STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 01/02/19 and concluded on 01/04/19.	F 000		
F 550 SS=D	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 from the facility.	F 550		2/8/19

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

Electronically Signed | 01/25/2019

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F 550	Continued From page 1 §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: Based on observation and resident and staff interviews, the facility failed to provide care and services for 1 of 1 resident (Resident #30) in a manner or environment that maintained and enhanced the resident's dignity. Failure of the facility to ensure residents are free of odor does not preserve the resident's personal dignity and places them at risk of embarrassment and well being. Findings include: During the initial tour of the facility on the morning of 01/02/19, a strong pungent urine odor presented outside Resident #30's room. An interview with Resident #30 occurred on 01/02/19 at 10:16 a.m. The resident indicated she wears a leg bag [a device for collection of urine through a tube inserted into the bladder]. The strong pungent odor was present by Resident #30's doorway on all days of survey. Review of Resident #30's medical record occurred on all days of survey and included diagnoses for a history of pyelonephritis. The current care plan indicated the resident needed staff assistance to complete toileting needs and hygiene cares. Current physician orders	F 550	1. Resident #30 has been evaluated to replace her urinary bag every other day. Resident #30's room has been cleaned to remove urine odors on 1/23/2019. Replacing the bed mattress on 1/23/2019. 2. All residents with a urinary bag can be affected by this deficiency and will be observed for urinary odors. 3. Education about the policy titled, "Urinary Leg Drainage Bags" will be provided by the Director of Nursing to all nursing staff at the 1/29/19 meeting. Maintenance staff will be educated on 2/4/19 by the director of environmental services about proper room cleaning practices for odors. 4. Monitoring of Resident #30 and all residents with a Foley catheter odor will be done by the unit care managers by doing an odor check starting on 1/31/19 and be daily Monday to Friday for 1 week, weekly for 3 weeks, monthly for 3 months, and 3 times quarterly and all results will be taken the QA committee with concerns.	

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F 550	Continued From page 2 identified the following: * change leg bag every two weeks (initiated 11/11/17) * change foley catheter (a tube inserted into the bladder for urine to pass into a collection bag) every 4-6 weeks (initiated 09/18/17) * flush catheter as needed (initiated 06/08/18) During an interview on 01/04/19 at 7:20 a.m., an administrative nurse (#4) stated, "We are very aware of the urine odor. When we have her in a closed room when we have care conference it's very present . . . We have tried several things in the past to fix it." When asked if recent measures had been researched/tried to reduce Resident #30's urine odor, the nurse (#4) stated, "No."	F 550		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		2/8/19

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F 585	Continued From page 3 to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 4 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: RESIDENT/FAMILY GRIEVANCES 1. Based on observation, review of facility policy,	F 585	One 1. Resident's #30, #46, #6, #37, and #29's family member was all given formal	

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F 585	Continued From page 5 and resident, family and staff interviews, the facility failed to ensure the concerns and grievances were communicated and addressed for 5 of 5 residents (Resident #6, #29, #30, #37, #46) and 1 family member (A) interviewed. Failure to address the residents' and family concerns in a timely manner resulted in continued privacy concerns. Findings include: Review of the facility's policy and procedure titled "Resident and Family Grievances" occurred on 01/04/19. This policy, dated November 2016, stated, ". . . A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (Long-Term Care) facility stay. . . . Grievances may be voiced in the following forums: a. Verbal complaint to a staff member . . . The staff member receiving the grievances will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. . . The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. . . ." During an interview on 01/02/19 at 10:06 a.m. and at 3:18 p.m., Resident #30 indicated staff used a stop sign on her door to keep another resident from wandering into her room. The resident stated the following: * "[Resident] used to come in at least 8 times a day and now at least once a day."	F 585	grievance resolution reviews. A new grievance form was created and incorporated into care conferences. The unidentified resident wandering was evaluated by the psychiatrist on 1/10/19 and was increased on their risperidone and clonazepam to decrease intrusive behaviors. The resident is also being evaluated for discharge from St. Lukes. 2. All residents can be affected by this wandering resident and be affected by ineffective grievance reporting. 3. Education will be provided by the Director of Nursing to all nursing staff at the 1/29/19 meeting about the grievance policy, new form, and reporting. Facility wide education on the grievance policy and reporting will be completed February 6th, 2019. 4. Monitoring will start on February 8th, 2019 of ensuring grievances will be done by the social services office and auditing will occur daily Monday to Friday for 2 weeks, weekly for 2 weeks, monthly for 3 months, and 3 times quarterly with all results taken to the QA committee for concerns. Two 1. Certified Dietary Manager will address concerns voiced during the surveys' resident council interview re: cold foods, foods not being appealing, warm pop, Spanish Rice Hot dish and spicy bbq sauce at the next resident council meeting to be held 2/6/2019. 2. Certified Dietary Manager will start	

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F 585	Continued From page 6 * "Once the resident tried to take my clothes that were laying on the bed but I told [Resident] to leave them and [Resident] did. * "I put my call light on and staff are usually here right away to take [Resident] out of my room." During an interview on 01/02/19 at 9:12 a.m., Resident #46 stated, "[Resident] comes into my room and tries to sleep with me. That shouldn't be." Resident #46 asked this surveyor to shut the door to Resident #46's room so the wandering resident could not come in. During an interview on 01/02/19 at 9:54 a.m., Resident #6 stated her only complaint at the facility is a resident that wanders into her room and stated, "[Resident] likes to sleep with me." Resident #6 asked this surveyor to close the door when leaving to keep the wanderer out. During an interview on 01/02/19 at 4:52 p.m., Resident #37 indicated a concern of a resident wandering into his room. The resident stated, "They [staff] usually see her and come and get her. It bothers me. [Resident] goes in all the rooms." During an interview on 01/02/19 at 1:31 p.m., Resident #29's family member (A) identified the following concerns: * A resident wandered into the room and tried to take a necklace off the dresser. When the family member confronted the resident, the resident grabbed her wrist and would not let go until a staff member came into the room, intervened, and directed the resident out. * When the resident wandered into the room another time with the family member present,	F 585	and run a Food Council Meeting starting 2/11/2019. The Food Council will meet monthly, pending resident participation; this will be introduced /discussed with residents at the resident council meeting on 2/6/2019. 3. All dietary concerns that are brought forward during resident council or the new food council will be addressed with the completion of a Grievance/Customer Concern Report Form. The concern will be investigated, and plan of action will be taken back to the resident/individual who originally voiced the concern. These concerns will be reviewed/discussed during monthly Food Council Meetings. 4. Nutrition and Food Service Employees will be educated on using the Grievance/Customer Concern Report Form 2/6/2019. 5. Monitoring to ensure grievances/concerns are addressed will be completed by Social Services. Audits will start on 2/8/2019 and will be performed monthly and taken back to the Quality Committee by Social Services and the Food Council Meeting by the Certified Dietary Manager or Designee.	

