STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355127	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE FARGO	**3225 51ST ST S FARGO, ND 58104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 05/08/17 and completed on 05/11/17, the sample included 4 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an	F 156		6/15/17

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

Electronically Signed | 05/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning	F 156		

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

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

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

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F 156	Continued From page 5 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post, in a manner accessible to all residents, the names, addresses, and/or telephone numbers of State advocacy groups including the State Survey Agency and the Medicaid Fraud Control Unit on 4 of 4 days of survey (May 8-11, 2017). Failure to provide this information has the potential to limit all residents and their families access to these agencies.	F 156	F-156 Notice of Rights, Rules, Services, Charges 1.) All residents and family will be informed of all required information posted at 1st Floor entrance and added to resident room binder allowing residents and families access to the information. 2.) All residents have the potential to be affected.	

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F 156	Continued From page 6 Findings include: Observations on May 8-11, 2017, showed advocacy groups displayed on a wall near the entrance to the East unit on the first floor. The facility failed to include/post contact information for the State Survey Agency and the Medicaid Fraud Control Unit, and failed to post the information in a location easily accessible to residents on the second floor and their families. During an interview on the morning of 05/11/17, two administrative staff members (#1 and #4) confirmed the display lacked the required information.	F 156	3.) All staff will be educated and residents will have access to all required information prior to June 15, 2017. 4.) Administrative staff will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/Designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017.	
F 203 SS=E	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section.	F 203		6/15/17

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F 203	Continued From page 7 (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;	F 203		

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F 203	Continued From page 8 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable	F 203		

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F 203	Continued From page 9 once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident and/or resident's family/legal representative, in writing, of a transfer, including destination and the reason for the transfer and the resident's right to appeal the action, for 5 of 5 sampled residents (Resident #5, #11, #12, #14, and #16), and 1 closed record (Resident #19). Failure to provide a notice of transfer or discharge does not allow the resident to make an informed choice regarding their rights. Findings include: Review of the facility policy titled, "Bed Hold" occurred on 05/11/17. This policy, revised December 2013, stated, ". . . Upon transfer/admission to the hospital, the Social Worker or designee reviews the following information with the resident responsible party . . . Review Notice of Transfer for Hospitalization and obtain signature. . . . File signed forms in resident's record. . . . Social Worker or designee documents in resident record and notifies staff of	F 203	F 203 Notice Requirements Before Transfer/Discharge 1.) Facility will reassess and communicate with residents 5, 11, 12, 14, 16 and 19 to ensure residents and families/legal representatives are informed of resident rights during transfers. 2.) All residents have the potential to be affected. 3.) All social services and nursing staff will be educated prior to June 15, 2017 on facility Bed Hold policy and discharge and transfer policy. 4.) The DON or designee will be responsible to monitor that all resident□s and legal representatives are to be notified of transfer/discharge rights upon transfer/discharge and are given both facility bed hold and transfer forms at that time. QA monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as	

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F 203	Continued From page 10 bed hold preference. . . ." - Review of Resident #5's medical record occurred on all days of survey, and identified the resident had a hospital admission from 09/08/16 to 09/12/16. The record lacked evidence the facility provided the resident and/or his responsible party with a written notice of transfer. During an interview on 05/10/17 at 10;45 a.m., an administrative nurse (#1), confirmed Resident #5's record lacked a notice of transfer form for the resident's transfer/admission to the hospital. - Review of Resident #11's medical record occurred on all days of survey, and identified the facility transferred the resident to the emergency room with a hospital admission on 03/14/17. The record lacked evidence the facility provided the resident and/or her responsible party with a written notice transfer. During an interview on 05/10/17 at 12:35 p.m., an administrative nurse (#1) confirmed Resident #11's medical record lacked a notice of transfer form for her transfer/admission to the hospital. - Review of Resident #12's medical record occurred on May 10-11, 2017 and identified the facility transferred Resident #12 to the hospital on 11/21/16 and 12/07/16. The record lacked evidence the facility provided the resident and/or the resident's representative with a written notice of transfer for both hospitalizations. - Review of Resident #14's medical record occurred on May 10-11, 2017, and identified the facility transferred the resident to the emergency	F 203	needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 203	Continued From page 11 room on 11/10/16, where he was later admitted to the hospital. The record lacked evidence the facility provided the resident and/or his responsible party with a written notice of transfer. During an interview on 05/11/17 at 10:15 a.m., a managerial nurse (#2) confirmed Resident #14's medical record lacked a notice of transfer form for his 11/10/16 transfer/admission to the hospital. - Review of Resident #16's medical record occurred on May 10-11, 2017, and identified the resident had a hospital admission from 03/19/17 to 03/22/17. The record lacked evidence the facility provided the resident and/or his responsible party with a written notice of transfer. During an interview on 05/11/17 at 10:35 a.m., an administrative nurse (#1) confirmed Resident #16's medical record lacked a notice of transfer form for the residents' transfer/admission to the hospital. - Review of Resident # 19's medical record occurred on 05/11/17, and identified the facility transferred the resident to the emergency room with a hospital admission on 09/23/16. The record lacked evidence the facility provided the resident and/or her responsible party with a written notice of transfer. During an interview on 05/11/17 at 10;35 a.m., an administrative nurse (#1) confirmed Resident #19's medical record lacked a notice of transfer form for his transfer/admission to the hospital.	F 203		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		6/15/17

