Monitor/document/report to MD [medical doctor] for s/sx [signs and symptoms] of dysphagia: pocketing, choking, coughing, . . . RD [registered dietician] to evaluate and make diet change recommendations PRN [as needed]. Regular Level 2 Diet-soft cookies, pancakes, cakes OK . . . ADL [activities of daily living] . . . EATING: Independent with set up to supervision . . ." Observation on 02/16/16 from 4:55 to 5:35 p.m. showed Resident #11 seated in the dining room for his evening meal. The meal included two pureed food items and a broccoli/cauliflower salad of regular consistency. A staff member (#5) identified the pureed food items as pizza and chocolate cake. Observation on 02/17/16 at 5:10 p.m. showed Resident #11 seated in the dining room and eating his evening meal. The staff member (#5) identified the food items as a pureed/liquid biscuit, turkey gravy, and chocolate peanut butter pudding. The staff member (#5) stated dietary staff prepare Resident #11's food in the kitchen and deliver to the kitchenette on the unit for serving. This staff member stated dietary staff did not usually puree Resident #11's food to a watery texture. During an interview on 02/17/16 at 5:15 p.m., when asked why Resident #11 received pureed	F 365	monitor the correction.	

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F 365	Continued From page 31 foods, the dietary manager (#6) stated he should receive a Level 2 diet consisting of ground meats and soft foods, not pureed foods. The manager (#6) provided the menu for 02/17/16 and the menu identified the food texture for both Level 2 (mechanically altered foods) and Level 1 (pureed foods) as pureed. When asked why the dietary staff puree the Level 2 diet, the manager (#6) stated the facility follows the menus provided by a distributor of food products. The manager agreed the distributor's menu and the facility's definition of a Level 2 diet were different. On 02/17/16 at 5:25 p.m., the dietary manager (#6) observed Resident #11's meal (pureed biscuit and gravy), identified it as "a soup consistency," and stated she would "talk" to the dietary staff members who prepared the meal. The manager also stated dietary staff should have served Resident #11 soft pizza, soft/fork-mashable vegetables, and regular chocolate cake for the evening meal on 02/16/16.	F 365		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		3/24/16

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F 441	Continued From page 32 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 5 of 14 sampled residents (Resident #3, #4, #5, #9, and #13) observed during meals, medication pass, and/or toileting/perineal cares. Failure to follow infection control practices related to bare hand contact, sanitizing equipment, and glove usage/hand hygiene has the potential to cause/spread infection within the facility. Findings include:	F 441	1. Proper hand hygiene, glove use and appropriate disinfection of equipment will be used with cares for resident #3, #4, #5, #9, and #13. 2. All residents receiving assistance with peri-cares, catheter cares, utilizing medical equipment and assistance with meals have the potential to be affected. 3. Education with nursing staff on the proper infection control practices of glove	

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F 441	Continued From page 33 Review of the facility policy titled "Pericare for the Resident" occurred on 02/18/16. This policy, dated 06/04/10, stated, ". . . Clean . . . gently with soapy cloth from vagina . . . to anus with one stroke. Repeat this step as often as necessary until clean, turning cloth each stroke. . . ." - Review of Resident #4's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 01/06/16, identified intact cognitive skills and extensive assistance of one or more persons required for toileting and personal hygiene. Observation on 02/17/16 at 9:30 a.m., showed Resident #4 in the bathroom. After the resident had a bowel movement, a certified nursing assistant (CNA) (#7) donned gloves, assisted the resident to stand, and provided pericares using a pre-soaked wipe. The CNA (#7) cleansed the resident's perineum from the pubis to the rectum, using the same soiled wipe without turning it to a clean area. Per facility policy, the CNA (#7) failed to use a different area of the cleansing wipe or obtain a fresh wipe when cleansing the resident's perineum. Review of the facility policy titled "Catheters/Urinary/Catheter Care" occurred on 02/18/16. This undated policy stated, ". . . Cleanse the spigot on the drainage bag with an alcohol sponge after emptying. . . . Hands must be washed immediately after each time gloves are removed according to Standard Precautions. . . ." - Review of Resident #3's medical record	F 441	usage, hand hygiene and facility disinfection practices will be completed by March 24, 2016. 4. Date of correction is March 24, 2016, 5. Auditing of disinfection practices, hand hygiene, and glove use with peri-care, catheter care and dining assistance will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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F 441	Continued From page 34	F 441		

occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 01/21/16, identified moderately impaired cognitive skills and supervision-to-limited assistance of one person required for toileting and personal hygiene.