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F 585	Continued From page 7	F 585		

Resident #29 became very upset and yelled, "Get her out. I don't want her here."
* During a care conference Resident #29's family member brought up the concern of privacy and indicated the facility responded by saying nothing could be done about it. Staff offered to move Resident #29 but the family refused.

Review of Resident #29's progress note, dated 12/28/18, identified a care conference attended by several family members. The care conference notes failed to show documentation of the family's concerns related to the wandering resident.

During an interview on 01/04/19 at 2:30 p.m., an administrative staff member (#2) and a social services staff member (#6) indicated the following:
* Aware of a resident's wandering behaviors
* Staff members had failed to communicate to either of them (#2 and #6) the incidents of a resident grabbing a family member's wrist, trying to crawl in bed with a resident, and the continued concerns/frustrations of residents regarding the wandering resident and privacy.
* Agreed Resident #29's family had brought up privacy concerns due to a wandering resident during the care conference on 12/28/18, and staff present failed to document those concerns.
* Agreed staff offered to move Resident #29 to another room due to the concerns, but family refused.

The facility failed to ensure staff reported and documented concerns and grievances of residents regarding another resident's wandering behaviors and to address the grievances and the

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F 585	Continued From page 8 wanderer's behavior. RESIDENT COUNCIL 2. Based on the resident council interview, review of Resident Council meeting minutes, and staff interview, the facility failed to actively seek a resolution to resident grievances related to dietary concerns for 12 of 12 residents (Resident A, B, C, D, E, F, G, H, I, J, K, and L) attending the Resident Council interview. Failure to address the residents' concerns in a timely manner resulted in continued dissatisfaction regarding their dietary concerns. Findings include: During the Resident Council interview on the afternoon on 01/02/19, Resident A, B, C, D, E, F, G, H, I, J, K, and L stated the food is cold and does not look appealing to eat. The residents also stated the staff do not address dietary concerns and no changes are made. Resident C stated food is sent back to the kitchen frequently due to the food not being edible. Resident L stated the food does not look edible and is cold. Resident B stated the food could be better. Review of the Resident Council Minutes from October, November, and December 2018 showed: * "[Resident] stated that he would like his pop kept cold until he arrives at the table and soups taste salty to him . . ." The facility failed to address this concern during the November or December Resident Council. * "[Resident] stated she felt the lunch serving was	F 585		

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F 585	Continued From page 9 starting later on her unit . . ." The facility failed to address this concern during the November or December Resident Council. * "[Resident] stated she wondered if the Spanish Rice Hot dish should be taken off menu, felt it was too [sic] little spicy. . . ." The facility failed to address this concern during the December Resident Council. * "[Resident] stated the BBQ sauce seems a little 'sharp' or spicy. . . ." The facility failed to address this concern during the December Resident Council. On the afternoon of 01/04/18, a dietary manager (#2) failed to provide documentation regarding dietary concerns being addressed from Resident Council. The facility failed to make prompt efforts to resolve a grievance and to keep the residents appropriately informed of progress toward resolution.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS STANDARD SURVEY ON 02/08/18. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure accurate coding of Minimum Data Set (MDS) for 1 of 18	F 641	1. Resident #24's MDS dated 12/21/18 had correction done to sections I15950, J0100A, and N0350A and submitted to correction. 2. All residents have the possibility to be affected by this deficiency. 3. Education will be provided individually to the two MDS nurses on reading section	2/8/19

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F 641	Continued From page 10 sampled residents (Resident #24). Failure to accurately complete Section I (Active Diagnoses), Section J (Health Conditions), and Section N (Medications) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2018, pages I-9 to I-10 stated, ". . . Psychiatric/Mood Disorder . . . I5950, psychotic disorder (other than schizophrenia) . . . The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS . . .The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc. . . ." - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included unspecified psychosis not due to a substance or known physiological condition. A quarterly MDS, dated 12/21/18, showed staff failed to code section I5950, psychotic disorder (other than schizophrenia). During an interview on 01/04/19 at 1:23 p.m., an administrative nurse (#5) confirmed staff failed to code the resident's current psychotic disorder at I5950 for the 12/21/18 MDS.	F 641	I15950, J0100A, and N0350 A from the RAI manual on 1/29/19. The two MDS nurses will also be provided education from HealthCare Academy modules focusing on Sections I, J, and N starting 1/22/19. 4. Monitoring for ensuring MDSs sections I15950, J010A, and N0350 A are completed correctly prior to submission will be done on Resident #24 and four other resident by the MDS nurse and then by the director of nursing starting 1/31/19 weekly for 4 weeks, then monthly for 3 months, then quarterly three times. All results will be taken to the QA committee for concerns.	