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F 225	Continued From page 12 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		

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F 225	Continued From page 13 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 1 sampled resident (Resident #3) with a documented arm hematoma with skin tears. Failure to investigate an injury of unknown origin placed Resident #3 and other residents at risk for abuse and/or neglect, and did not allow the facility to determine causative factors for the injury and implement corrective action. Findings include:	F 225	F 225 Investigate Report/Allegations 1.) Facility will reassess resident 3 to ensure safety and communicate to family and provider. 2.) All residents who have an injury have the potential to be affected. 3.) All Nursing staff will be educated prior to June 15, 2017 on vulnerable adult policy and requirements for reporting and investigating. 4.) The DON, designee in cooperation with the Executive Director will be	

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F 225	Continued From page 14 Review of the facility policy titled "Vulnerable Adult - North Dakota" occurred on 05/11/17. This policy, revised April 2017, stated, "It is the policy of Eventide that all staff, residents, and families are required to report suspected abuse or neglect of vulnerable adults . . . PURPOSE: To provide safe services and living environments for vulnerable adults . . . An injury should be classified as an "injury of unknown source: when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and, b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time . . . Examples: . . . bruises with unknown cause, etc . . . it should be reported immediately and not to exceed two hours . . . The Nursing DON/Clinical Coordinator (or designee on-call) must be immediately notified to begin the investigation. They will notify: the Administrator . . . immediately . . . Send an email to the Administrator after notifying via phone. Also send email information to the DON and Clinical Coordinator . . . The DON or designee will call the report to the ND Department of Health . . . as soon as possible but not later than two hours after the allegation is made . . . do not involve abuse and do not result in serious injury notification must be made within 24 hours . . . The final report of the investigation and results will be sent to the North Dakota Department of Health within 5 working days . . . Documentation of the internal investigation will be completed and retained on file . . . Corrective action will be taken	F 225	responsible to ensure the process of investigation/allegation is completed. QA monitoring was implemented on 5/26/2017. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/Designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 225	Continued From page 15 if appropriate. this could include a change of policy or procedure; coaching or staff education. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes and generalized muscle weakness. A quarterly Minimum Data Set, dated 03/02/17, identified intact cognition and extensive assist of 2 or more persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The current care plan stated, ". . . Transfers: assist of two and Hoyer lift . . . [resident] is considered a vulnerable adult due to placement in a skilled nursing facility . . . would be unable to cope with a potentially harmful situation . . . Resident rights will be upheld. . . ." Review of nurses' notes showed the following: * 04/24/17 8:04 a.m. - "Skin tear to L [left] lateral upper arm noted with am cares. appeared to have occurred some time before being discovered. Skin was able to be replaced and measuring 2.6 cm [centimeters] in length. Surrounding skin is intact but remains fragile." * 04/28/17 7:43 p.m. - "CNA [certified nurse assistant] notified Nurse of a tear to the upper left posterior arm on [Resident]. The tear was 2cm x [by] 1cm . . . cleaned and covered with steri strips . . . no pain. HCP [Health Care Provider] notified. * 05/04/17 8:59 a.m. - "Skin tear to L) posterior lateral arm cleansed and covered with Adaptic, telfa, and roll gauze, steri strips are still in place. . . ." * 05/08/17 8:38 p.m. - ". . . CNP [Certified Nurse Practitioner] . . . Saw and assessed hematoma to LUE [left upper extremity] with [medical doctor] . . . No new orders."	F 225		

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F 225	Continued From page 16 * 05/09/17 6:13 a.m. - "Weekly skin check complete. [Resident] has a hematoma with skin tears to upper left arm." Review of the Practitioner Communication/Order Form showed the following: * 04/24/17 - "Skin tear to (L) lateral upper arm Steri-strips applied. Measures 2.6cm length" * 04/28/17 - "Noticed a skin tear 2 cm x 1 cm on post left arm. Skin open and bleeding - steri strips applied to hold wound together. . . ." * 05/03/17 - "On 4/24 & 4/28 skin tears noted to L upper arm. Skin tears measure 2x1.5cm, 2.2x0.6cm & 2.3x0.5cm. Also under most distal of these 3 skin tears, 6x4cm lump/hematoma palpated under skin" Practitioner Response/Orders: "Daily arm circumference at wound site to ensure hematoma not getting larger. [Change] adaptic to xeroform, [change on] bath day (3 x per week)." Review of the Skin Finding Investigation Report showed an investigation completed for a skin tear found on 04/24/17 at 8 a.m., measuring 2.6 cm in length, and secured with steri-strips. Documentation identified the facility updated the family and provider. The resident's interview identified he was "alert and oriented x4 at the time and stated he could not recall exactly when tear occurred. He stated he did not know tear was present until staff pointed it out . . . [Resident] was asked whether or not he felt as through skin tear could have come from hoyer lift sling or bath sling. [Resident] stated he wasn't sure, but that he could see this as possible cause. . . ." Additional investigations were not conducted	F 225		