Observation on 02/16/16 at 5:05 p.m., showed a CNA (#8) provided perineal cares for Resident #3. The CNA (#8) placed the catheter bag drainage port into a container, emptied the urine from the catheter bag, and reinserted the port into the catheter bag port sheath. The CNA (#8) removed her gloves, emptied the garbage can, and then re-filled Resident #3's water glass. Per facility policy, the CNA (#8) failed to cleanse the spigot on the drainage bag with an alcohol sponge and failed to wash her hands after removing her gloves.

Review of the facility policy titled "Use of Plastic Gloves" occurred on 02/18/16. This policy, dated 2008, stated, ". . . Plastic gloves are to be worn whenever handling the food directly with hands when: . . . Handling ready-to-eat foods . . ."

- Random observation on 02/17/16 at 5:35 p.m., showed an unidentified dietary staff member providing tray set-up for Resident #9. The unidentified dietary staff member held the resident's peeled banana in his hand and sliced it into her cereal bowl. The unidentified dietary staff member came into direct bare-hand contact with Resident #9's ready-to-eat food.

- Observation in the dining room on 02/17/16 at 10:38 a.m. showed Resident #13 seated at a dining room table. An unidentified dietary staff

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F 441	Continued From page 35 member brought Resident #13 toast (a ready-to-eat food), and proceeded to butter the toast without wearing gloves. Review of the facility policy titled "Blood Glucose Monitoring" occurred on 02/18/16. This policy, revised May 2013, stated, ". . . After each use the unit must be disinfected with a germicidal wipe. Follow the germicidal wipe manufacturer's recommendation for use. (As of July 2010 the wipe being used from PDI requires the unit to be wiped down and have 2 continuous minutes of wet contact. You may need to use more than 1 wipe). Let air dry before putting unit away. . . ." - Observation of blood glucose monitoring occurred on 02/17/16 at 8:13 a.m. with Resident #5. After obtaining the blood glucose level, a nursing staff member (#4) placed the monitoring device back into a zippered pouch without disinfecting it. The staff member identified Resident #5 does not have a monitoring device designated as her own. Failure to disinfect the blood glucose meter according to facility policy may result in the spread of bloodborne pathogens to other residents/staff in the facility.	F 441		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced	F 507		3/24/16

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F 507	Continued From page 36 by: Based on record review, policy review, and staff interview, the facility failed to include all laboratory reports in the resident's clinical record for 1 of 14 sampled residents (Resident #8) reviewed. Failure to contain all laboratory reports in the resident's long-term care electronic medical record does not provide facility staff access to all pertinent information necessary to provide clinical management to the residents in the facility. Findings include: Review of the facility policy titled "Medical Records" occurred on 02/18/16. This policy, revised July 2015, stated, ". . . 3. A clinical record includes the following: . . . Laboratory and x-ray reports . . ." Review of Resident #8's medical record occurred on all days of survey and diagnoses included anemia and a bone marrow disorder requiring routine labs and blood transfusions. Resident #8's medical record identified the results of a Complete Blood Count (CBC), dated 10/26/15. The electronic medical record lacked all other CBC reports ordered by the physician. During an interview on 02/17/16 at 3:55 p.m., an administrative nurse (#14) provided more of Resident #8's laboratory reports and stated she found the rest on the hospital and clinic's electronic medical record. The nurse stated only administrative nurses have access to the hospital record.	F 507	1. Resident #8 lab reports obtained and placed in electronic health record. 2. Any resident having lab work completed has the potential to be affected. 3. Education with nursing staff will be conducted on the proper review and scanning of lab reports into the electronic health record by March 24, 2016. 4. Date of correction is March 24, 2016. 5. Auditing of completed lab work to ensure reports are received, reviewed and scanned into the electronic health record will be completed as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn. Results of audits will be brought to QA Committee for review and recommendation. The Director of Nursing (or designee) will be responsible to monitor the correction.	

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 _____	02/18/2016

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 507	Continued From page 37 The additional laboratory reports provided by the administrative nurse (#14) included CBC results for the following dates: *02/16/16 *02/09/16 *01/26/16 *01/19/16 *01/12/16 *12/29/15 *12/22/15 *12/15/15 *12/01/15 *11/24/15 *11/17/15 *11/03/15	F 507		