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F 641	Continued From page 11 SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, pages J-1 to J-2 stated, ". . . J0100: Pain Management . . . J0100A, Been on a Scheduled Pain Medication Regimen . . . Code 0, no: if the medical record does not contain documentation that a scheduled pain medication was received . . . Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received . . . " - Review of Resident #24's medical record occurred on all days of survey. The December 2018 electronic medication administration record (eMAR) showed Resident #24 received pain medication all 7 days during the look-back period. A quarterly MDS, dated 12/21/18, showed staff failed to code section J0100A for receiving scheduled pain medication. During an interview on 01/04/19 at 1:23 p.m., an administrative nurse (#5) confirmed staff failed to code the resident's scheduled pain medication regimen at J0100A for the 12/21/18 MDS. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2018, page N-3 stated, ". . . N0350A . . . Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received. . . . " - Review of Resident #24's medical record occurred on all days of survey. The December	F 641		

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F 641	Continued From page 12 2018 eMAR showed Resident #24 received insulin injections all 7 days during the look-back period A quarterly MDS, dated 12/21/18, showed staff failed to code N0350A, insulin injection. During an interview on 01/04/19 at 1:23 p.m., an administrative nurse (#5) confirmed staff failed to code the resident's insulin injections at N0350A for the 12/21/18 MDS.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the	F 644	1. Residents #24, #31, and #39 have had their diagnoses reviewed and their PASRRs have been update through Ascend. 2. All resident's have the risk of being	2/8/19

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F 644	Continued From page 13 facility failed to complete a status change assessment for 3 of 4 sampled residents (Resident #24, #31 and #39) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #24's medical record occurred on all days of survey. The record showed an initial PASARR completed on 09/28/17 and identified no mental illness. The screening, dated 09/28/17, stated the Level I screen conducted for the individual determined there was no evidence to suggest presence or known conditions of mental illness, mental retardation, or a condition related to mental retardation. Resident #24's medical record identified the	F 644	affected by this deficiency. All potentially affected residents have had their diagnoses reviewed and if needed, status changes submitted to Ascend by 1/31/19. 3. Social Services Staff will review PASRR manual on Ascend in regards to status changes by 1/31/19 and have signed off as completed by the Administrator. 4. Monitoring of Resident #24, #31, and #39 and three random residents will be done by Social Services weekly starting 1/31/19 for 4 weeks and then monthly for three months, then quarterly three times. Any needed status changes will be submitted. All results will be taken to the QA committee for concerns.	

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F 644	Continued From page 14	F 644		

following current diagnoses: mood disorder due to known physiological condition with depressive features (07/25/17), dementia in other disease classified elsewhere without behavioral disturbance (07/24/18), unspecified psychosis not due to a substance or known physiological condition (07/24/18), generalized anxiety (07/24/18), Alzheimer's disease (07/24/18) and delirium due to known physiological condition (09/26/18). The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses.

During an interview on the afternoon of 01/04/19, an administrative staff member (#6) stated staff failed to complete an updated Level I PASARR for Resident #24's new diagnoses.

- Review of Resident #31's medical record occurred on all days of survey. The record showed a Level I PASARR, completed on 02/06/17 and identified no mental illness.

A progress note dated 02/21/2018 at 4:09 p.m., showed ". . . add diagnosis of wandering due to a mental disorder . . ." A psychiatric consult dated 07/24/18 showed a diagnosis of unspecified psychosis not due to a substance or known physiological condition.

The record showed Resident #31 hospitalized on 08/02/18 through 09/13/18 due to a mental illness. A new Level I PASARR completed on 09/12/18 and identified no mental illness. The medical record lacked evidence of an updated Level I PASARR rescreening/change in status assessment for the new diagnoses.

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F 644	Continued From page 15 During an interview on 01/04/18 at 2:35 p.m., an administrative staff member (#6) stated staff failed to complete the required Level I screening/change in status assessment. - Review of Resident #39's medical record occurred on all days of survey. The record showed a Level I PASARR, completed on 02/12/18, identified no mental illness. The screening, dated 02/12/18, stated the Level I screen conducted for the individual determined there was no evidence to suggest presence or known conditions of mental illness, mental retardation, or a condition related to mental retardation. Resident #39's medical record identified the following current diagnoses: Dementia in other diseases classified elsewhere without behavioral disturbance (11/05/17), unspecified psychosis not due to a substance or known physiology condition (07/24/18), generalized anxiety disorder (07/24/18), and major depressive disorder (02/08/18). The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses. During an interview on the afternoon of 01/04/19, an administrative staff member (#6) stated staff failed to complete an updated Level I PASARR for Resident #39's new diagnoses.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		2/8/19

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F 656	Continued From page 16 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 17 Based on observation, record review, and review of the facility policy, the facility failed to develop a comprehensive care plan for 3 of 18 sampled residents (Resident #7, #13, and #24). Failure to develop a care plan that includes the services to be provided to the resident may negatively impact the resident's quality of care Findings Include: Review of the facility policy titled "Care Plans" occurred on 01/03/19. This policy, dated 11/28/16, stated, "It is the policy of this facility to develop and implement a person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment . . ." - Review of Resident #7's medical record occurred on all days of survey. The current physician's order stated, ". . . call medical doctor (MD) if BS [blood sugars] < [less than] 70 OR > [greater than] 400 If HS [bedtime snack] BS <130 give snack with protein and carbohydrate BID [twice a day] . . ." The care plan failed to address Resident #7's diabetes and lacked goals and interventions for staff to follow to ensure continuity of care. - Review of Resident #13's medical record occurred on all days of survey. The current	F 656	1. The residents care plans have been updated with goals and interventions for Resident #7's diabetes, Resident #13's oxygen and diabetes, and Resident #24's diabetes. 2. All resident's have the risk of being affected by this deficiency. 3. Education by the director of nursing provided to all nurses at the 1/29/19 staff meeting about ensuring care plans are updated. Educated on 1/29/19 including reviewing F656 requirements for care plans and the facility policy titled "Care Plans". 4. Monitoring diabetes and oxygen will be done starting 1/31/19 by nurse managers on Resident #7, #13, and #24 and five other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the care plan committee and quality assurance for review.	