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F 225	Continued From page 17 when further skin tears and a hematoma were identified. There was no evidence of staff education regarding possible causes and changes to the resident's care. Facility staff failed to report the injuries of unknown origin to the State Survey Agency. During an interview on 05/10/17 at 8:25 a.m., an administrative nurse (#1) agreed the investigation failed to include interviews with staff regarding possible causes of the skin tears and subsequent hematoma or education/interventions to prevent further injuries. The administrative nurse verified facility staff failed to report the injury of unknown origin to the State Survey Agency.	F 225		
F 250 SS=E	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: SUICIDE IDEATION 1. Based on record review and staff interview, the facility failed to provide medically-related social services for 1 of 2 sampled residents (Resident #7) who expressed suicidal ideation. Failure to address the psychosocial needs of Resident #7 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect the resident's overall level of functioning. Findings include:	F 250	F 250 - Provision of Medically Related Social Services 1.) The Interdisciplinary Team (which includes Social Services) will meet to determine the care needs for Residents 3, 4, 7, 13, 15, 16, 20, and 21 and changes implemented. These residents will be assessed by nursing and or social services. Interventions will be identified and implemented that will assist in diversion of residents who wander and protect and support those residents who are affected by wandering. Resident 7 was seen by psychiatry on 6/09/2017.	6/15/17

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F 250	Continued From page 18 Resident #7's medical record, reviewed on all days of survey, identified diagnoses including depression and dementia. A quarterly Minimum Data Set (MDS), dated 02/28/17 identified a Brief Interview for Mental Status score of "12" indicating mild cognitive impairment. The Resident Mood Interview identified a score of "4" indicating minimal depression. During the mood interview, the resident did not express feelings that he would be better off dead or of hurting himself. A nursing progress note, dated 03/09/17 at 11:54 a.m., identified the resident's wife reported to nursing staff that he had made "several suicide statements." His wife stated she "would like him to be assessed by psychiatry." The record showed, on 03/13/17 at 10:45 a.m., the provider wrote an order for a "Psych [psychiatric] consult with [clinic name] - depression." That same day at 4:33 p.m., the provider ordered Celexa (an antidepressant) 10 milligrams (mg) daily for depression. The record lacked evidence staff made an appointment for Resident #7 to see a psychiatrist, as requested by his wife and ordered by the provider. The record showed, on 04/20/17, the provider increased Resident #7's Celexa dose to 15 mg daily and also ordered: "Re [regarding] Mood. Please ensure he's seen by psych." The record again lacked evidence staff arranged for the appointment as ordered. During an interview, on 05/10/17 at 11:00 a.m., an administrative nurse (#1) stated the	F 250	2.) All residents who exhibit impaired psychosocial wellbeing (suicide ideation), who wander, and or are affected by wandering have the potential to be affected. 3.) Social Services will be involved with all aspects of care for the residents and documentation will be completed. Social Services and nursing staff will be educated on strategies to implement interventions. They will also ensure that they are care planned, and implemented as they pertain to both psychosocial needs and wandering behaviors prior to June 15, 2017. Nursing staff have been educated on and have implemented the process of prioritizing the list of residents who have psychiatric consults ordered, and on utilizing outside psychiatric resources when/if the in-house provider is unable to complete the consultation in a timely manner. 4.) The DON or designee will be responsible to monitor residents with impaired psychosocial wellbeing (suicide ideation), residents who wander, and residents who are affected by wandering to ensure that assessments are completed and interventions implemented, including appropriate and timely psychiatric referrals. QA monitoring was implemented on 5/26/17. The DON or designee will monitor behaviors which includes wandering, weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be	

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F 250	Continued From page 19 psychiatrist was scheduled to see Resident #7 that day (eight weeks after the original physician's order), but was sick, so the visit was canceled. The nurse (#1) did not indicate when the psychiatrist would see Resident #7. During an interview on 5/10/17 at 11:20 a.m., a licensed social worker (#19) stated she interviewed Resident #7 that morning and he did express thoughts of being better off dead 2 to 6 days of the last 14 days. The social worker stated Resident #7's depression score that morning was a "5" indicating mild depression. She stated the resident had no plan to harm himself and told the social worker he had expressed those thoughts to his wife so she would realize how unhappy he was. Resident #7's care plan failed to address his psychosocial needs related to the suicidal ideation reported by his spouse approximately two months ago. Failure to ensure staff arranged for Resident #7 to see a psychiatrist, as requested by his spouse and ordered twice by the provider, and to develop and implement interventions related to those needs, including ensuring a safe environment free of items the resident could use to harm himself, placed the resident at risk of self harm. RESIDENTS WANDERING 2. Based on observation, record review, and resident and staff interview, the facility failed to provide social services to ensure an environment that maintained, enhanced, and respected each resident's dignity and individuality for 2 of 4 sampled residents (Resident #3 and #4) and 2	F 250	immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 250	Continued From page 20	F 250		

supplemental residents (Resident #20 and #21) who when interviewed had concerns regarding residents wandering into their rooms, and 3 of 4 sampled residents (Resident #13, #15, and #16) who wandered. Failure to address the psychosocial needs of residents and develop and implement interventions related to these needs may be detrimental to the residents' psychological and mental well-being and may negatively affect the residents' overall level of functioning.