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F 656	Continued From page 18 physician order stated, ". . . NovoLog [short acting insulin] . . . Hold for BS less than 80 or meal intake is less than 50% TID [three times a day] . . . Blood sugar checks QID [four times a day] notify MD if less than 70 . . . notify MD if >400 or < 70 . . ." The care plan failed to address Resident #13's diabetes and lacked goals and interventions for staff to follow to ensure continuity of care. The current physician order stated, ". . . Titrate O2 [oxygen] up to 3L [liters] (NOT ABOVE) to keep sats [saturations] >88% as needed [PRN] . . ." The care plan failed to address Resident #13's use of oxygen and lacked goals and interventions. Observations 01/02/19 at 12:35 p.m., 01/03/19 at 9:10 a.m., and 01/04/19 at 10:13 a.m. showed Resident #13 wearing oxygen by nasal cannula. - Review of Resident #24's medical record occurred on all days of survey. The current physician order stated, ". . . NovoLog [short acting insulin] . . . sliding scale . . . If Blood Sugar is 150 to 199, give 1 units . . . 200 to 249, give 2 Units . . . 250 to 299, give 3 Units . . . 300 to 349, give 4 Units . . . 350 to 400, give 5 Units . . . If Blood Sugar is greater than 400, call MD . . ." The care plan failed to address Resident #24's diabetes and lacked goals and interventions for staff to follow to ensure continuity of care.	F 656		
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-	F 657		2/8/19

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F 657	Continued From page 19 (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 comprehensive and quarterly review assessments. 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 the comprehensive care plan to reflect the residents' current status for 3 of 18 sampled residents (Resident #56, #75, and #384). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans"	F 657	1. The residents care plans have been updated for Resident #56's edema and resident refuses ted hose and oxygen is set at 3L continuous. For resident #75 15-minute checks were removed as they are not needed. Resident #384's pressure ulcer has healed. 2. All resident's have the risk of being affected by this deficiency. 3. Education was provided to all nurses at the 1/29/19 staff meeting about ensuring care plans are updated.	

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F 657	Continued From page 20 occurred on 01/03/19. This policy, dated 11/28/16, stated, "It is the policy of this facility to develop and implement a person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment . . ." - Review of Resident #56's medical record occurred on all days of survey. Current diagnosis included chronic diastolic congestive heart failure. A physician's order stated, "Check for edema weekly . . . " Observation of Resident #56 on 01/02/19 at 1:19 p.m. showed bilateral lower leg edema. Resident #56's care plan failed to address edema. During an interview on 01/03/19 at 3:20 p.m., an administrative nurse (#4) stated she would expect staff to address edema on Resident #56's care plan. - Review of Resident #75's medical record occurred on all days of survey. The current care plan stated, "Resident is a fall risk related to falls . . . Staff are to increase the frequency of checking on resident at night. Flowsheet: ADL [activity of daily living] Every 15 minutes . . ."	F 657	Educated on 1/29/19 including reviewing F657 requirements for care plans and the facility policy titled “Care Plans”. 4. Monitoring oxygen, 15 minute checks, edema, and pressure ulcers for Residents #56, #75, #384 and four other residents will be done starting 1/31/19 by the nurse managers daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the careplan committee and quality assurance for review.	

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F 657	Continued From page 21	F 657		

Review of there facility's 15 minute Resident Checks flow sheet show staff failed to follow Resident #75's care plan and record 15 minute checks at night.

During an interview on 01/04/19 at 1:22 p.m., an administrative nurse (#4) agreed staff failed to follow the care plan and review and revise the care plan.

- Review of Resident #56's medical record occurred on all days of survey. Review of Resident #56's oxygen (O2) saturation showed documentation six times during the month of December 2018 and none during January 1-4, 2019.

Review of Resident #56's current care plan stated . . . "Check oxygen saturation every shift related to history of pneumonia. If her saturation falls below 90% apply supplemental oxygen at 2L per NC (nasal cannula) and notify physician . . . "

During an interview on 1/03/19 at 4:48 p.m., an administrative nurse (#3) stated that O2 saturation checks should be removed from Resident #56's care plan.

- Review of Resident #384's progress note dated 12/24/18 at 9:47 a.m. stated, "[Resident] has two stage II areas of pressure to bilateral gluteal crease . . . Continue with Roho Cushion . . . "A quarterly MDS, dated 12/25/18, showed a Stage II pressure ulcer.

Review of Resident #384's current care plan failed to address the facility acquired pressure ulcer and Roho Cushion.

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F 657	Continued From page 22 During an interview on 01/04/19 at 12:10 p.m., an administrative nurse (#4) stated staff should have updated Resident #384's care plan after acquiring a pressure ulcer.	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: THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS STANDARD SURVEY ON 02/08/18 REGARDING TIMELY MEDICATION ADMINISTRATION. MEDICATION ADMINISTRATION 1. Based on record review, review of facility policy, review of professional reference, and resident and staff interviews, the facility failed to follow professional standards of practice regarding medication administration for 3 of 3 residents (Resident #24, #26, and #72) with medications administered late or without proper monitoring. Failure to ensure staff administered medications in a timely manner for Resident #26 and #72 and check Resident #24's blood pressure before administering Lasix (diuretic) may result in adverse reactions. Findings include: Review of the facility policy titled "Administering	F 658	One 1. For resident #72 a grievance report was completed on his medication times. Resident #26 had a grievance report completed on medication times and Elmiron change to two hours after meals with preference of sleeping in. Resident #24 has had blood pressure checks added to the Emar to ensure checks before administration. 2. All residents have the risk of being affected by this deficiency. 3. Education was provided by the director of nursing to all nurses at the 1/29/19 staff meeting about the policy titled, “administering medication” to ensure medications are given within time frames and to ensure medications that need monitoring are charted on. 4. Monitoring of medication administration times, residents needing blood pressure checks with medications, and residents on Elmiron and will be done	2/8/19

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F 658	Continued From page 23 Medications" occurred on 01/04/19. This policy, revised December 2012, stated, ". . . Medications shall be administered in a safe and timely manner, and as prescribed. . . . 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example one hour before or one hour after, AM [a.m.] 7:30 am, NOON 11:15 am, PM [p.m.] 3:00 pm, and HS [hour of sleep] 730 [sic] pm). . . . 8. The following information must be checked/verified for each resident prior to administering medications . . . b. Vital signs, if necessary. . . ." Review of the facility's document identifying medication pass times per the facility's pharmacy showed the following: * A.M. = 7:30 a.m. * Noon = 11:15 a.m. * P.M. = 3:00 p.m. * Hour of Sleep (HS) = 7:30 p.m. Review of Drugs.com medication reference for Elmiron (pentosan polysulfate sodium) stated, "Elmiron works like an anticoagulant (blood thinner) that prevents the formation of blood clots. However, it is used to treat bladder pain and discomfort caused by cystitis (bladder inflammation or irritation). . . . Take the medicine on an empty stomach, at least 1 hour before or 2 hours after a meal. . . ." - During an interview on 01/02/19 Resident #72 stated staff administered his medications late, he had complained to staff regarding the late medications, especially at bedtime. Review of Resident #72's medical record	F 658	by nurse managers starting 1/31/19 on residents #72, #26, and #24 and eight other random residents daily Monday to Friday for two weeks, then weekly for two weeks, monthly for 3 months, then quarterly three times. All concerns will be brought to the director of nursing and quality assurance committee. Two 1. Resident #27 did not have observed side effects of from non-priming of Novolog. Resident #75 did not have observed side effects of the Novolog. 2. All diabetic residents have the possibility to be affected by this deficiency. 3. All nursing staff was educated at the 1/29/19 nurses meeting on manufacture guidelines of Novolog administration times and how to prime insulin pens. 4. Audits on timing of insulin in relationship to meals will start 1/31/19 and be done by the nurse educator or director of nursing on resident #75 and two other residents daily Monday to Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. Audits on priming of insulin will start 1/31/19 for resident #27 and two other residents will be done by the nurse educator or director of nursing daily for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times.	

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F 658	Continued From page 24	F 658		

occurred on all days of survey. Diagnoses included chronic atrial fibrillation, essential (primary) hypertension, hypokalemia (low potassium), and iron deficiency anemia. The resident's medication administration records (MARs) from 12/05/18 to 01/03/19 showed staff administered medications late on 10 occasions in the last 29 days.

- During an interview on 01/02/19, Resident #26 complained staff administered her medications late, especially at bedtime.

Review of Resident #26's medical record occurred on all days of survey. Diagnoses included heart failure, pain, Type 2 diabetes, and interstitial (chronic) cystitis (bladder pain). The resident's MARs from 12/05/18 to 01/03/19 showed staff administered medications late on 18 occasions in the last 29 days. Further review of the MARs identified Elmiron 100 mg scheduled at 7:00 a.m., 11:00 a.m., and 4:00 p.m. before scheduled meals. Special instructions stated, "Administer with water on an empty stomach at least one hour before meals." Documentation showed staff failed to administer the medication during the appropriate time frame on 9 occasions in the last 29 days.

The facility failed to ensure staff administered medications in a timely manner and per special instructions.

- Review of Resident #24's medical record occurred on all days of survey. The current physician's order stated, ". . . Furosemide [Lasix] 40 mg [milligrams] . . . once A day [QD] . . . Furosemide . . . 60 mg . . . Hold if SBP [systolic

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F 658	Continued From page 25 blood pressure] <90 QD . . . started 12/14/18 . . ." Review of Resident #24's MAR from December 14, 2018 to January 3rd, 2019 showed Resident #24 received Lasix each day. The medical record lacked evidence staff checked Resident #24's blood pressure before administration of Lasix 15 of 22 days. During an interview on 01/03/19 at 3:48 p.m., an administrative nurse (#3) confirmed he expected staff to check blood pressure before administration of Lasix. INSULIN ADMINISTRATION 2. Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice during 1 of 1 sampled resident (Resident #75) and 1 supplemental resident (#27) observed during insulin administration. Failure to prime an insulin pen and ensure staff offered food within the recommended time after rapid-acting insulin administration may result in the resident receiving an inaccurate amount of insulin and hypoglycemia (low blood sugar). Findings include: Prescribing information for NovoLog insulin found at www.nov-pi.com/novolgpdf, stated, ". . . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up.	F 658		

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F 658	Continued From page 26 Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times . . . 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. . . ." Review of the facility policy titled "Use of Insulin Pens" occurred on 01/03/19. This policy, dated 12/14/16, stated, "Insulin pens will be prepared and primed prior to actual dose administration to ensure expelling of air and accuracy of dosage." - Observation on 01/02/19 at 5:15 p.m. showed a licensed nurse (#7) prepared an insulin pen for injection. The nurse failed to prime the insulin pen. Observation showed a licensed nurse (#7) administered 22 units of NovoLog insulin to Resident #27. Observation showed Resident #27 received her meal tray at 5:36 p.m., 21 minutes after receiving NovoLog insulin. - Observation on 01/03/19 at 12:11 p.m. showed a licensed nurse (#8) prepared an insulin pen for injection. The nurse failed to prime the insulin pen. Observation showed a licensed nurse (#8) administered 18 units of NovoLog insulin to Resident #75. During an interview on 01/04/19 at 12:17 p.m., an administrative nurse (#4) stated she expected	F 658		

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F 658	Continued From page 27 staff to prime insulin pens prior to administration and to ensure residents receive food within 15 minutes after administration of fast-acting insulin.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of facility's hospice contract, and resident and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental and psychosocial well being for 1 of 1 sampled resident (Resident #37) with uncontrolled pain under hospice care. Failure of staff to effectively assess and treat Resident #37's pain resulted in unnecessary pain and discomfort. Findings include: Review of the hospice contract titled "HOSPICE AND NURSING FACILITY SERVICES AGREEMENT" occurred on 01/04/19. This contract, dated December 2015, stated, ". . . 3.1.11 General Hospice Responsibilities. Hospice's responsibilities under the Agreement include, but not limited to, providing medical direction and management of Hospice Patients . .	F 684	1. Resident #37 was discussed with Hospice on 1/10/19 about resident pain needs and resident had agreed to try Mobic, Shakra Therapy, and Aroma Therapy. 2. All residents have the possibility to be affected by this deficiency and have added non-pharmacological measures for all residents. 3. All nursing staff was educated at the 1/29/19 nurse meeting by the Director of Nursing on the, “Hospice and Nursing Facility Services Agreement” and “Pain Assessment Policy” with a focus on areas of non-pharmacological pain interventions and numerical pain scales. 4. Audits on pain needs for hospice residents will start 1/31/19 and be evaluate using pharmacological and non-pharmacological interventions and involving Hospice for additional relief.	2/8/19