Findings include:

- During an interview on 05/08/17 at 11:15 a.m., Resident #21 expressed concerns regarding two or three unnamed residents, with rooms near her own, who frequently wandered into her room. On one occasion, Resident #21 returned to her room to find a picture frame on the floor with the glass broken, which she now keeps in a drawer. One resident would wander into her room, sometimes standing in the doorway and staring at her. Resident #21 stated staff are aware of her concerns and offered to move her to a different room. The resident stated she likes her room and does not want to move, but wants something done to keep the wanderers out of her room.

Review of Resident #21's medical record occurred on May 11, 2017. The quarterly Minimum Data Set (MDS), dated 03/13/17, identified cognitively intact, understands others, and makes self understood. The undated care plan failed to address the resident's concern of other residents wandering into her room.

Review of Resident #21's nurses' progress notes

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F 250	Continued From page 21 showed the following: * 02/03/17 6:37 p.m. - Concerned regarding another resident going in her room. Stated she doesn't feel safe and "is concerned they will take her stuff." Put Resident #21 in a different room for the night. * 04/15/17 7:35 p.m. - Received call from other wing. [Resident #21] looking for nurse to complain about another resident. Nurse met resident in her room. Resident #21 stated resident in room next door (Resident #16) stands in her doorway. Resident #21 is afraid of her. - During an interview on 05/08/17 at 4:57 p.m., when asked if other residents respect her privacy, Resident #4 stated, "One woman down the hall goes into other [residents'] rooms, that's why I keep my door shut. She came in here [Resident #4's room] before. People saw her in here. She goes through [residents'] stuff." Observation on 05/09/17 at 11:17 a.m. showed two certified nursing assistants (CNAs) (#6 and #7) repositioning Resident #4 in bed. As the CNAs provided Resident #4's cares, someone could be heard fidgeting with the knob on the closed door to her room. One of the CNAs (#6) walked across the room, opened the door, and saw Resident #13 sitting in a wheelchair directly outside Resident #4's room. The CNA (#6) told Resident #13 she would have to "wait just a minute" and closed the door before continuing Resident #4's cares. Resident #13 remained directly outside Resident #4's door, fidgeting with the knob until the door swung wide open. Resident #13 sat in the doorway, peering inside. She remained there until one of the CNAs (#6) closed the door for a second time.	F 250		

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F 250	Continued From page 22 - Review of Resident #13's medical record occurred on May 10-11, 2017. Diagnoses included dementia with behavioral disturbances and hallucinations. The quarterly MDS, dated 03/13/17 identified daily decisions as severely impaired and wandering occurred 1 to 3 days during the 7 day look-back period. Review of Resident #13's nurses' progress notes showed the following: * 03/14/17 - Frequently redirected our of other resident rooms * 03/23/17 - In another resident's bed taking a nap * 03/30/17 - Found on the floor of another resident's room - Observation on 05/08/17 at 5:20 p.m. showed a resident (Resident #15) in a wheelchair in Resident #3's room. A nurse (#8) transported Resident #15 out of the room and closed the door before administering medications to Resident #3. After the nurse left, Resident #3 stated, "That resident comes into my room a lot, looks out my window, and looks at my pictures on the shelf. She shouldn't be in here, and I usually have to put my call light on for staff to come and remove her. What can they [facility] do about that? I might not know if she took any of my things in my room." Review of Resident #3's medical record occurred on all days of survey. The current quarterly Minimum Data Set (MDS), dated 03/02/17, identified cognitively intact. The undated care plan failed to address the resident's concern of other residents wandering into his room.	F 250		

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F 250	Continued From page 23 - During an interview on 05/10/17 at 3:30 p.m., Resident #20 complained of residents wandering into her room even when the room door is shut. The resident stated two or three unnamed residents frequently wandered. On one occasion, Resident #20 returned to her room to find a broken ornament lying on the floor. The resident stated staff are aware of her concerns, but the wandering continues to happen. Review of Resident #20's medical record occurred on May 11, 2017. The quarterly MDS, dated 03/14/17, identified cognitively intact. The undated care plan failed to address the resident's concern of other residents wandering into her room. - Review of Resident #15 medical record occurred on May 10-11, 2017 and included diagnoses of Alzheimer's disease, mood disorder, and restless/agitation. Review of the nurses' notes showed the following: * 02/11/17 - Found in Room 204 in recliner. * 02/24/17 - Transferred to another resident's recliner * 03/21/17 - Frequently wanders into other residents' rooms * 03/26/17 - Removed from at least 4 other residents' rooms * 04/01/17 - Found in room 215 (Resident #3) * 04/06/17 - Wandering halls and into residents' rooms. Physical toward staff * 04/09/17 - In another resident's bathroom in wheelchair with pants around thighs * 04/23/17 - Entering residents' rooms that had	F 250		