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F 684	Continued From page 28 . and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions . . . EXHIBIT E . . . FACILITY RN/LVN/LPN RESPONSIBILITIES . . . 5. Notifying Hospice of change in Patient's condition, uncontrolled symptoms . . ." Review of facility policy titled "Pain Assessment Protocol" occurred on 01/04/19. This policy, dated September 2016, stated, ". . . Policy: To help aide in performing a resident's pain assessment in efforts to obtain the most reliable assessment data. Pain is a complex phenomenon that is physical and/or mental in nature. Pain is subjective and highly individualized. . . . 3. Assess characteristics of pain . . . Severity: use pain-intensity scale . . . 4. Document assessment findings in the medical record . . . 5. Guidelines for pharmacological and non-pharmacologic interventions for pain: Oral medications: 1-2 hours after administration . . . Non-pharmacologic interventions: at appropriate intervals . . . Adverse side effects of pain medications . . . ." During an interview on 01/02/19 at 9:18 a.m. and 4:57 p.m., Resident #37 stated, "I can have Tylenol and morphine. . . Morphine makes me sick . . . I'm always in pain . . . They could treat it [the pain] better. I think they could do better. . . I lay in pain all day. . . I have bladder cancer. . . All I'm allowed is Tylenol and morphine. They are not doing all they can for me. . . ." and repeated several times, "They are just waiting for me to die." Review of Resident #37's medical record occurred on all days of survey. Diagnoses	F 684	This audit will be done by the nurse managers and include Resident #37 and all other resident's on Hospice daily Monday through Friday for two weeks, weekly for two weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the director of nursing, Hospice, and quality assurance committee.	

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included malignant neoplasm of bladder, bilateral primary osteoarthritis of knee, and pain. Medications included acetaminophen (Tylenol) 325 milligrams (mg) 2 tablets by mouth every 6 hours as needed (PRN) for mild/moderate pain, Aspercreme Heat (menthol) gel topical 4 times a day PRN to affected areas and on 11/10/18 ordered to have at bedside, Morphine Sulfate liquid 20 milligrams per milliliter (mg/ml) 5 mg by mouth every 30 minutes PRN for pain or shortness of breath.

The Admission Minimum Data Set (MDS), dated 10/22/18, identified cognitively intact, frequent pain rated 6 out of 10 on the pain scale (6/10) (zero being no pain and ten being the worst pain), pain made it hard to sleep at night, limited day to day activities because of pain, and received only as needed (PRN) medications for pain.

Resident #37's current facility care plan stated, ". . . keep hospice staff updated on medical condition/needs/concerns . . . Problem Start Date: 10/16/18, Category: Pain, [Resident #37] has moderate amount of pain related to bilateral knee pain and bilateral shoulder pain. He is also at risk for pain related [to] diagnosis of bladder cancer with metastasis. . . . Goal [Resident #37] will be able to state his pain is at a manageable level with current pain management interventions . . . ask resident what his pain goal is. Help him to achieve his pain goal through pharmacological and non-pharmacological pain interventions . . . assess resident's pain per facility protocol . . . offer non-pharmacological pain interventions such as heat, ice, repositioning, music, activities, distraction. Document effectiveness of

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F 684	Continued From page 30 interventions . . . Offer pain medications per physician order. Document effectiveness of medications and monitor for unwanted side effects of medication . . ." Review of Resident #37's electronic medication administration record (eMAR) showed the following: - 10/16/18 through 10/31/18: PRN acetaminophen 650 mg administered on 8 occasions for knee pain and PRN Morphine Sulfate Liquid 5 mg administered 3 times on one day for areas including knee, groin, and generalized pain. The eMAR reflected the pain medication as effective or somewhat effective on all the occasions, with no numeric pain scale indicators documented. - 11/01/18 through 11/30/18: PRN acetaminophen 650 mg administered on 18 occasions for pain to areas including headache, knee, shoulder, foot, groin, and generalized. The eMAR reflected the pain medication as effective or somewhat effective on 16 occasions, with no numeric pain scale indicators documented. No Morphine Sulfate Liquid 5 mg administered. - 12/01/18/ through 12/31/18: PRN acetaminophen 650 mg administered on 24 occasions for pain to areas including headache, leg cramps, stomach, and generalized. The eMAR reflected the pain medication as effective or somewhat effective on all occasions, with no numeric pain scale indicators documented. No PRN Morphine Sulfate Liquid 5 mg administered. - 01/01/18 through 01/03/18: PRN acetaminophen 650 mg administered on 2 occasions for headache. The eMAR reflected the pain medication as effective or somewhat effective on 1 of the 2 occasions, with no numeric	F 684		

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pain scale indicators documented. No PRN Morphine Sulfate Liquid 5 mg administered.

Review of Resident #37's hospice progress notes showed the following:
* 11/28/18 Registered Nurse (RN) Hospice Revisit - Pain daily but not constantly to bilateral knees. Resident stated pain affects activity, movement, appetite and sleep. Notes indicated aspercreme to resident's knees is helpful, only takes Tylenol for a headache, and refused morphine for pain per skilled nursing staff. The hospice care plan stated to assess generalized pain using the numeric scale and clients pain will be controlled to 2/10 by 10/26/18.
* 11/29/18 Interdisciplinary Group (IDG) Meeting - Complains of pain to bilateral shoulders/knees.
* 12/06/18 RN Hospice Revisit - Pain all the time to bilateral knees. Resident described pain as aching, dull, and constant. Resident refused scheduled Tylenol stating, "No, I want to make the decision if I want it or not." Care plan stated facility nursing staff to contact hospice for direction if new symptoms such as pain present.
* 12/13/18 RN Hospice Revisit - Pain all the time to bilateral knees. Resident described pain as aching and constant.
* 12/13/18 IDG Meeting - Client continues to complain of pain to bilateral shoulders and knees. Aspercreme heat applied independently with some relief.
* 12/19/18 RN Hospice Revisit - Pain all the time to bilateral knees. Resident described pain as aching, dull, and constant. Teach and implement non-pharmacological measures to decrease pain such as massage, heat, cold, relaxation techniques, music, essential oil diffusion added to care plan.

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F 684	Continued From page 32 * 12/26/18 RN Hospice Revisit - Pain all the time to bilateral knees. Resident described pain as aching, dull, and constant. Resident #37's medical record failed to show evidence staff offered non-pharmacological interventions or contacted hospice for additional pain medication relief. During an interview on the morning of 01/04/19, an administrative nurse (#4) stated, "[Resident #37] won't take morphine." The nurse (#4) confirmed the resident received only Tylenol for pain and staff had not documented any non-pharmacological interventions. During an interview on 01/04/19 at 9:13 a.m., a staff nurse (#10) stated, "[Resident #37] only asks for Tylenol for headaches and knee pain." The nurse (#10) confirmed the resident refused morphine because it made him sick. When asked if staff considered any other pain medications, the nurse (#10) stated, "No, because he only asked for the Tylenol." When asked if staff considered visiting with hospice about the resident's pain, the nurse (#10) stated, "No, because he complains about the headache and knee pain and asks for Tylenol." The facility failed to appropriately monitor, assess, and document Resident #37's pain and communicate with hospice to adequately control the resident's continued pain or offer other medications or non-pharmacological interventions.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		2/8/19

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F 692	Continued From page 33 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to monitor and evaluate weight changes for 2 of 5 sampled residents (Resident #13 and #47). Failure to report weight fluctuations to the medical doctor (MD) (Resident #13) and consistently monitor weights (Resident #47) may delay needed treatment for weight loss or gain. Findings include: Review of the facility policy titled "Weighing and Measuring the Resident" occurred on 01/04/19. This policy, revised March 2011, stated, ". . . The purposes of this procedure are to determine the	F 692	1. Resident #13's weights have stabilized at 146.8 pounds as of 1/21/19 and physician updated of weights. Resident #47's now has weights consistently done every other day. 2. All residents have the possibility to be affected by this deficiency. 3. All nurse staff were educated by the Director of Nursing on 1/29/19 at the nurses meeting on the policy titled, "Weighing and Measuring the Resident" and focus on notifying the physician of weight gain and loses and ensuring weights are done. 4. Audits on weighing Resident #13 and	

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F 692	Continued From page 34 resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status . . ." - Review of Resident #13's medical record occurred on all days of survey. The current physician's order stated, ". . . Weekly weight . . . Notify PCP [primary care provider] if weight gain of 5 lbs [pounds] in one week related to heart failure . . ." The current care plan stated, ". . . [Resident] has heart failure . . . Closely monitor weight and notify physician if notable weight gain and/or fluid retention is observed . . ." Review of Resident #13's weight record identified the following: 11/05/18 - 141.8 lbs. 11/12/18 - 149.5 lbs. (gained 7.7 lbs.) 11/20/18 - 133.5 lbs. 11/26/18 - 141.9 lbs. (gained 8.4 lbs.) 12/03/18 - 141 lbs. 12/10/18 - 145.1 lbs. 12/17/18 - 144.4 lbs. 12/17/18 - 139 lbs. 12/24/18 - 144 lbs. (gained 5 lbs.) The medical record lacked evidence the staff notified the primary care provider of the 5 lb. weight gain. - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included unspecified dementia with behavioral disturbance and major depressive disorder. The current physician's orders identified vital signs weekly to include weekly weights.	F 692	Resident #47 and four residents starting on 1/31/19 as ordered and reporting these to the physician will be done by the nurse managers daily Monday to Friday for one week, weekly for three weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the director of nursing, physician, and quality assurance committee.	

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F 692	Continued From page 35 Review of Resident #47's weight record showed the following: 10/17/18 - 148.4 lbs 10/24/18 - 149.2 lbs 10/31/18 - 152.4 lbs 11/07/18 - 151.2 lbs 11/14/18 - no weight recorded 11/21/18 - 150.0 lbs 11/28/18 - 152.8 lbs 12/05/18 - 153.2 lbs 12/12/18 - no weight recorded 12/19/18 - no weight recorded 12/26/18 - no weight recorded 01/02/19 - no weight recorded During an interview on 01/04/19 at 7:19 a.m., an administrative nurse (#4) confirmed staff failed to weigh Resident #47 weekly and failed to obtain a weight from 12/05/18 to 01/04/19.	F 692		
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: Based on observation, record review, and review of professional reference, the facility failed to ensure proper respiratory care for 1 of 2 sampled resident (Resident #13) with orders for oxygen therapy. Failure to provide oxygen (O2) as	F 695	1. Resident #13's oxygen has been changed to continuous and will have three times a day oxygen monitoring. 2. All residents with oxygen can be affected by this deficiency.	2/8/19

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F 695	Continued From page 36 ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1257-1259, stated, "OXYGEN THERAPY . . . Determining the effectiveness of oxygen therapy involves several measures, including checking vital signs . . . oxygen saturations . . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." - Review of Resident #13's medical record occurred on all days of survey. The current physician's order stated, ". . . Titrate O2 [oxygen] up to 3L [liters] (NOT ABOVE) to keep sats [saturations] > [greater than] 88% as needed [PRN] . . ." The care plan lacked documentation of the use of oxygen. Observations on 01/02/19 at 12:35 p.m., 01/03/19 at 9:10 a.m., and 01/04/19 at 10:13 a.m. showed Resident #13 wearing oxygen by nasal cannula. The medical record lacked evidence of nursing assessments of lung sounds, oxygen saturations, and documentation of use of oxygen during survey. The facility failed to regularly check the resident's	F 695	3. All nurse staff were educated by the Director of Nursing at the 1/29/19 nurse meeting on the policy titled, “Oxygen Concentrator” that was updated on 1/23/19. The education focused on oxygen saturation checking and oxygen orders. 4. Audits on oxygen usage orders and oxygen saturations will start on 1/31/19 for Resident #13 and three other random residents with oxygen and will be done by the nurse managers daily Monday to Friday for one week, weekly for three weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the director of nursing, physician, and quality assurance committee with concerns.	