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F 250	Continued From page 24 door shut. Striking out when redirected * 05/08/17 - Wandering in another resident's room The undated care plan failed to specifically identify the problem of Resident #15 wandering into Resident #3's room and into other resident rooms. - Review of Resident #16 medical record occurred on May 10-11, 2017. Diagnoses included vascular dementia with behavioral disturbance. The undated care plan and care card stated, ". . . frequently wanders throughout the facility . . . occasionally gets verbally aggressive and has swung her fists at staff . . . Ambulates independently . . . Hx [History] of wandering into other resident's rooms; redirect as able. . . ." Review of Resident #16's nurses' notes showed no current documentation of Resident #16 wandering into other resident rooms. During an interview on 05/10/17 at 5:30 p.m., a nursing supervisor (#7) agreed there were residents that wandered into other resident rooms who staff should redirect. Staff have tried placing a plant near the doorway of Resident #3's room and a "Do not touch" sign on Resident #20's shelf.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) 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	F 274		6/15/17

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F 274	Continued From page 25 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) 3.0 User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 2 of 16 sampled residents (Resident #4 and #7) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline or improvement limited the facility's ability to accurately assess each resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. This may include two changes	F 274	F274 Significant Change/Comprehensive Assessment 1.) Facility will reassess resident 4 and 7 complete a significant change in status assessment if indicated. 2.) All residents have the potential to be affected. The facility will ensure staff will complete a significant change in status assessment and MDS coded accordingly as indicated in the long-term care facility RAI 3.0 user□s manual. 3.) Staff will be educated on completing the significant change in status assessment per the long-term care facility RAI 3.0 user□s manual prior to June 15, 2017. 4.) The DON or designee will be responsible to monitor the appropriate completion of the significant change in status assessment. QA monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are	

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F 274	Continued From page 26 within a particular domain (e.g., [such as] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." - Review of Resident #4's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 11/17/16, identified the resident required supervision from one person during locomotion on the unit and limited assistance of one person with bathing. A quarterly MDS, dated 02/17/17, identified the resident required extensive assistance from one person during locomotion on the unit and total assistance of one or more persons with bathing. The record lacked evidence why staff did not complete a SCSA for Resident #4. During an interview, on 05/10/17 at 11:40 a.m., an MDS nurse (#3) confirmed the record lacked a reason why staff did not complete a SCSA for Resident #4. - Review of Resident #7's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated 12/05/16, identified the resident required extensive assistance of two or more persons with bed mobility, or locomotion on and off the unit, and frequently incontinent of bowel. A quarterly MDS, dated 02/28/17, showed the resident required limited assistance of one person for bed mobility and locomotion on and off the unit, and continent of bowel. The record lacked evidence why staff did not complete a SCSA for Resident #7. During an interview, on 05/10/17 at 8:35 a.m. an MDS nurse (#3) stated she did not complete a SCSA because Resident #7 had an expected	F 274	identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 274	Continued From page 27 improvement. The nurse confirmed staff failed to document in Resident #7's record that the improvement was expected.	F 274		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		6/15/17

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F 278	Continued From page 28 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 3 closed resident records (Resident #17) with coding related to cognitive pattern and mood; and failed to ensure a registered nurse accurately certified completion of the MDS. Failure to accurately code and complete the MDS limited the facility's ability to develop and implement an individulized care plan consistent with Resident #17's needs, and may affect the level of care provided to the resident. Findings include: Review of the facility policy titled, " RAI Process-MDS 3.0" occurred on 05/11/17. This policy, revised 09/16, stated, ". . . Individual discipline MDS assignments are as follows: . . . Section C- Social worker to do all, Section D- Social worker to do all. . . . The RAI coordinator is responsible for reviewing the MDS, CAA's [care area assessment], and care plans to assure it is completed signed, and dated per RAI manual requirements. . . ." The Long-Term Care Facility RAI Manual, revised October 2016, * Page C-1, stated, ". . . 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700-C1000, Staff Assessment of Mental	F 278	F278 Assessment Accuracy/Coordination/Certified 1.) Resident #17 MDS Assessments were modified to reflect the correct assessment of resident in completion of sections C and D. 2.) All residents who display they cannot or rarely understand/respond verbally or in writing have the potential to be affected. 3.) All staff who complete the MDS Assessments will be educated on proper coding of the MDS prior to June 15, 2017. 4.) The Director of Nursing or designee will be responsible to monitor the MDS Assessment Process to accurately reflect the condition of the resident. QA Monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months and random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 278	Continued From page 29 Status. . . . Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, . . . Skip to C0700, Staff Assessment of Mental Status. Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, . . . Proceed to C0200, Repetition of Three Words. . . ." * Page C-4, stated, " . . . Nonsensical responses should be coded as zero. . . . Stop the interview after completing (C0300C) "Day of the Week" if: 1. all responses have been nonsensical . . . 2. there has been no verbal or written response to any of the questions up to this point, or 3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. If the interview is stopped, do the following: 1. Code -, dash in C0400A, C0400B, and C0400C. 2. Code 99 in the summary score in C0500. 3. Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? 4. Complete the Staff Assessment for Mental Status." * Page D-2, stated, ". . . Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, . . . Skip to item D0500, Staff Assessment of Resident Mood . . . Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, . . . Continue to item D0200, Resident Mood Interview. . . ." * Page Z-8 stated, "Z0500: Signature of RN (registered nurse) Assessment Coordinator Verifying Assessment Completion . . . [the RN	F 278		