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	355063	A. BUILDING _____ B. WING _____	01/04/2019

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F 695	Continued From page 37 oxygen saturations prior to applying the oxygen to determine if the resident required oxygen therapy.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726		2/8/19

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F 726	Continued From page 38 Based on observation and staff interview, the facility failed to ensure nursing staff were knowledgeable on proper use of emergency oxygen tanks for 1 of 3 registered nurses (RN) (#9) observed. Failure to ensure all nursing staff are knowledgeable to operate emergency oxygen tanks placed residents at risk for adverse consequences and respiratory complications. Findings include: During the Unit 2 (Badlands) medication room inspection on 01/03/19 at 3:30 PM, the RN (#9) identified an oxygen tank in this medication room as the emergency oxygen. When asked to check the level of oxygen in the tank, the RN attempted to open the tank and stated, "I don't know how this works." A few minutes later, when asked what she would do if a resident suddenly needed oxygen, the RN (#9) stated, "I would get the emergency oxygen" and pointed back to the same medication room where the nurse had failed to operate the tank.	F 726	1. The nurse #9 was educated on 1/21/19 on how to properly use a metal oxygen tank and demonstrated how to use the items on 1/22/19. 2. All nurses and residents have the possibility to be affected by this deficient practice. 3. All nurses were educated at the 1/29/19 nurses meeting on how to use a metal oxygen tanks and provided with a fact sheet for portable oxygen cylinder use. 4. Audits on metal oxygen tank usage will be done by the education nurse starting on 1/31/19 on nurse #9 (if available) and two other nurses daily Monday to Friday for one week, weekly for three weeks, monthly for 3 months, and quarterly 3 times. All concerns will be brought to the director of nursing and quality committee for review.	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes,	F 804	1. All residents have the possibility of	2/8/19

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F 804	Continued From page 39 review of facility policy, resident interview, and group interview, the facility failed to serve foods at palatable temperatures for 1 of 2 meals observed (Lunch 01/03/19). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Food Tasting" occurred on 01/04/19. This policy, revised 02/16/17, stated, ". . . All food is tasted prior to serving to ensure palatability and flavor . . . Foods not passing the taste tests due to seasoning, toughness, color, or other negative factors are not served until the problem has been corrected . . ." Review of the Resident Council Minutes from October, November, and December 2018 showed: * "[Resident] stated that he would like his pop kept cold until he arrives at the table and soups taste salty to him . . ." * "[Resident] stated she felt the lunch serving was starting later on her unit . . ." * "Residents' voiced that some foods at sometimes are not hot enough, nothing specific . . ." During a confidential interview on the morning of 01/02/19, Resident M stated during mealtimes the food served had been cold especially the toast at breakfast. The resident indicated he/she had complained several times to staff regarding the cold food but it still continued.	F 804	being affected by this deficiency. 2. Nutrition and Food Services employees were provided education re: F804 on 1/21/2019, re: preparing and serving foods the residents find palatable, attractive and at appetizing temperatures. Ideas were discussed on how to maintain food temperatures during transporting and holding of food with adjustments made to loading, transporting and holding of foods starting 1/22/19. Education re: food palatability and attractiveness will be performed at the next Nutrition and Food Services Meeting on 2/6/2019. 3. Food palatability monitors (addressing food appearance, temperature and taste) will be performed by Certified Dietary Manager or Designee starting 2/1/2019, by interviewing 20 residents per week for 4 weeks, 20 residents every 2 weeks for 4 weeks, 20 residents every 2 weeks for 4 weeks, 20 residents monthly for 3 months and 20 residents quarterly times 3. All results will be shared with the Quality Committee and at Food Council Meetings. Certified Dietary Manager or Designee will start and run a Food Council Meeting starting 2/7/2019; the Food Council will meet monthly, pending resident participation. Food Temperature test tray monitors will be performed by Certified Dietary Manager or Designee, starting 2/1/2019 with 8 test tray monitors weekly times 4 weeks, 4 test tray monitors weekly times 4 weeks, 4 monitors monthly times 3 months and 12 test trays quarterly times	

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F 804	Continued From page 40 During the Resident Council interview on the afternoon on 01/02/19, Resident A, B, C, D, E, F, G, H, I, J, K, and L stated the food is cold and does not look appealing to eat. The residents also stated the staff do not address dietary concerns and no changes are made. Resident C stated food is sent back to the kitchen frequently due to the food not being edible. Resident L stated the food does not look edible and is cold. Resident B stated the food could be better. During a confidential interview on 01/02/19 at 2:28 p.m., Resident L stated, "The food here is bad. I have been losing my appetite. My kids bring in a lot of food for me, otherwise I wouldn't get enough to eat." Observation on 01/03/19 between 12:00 p.m. to 1:15 p.m. of the steam tables on all 4 units showed the temperature of the food dropped approximately 20 - 40 degrees from the beginning of service to the end of service. The surveyors received a lunch test tray on 01/03/19 at approximately 1:10 p.m. The test tray from Unit #2 consisted of chili, waxed beans, and a biscuit. 4 of 4 surveyors confirmed the food did not maintain a palatable temperature and the waxed beans did not look appealing. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804	3. All results of test tray monitors will be reported to Quality Committee and the Food Council.	