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F 278	Continued From page 30 assessment coordinator is to] Verify that all items on this assessment or tracking record are complete." Review of Resident #17's medical record occurred on 05/11/2017. The Admission 5-day MDS, dated 01/05/17, identified all dashes in section C and section D. This MDS lacked completion of section C (Cognitive Patterns) and section D (Mood). During an interview on 05/11/17 at 8:05 a.m., an administrative nursing staff member (#3) reviewed the MDS and confirmed Resident #17's admission 5 day MDS lacked completion of sections C and D, and thus failed to accurately reflect the resident's cognitive and mood status. In addition, the registered nurse who signed and dated the MDS at Z0500 failed to ensure staff completed sections C and D.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280		6/15/17

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F 280	Continued From page 31 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

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F 280	Continued From page 32 (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 policies and procedures, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 8 of 16 sampled residents (Resident #3, #6, #7, #8, #9, #13, #14, and #15) and two supplemental residents (#20 and #21). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include:	F 280	F 280 Care Planning 1.) Residents 3,6,7,8,9,13,14,15,20, and 21 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 appropriate to individual resident needs. 3.) Care Plans are reviewed and revised on admission as well as on every change of condition for each resident and are also reviewed quarterly. Changes to the care plan will to be communicated to staff and will be done immediately and	

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F 280	Continued From page 33 Review of the facility policy/procedure titled "Behavior Monitoring" occurred 05/11/17. This policy/procedure, revised May 2013, stated, ". . . An individualized care plan will be initiated on any resident that has exhibited behaviors. This will be revised as needed with input from interdisciplinary team. . . ." Review of the facility policy/procedure titled "Care Plans" occurred 05/11/17. This policy, revised May 2013, stated, ". . . Purpose: To develop a care plan as a workable tool that reflects the actual care and condition of each resident. . . . Procedure: . . . Documentation . . . 2. Care Plans will be updated and changes will be made as they occur to ensure the most current plan for the resident. 3. Care Plans will be reviewed at least monthly by each discipline with a progress note indicating that the care plan was reviewed and indicate with summary what changes, if any, were made. . . ." - Review of Resident #6's medical record occurred May 08-11, 2017. The current care plan, undated, stated, "Focus: Potential for falls r/t [related to] weakness due to CVA [cerebral vascular accident]. Scores as high risk for falls. . . . Interventions: . . . Mat on the floor next to bed. . . ." Observations on 05/09/17 at 8:05 a.m., 05/09/17 at 4:08 p.m., 05/10/17 at 11:06 a.m., 05/11/17 at 8:45 a.m., showed Resident #6 lying in bed without a mat on the floor next to the bed. Observation on 05/09/17 at 9:10 a.m. showed the CNA (#12) transported Resident #6 to the dining room table in his wheelchair. The CNA (#12)	F 280	appropriately. Staff will ensure the care plan accurately reflects the resident□s current condition. Education will be completed for staff completing care plans prior to June 15, 2017. 4.) The DON or designee will be responsible to monitor the Care Plan Process to accurately reflect the current condition of the residents. QA monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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moved a dining room chair out of the way and positioned Resident #6 at the table in his wheelchair.

The current care plan, undated, stated, "Focus: Potential for alteration in nutrition . . . Potential for weight fluctuations r/t Lasix. Hx [history] swallowing difficulties . . . Interventions: Encourage to sit in dining room chair for meals. . . . Position upright at 90 degrees with all oral intake and at least 45 degrees after 30 of eating. . . ." The CNA (#12) failed to encourage Resident #6 to utilize a dining room chair.

The current care plan, undated, stated, "Focus: Potential for changes to bowel and bladder function . . . Interventions: . . . Offer urinal every hour and PRN [as needed] . . . Toileting: assist of one to toilet every 2 hours and prn while awake. Check disposable incontinent product with toileting and change prn. . . . "

An observation of care on 05/09/17 at 4:10 p.m., showed a CNA [certified nurse aide] (#13) awakened the resident and offered to take him to the bathroom and to reposition. The resident said no to the bathroom and agreed to reposition. The CNA (#13) checked the resident's brief during the repositioning and changed the brief without offering Resident #6 the urinal. Before the CNA (#13) completed the brief change, the resident voided in his bed. The CNA (#13) failed to offer the urinal when Resident #6 chose not to get up to use the bathroom.

During an interview on 05/11/17 at 8:50 a.m., an administrative nurse (#5) stated staff should follow the care plan and Resident #6 does not

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have a mat, as they are a mat free facility.

Facility staff failed to update the care plan to reflect Resident #6 does not use a mat, and failed to follow care plan interventions for toileting and dining identified for Resident #6.

- Resident #7's medical record, reviewed on all days of survey, identified diagnoses including osteoarthritis, depression, and dementia. Observation on 05/09/17 at 8:52 a.m., showed Resident #7's fingers deformed and swollen at the joints. At 9:42 a.m. a CNA (#9) assisted him to shave using disposable razors.

A progress note, dated 02/14/16 at 9:47 a.m., identified Resident #7 received a 0.5 centimeter (cm) by 0.3 cm cut while shaving himself with a disposable razor. When staff notified his wife of the incident, she informed them he had an electric razor in his room. Resident #7's undated care plan lacked evidence staff identified if the resident should shave himself or if staff should assist him and what type of razor (disposable or electric) should be used.

A progress note, dated 03/09/17 at 11:54 a.m., identified Resident #7's wife reported to staff that he had made "several suicide statements." The record showed, on 03/13/17 at 4:33 p.m., the provider initiated Celexa (an antidepressant) 10 milligrams (mg) daily for depression and on 04/20/17 increased the Celexa to 15 mg daily. Resident #7's undated care plan lacked a focus for the suicide ideation or interventions to provide a safe environment free of items he might use to harm himself.

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F 280	Continued From page 36 - Resident #8's medical record, reviewed on all days of survey, identified diagnoses including osteoarthritis. Observation, on 05/09/17 at 11:03 a.m., showed the resident asked a CNA (#9) to remove a hot pack from his neck. Review of Resident #8's undated care plan identified a self care deficit related to osteoarthritis, but lacked the intervention of utilizing a hot pack to the resident's neck. - Resident #9's medical record, reviewed on all days of survey, identified diagnoses including major depressive disorder and adjustment disorder. The progress notes identified the following: * 06/15/16 at 12:41 p.m., Resident #9 asked, "'Do you have a gun?' and made a hand motion with his hand to his head in the form of a gun." At 7:39 p.m., he confirmed he was "sad about losing his independence and being treated like a child, began crying, and commented, 'I just want to go.'" * 06/16/16 at 4:38 p.m., Resident #9 reported "his family had recently sold his house from under him and his daughter was stealing money from him." Staff contacted a member of Resident #9's family regarding his suicidal comments. The family member reported [Resident #9] had made similar comments in the past. At 4:42 p.m., the family member reported she "noticed [he] seems to be more depressed." Staff further noted Resident #9 "was making comments to other residents about shooting himself." * 06/17/16 at 3:38 p.m., Resident #9's physician "ordered a psych [psychiatry] consult for suicidal comments" and started Resident #9 on "Zoloft for depression featuring adjustment disorder."	F 280		

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Resident #9's undated care plan lacked a focus for the suicide ideation or interventions to provide a safe environment free of items he might use to harm himself.

A progress note, dated 03/24/17 at 4:20 p.m., identified staff spoke with Resident #9's family about "increasing frequency of showers." During an interview on 05/09/17 at 8:40 p.m., a member of Resident #9's family indicated they had requested Resident #9 be bathed two-to-three times/week during his last care conference. Resident #9's CNA care card identified, "Shower PM (Sunday)." The care plan/card failed to reflect the family's request for increased bathing.

- Resident #13's medical record, reviewed on May 9-10, 2017, identified diagnoses including dementia with behavior disturbance and hallucinations. Progress notes, dated 03/07/17 at 6:56 a.m., identified the resident set off the wanderguard when she attempted to exit the unit. Progress notes further identified the resident wandered into other residents' rooms, moved their belongings, had a fall in another resident's room, and was found in another resident's bed. The record also showed Resident #13 had episodes of yelling and screaming at staff and her husband and hallucinations of children being locked in the basement.

The resident's undated care plan identified a focus: "The resident is a wanderer. Disoriented to place, Impaired safety awareness, Resident wanders aimlessly, [Resident name] has a history of hallucinating and has makes [sic] false accusations during hallucinations." The care plan identified the following interventions: "Medication

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as ordered for hallucinations. Provide redirection if noted in unsafe area. Redirect PRN [as needed] if wandering into unsafe areas. Wanderguard in place to right ankle." The care plan lacked specific, individualized interventions for staff to implement when Resident #13 wandered into other resident's rooms or displayed behaviors of yelling/screaming and/or hallucinations.

- Resident #14's medical record, reviewed on May 10-11, 2017, identified diagnoses including traumatic brain injury, dementia with behavioral disturbance, anxiety, and major depression. Review of Resident #14's record identified the following behaviors; disrobing in public areas, digging his nails into, pinching, scratching, squeezing, and/or twisting staff's arms, grabbing staff by the breast and/or buttocks, hitting, punching, and/or slapping staff, holding feces in his hand, kicking staff in the face, refusing cares, swearing and/or yelling at staff, throwing personal items (ie: dentures, glasses), and urinating on staff. The record also identified staff have been injured while trying to attend to Resident #14's needs.

The resident's undated care plan identified, ". . . Focus: . . . May become verbally and physically abusive to staff, other residents, and visitors. . . . Resistive with cares . . . Interventions: . . . 1:1 cares . . . 1:1 conversation with resident. . . . Allow resident to express frustration as able. . . . Allow [Resident #14] time to deescalate when behaviors are present . . . reproach [sic] at a later time to complete cares. . . ." The care plan lacked specific, individualized interventions for staff to implement when Resident #14 disrobes in public

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F 280	Continued From page 39 areas, demonstrates inappropriate sexual behaviors, urinates on others, and becomes too aggressive and/or combative for one staff member - which has resulted in staff injury. The care plan also failed to address the behavioral interventions identified in the medical record, which included physician consults and medication use. - Random observations on all days of survey identified a strong urine odor in the hallway and inside the room of Resident #3. Observation on 05/08/17 at 5:20 p.m. showed a resident (Resident #15) in a wheelchair in Resident #3's room. A nurse (#8) transported Resident #15 out of the room and closed the door. After the nurse left Resident #3 stated, "That resident comes into my room a lot, looks out my window, and looks at my pictures on the shelf. She shouldn't be in here, and I usually have to put my call light on for staff to come and remove her. What can they [facility] do about that?" Review of Resident #3's medical record occurred on all days of survey. The current quarterly Minimum Data Set (MDS), dated 03/02/17, identified cognitively intact and an indwelling catheter. Review of the nurses' notes for April through May 5, 2017 noted fragile skin with bruising and skin tears documented. The undated care plan failed to address the continuing odor from Resident #3's suprapubic catheter bag, the resident's concern of other residents wandering into his room, and the resident's fragile skin issues.	F 280		

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- Review of Resident #15 medical record occurred on May 10-11, 2017 and included diagnoses of Alzheimer's disease, mood disorder, and restless/agitation. The undated care plan failed to identify interventions to address the resident wandering into other resident's rooms.

- During an interview on 05/10/17 at 3:30 p.m., Resident #20 complained of residents wandering into her room even when the room door is shut. The resident stated two or three unnamed residents frequently wandered. On one occasion Resident #20 returned to her room to find a broken ornament lying on the floor. The resident stated staff are aware of her concerns, but it still is happening.

Review of Resident #20's medical record occurred on May 11, 2017. The quarterly MDS, dated 03/14/17, identified cognitively intact. The undated care plan failed to address the resident's concern of other residents wandering into her room.

- During an interview on 05/08/17 at 11:15 a.m., Resident #21 complained of residents wandering into her room. On one occasion, Resident #21 returned to her room to find a picture frame on the floor with the glass broken. She stated the room belonging to one of the residents who wanders was near her own room, and this resident would wander into her room, sometimes standing in the doorway. Resident #21 stated staff are aware of her concerns and offered to move her to a different room. The resident stated she likes her room and does not want to move, but wants something done to keep the wanderers

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F 280	Continued From page 41 out of her room. Review of Resident #21's medical record occurred on May 11, 2017. The quarterly MDS, dated 03/13/17, identified cognitively intact, understands others, and makes self understood. The undated care plan failed to address the resident's concern of other residents wandering into her room.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		6/15/17

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F 309	Continued From page 42 care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 2 of 2 sampled residents (Resident #4 and #9) observed receiving liquids were in the proper position. Failure to provide proper positioning has the potential to affect the residents' overall swallow safety, and placed them at risk of aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 125, and educational handouts, identified, ". . . Signs and symptoms of dysphagia . . . coughing/choking . . . During the oral intake of . . . liquids, it is optimal for a patient to be seated at a 90 degree angle . . . [when] in a bed . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Barrett's esophagus, reflux, weakness, and malaise. The quarterly Minimal Data Set (MDS), dated 03/11/17, identified intact cognition,	F 309	F 309 □ Provide Care/Services for Highest Well Being 1.) Resident's 4 and 9 were reassessed and Care Plan reviewed for accuracy for appropriate positioning while receiving food and liquids. Care plan changes made and communicated to staff. 2.) All residents who have swallowing difficulties have the potential to be affected. 3.) All Nursing staff will be educated prior to June 15, 2017 on appropriate positioning when providing hydration and food for residents who have been identified as having swallowing difficulties. 4.) The DON or designee will be responsible to monitor positioning when offering fluids. QA monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will	

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F 309	Continued From page 43 extensive assistance of two or more persons required for bed mobility, and supervision required while eating. Observation on 05/09/17 at 9:30 a.m., showed a certified medication assistant (CMA) (#16) administering Resident #4's medications mixed with pudding. The CMA (#16) raised Resident #4's bed to an approximate 30 degree angle (which placed her at an approximate 40 degree angle with the pillow behind her head) and offered her the medication/pudding mixture via teaspoon, which she swallowed. Following the medication pass, two certified nursing assistants (CNAs)(#6 and #7) stepped forward, and lowered the head of Resident #4's bed. Resident #4 immediately began coughing as staff lowered the head of her bed. The staff members failed to ensure Resident #4 sat at a 90 degree angle prior to offering her the medication/pudding mixture in bed. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included esophageal obstruction and history of pneumonia. The quarterly MDS, dated 03/11/17, identified impaired cognition, extensive assistance of two or more persons required for bed mobility, and supervision required while eating. Observation showed the following: * On 05/09/17 at 2:35 p.m., after assisting with cares, a certified nursing assistant (CNA) (#14) raised Resident #9's bed to an approximate 35 degree angle (which placed him at an approximate 45 degree angle with the pillow behind his head) and offered him a drink of	F 309	be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: June 15th, 2017	

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F 309	Continued From page 44 water, which he swallowed. * On 05/09/17 at 2:52 p.m., a CMA (#15) raised Resident #9's bed to an approximate 35 degree angle (which placed him at an approximate 45 degree angle with the pillow behind his head) and offered him several drinks of national supplement, which he swallowed. The CMA (#15) stated, "I'm gonna keep you up since you just drank that whole thing." The staff members failed to ensure Resident #9 sat at a 90 degree angle prior to offering him liquids in bed. During an interview on the morning of 05/11/17, two administrative staff members (#1 and #4) confirmed staff should ensure proper positioning of residents prior to offering them liquids.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		6/15/17

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F 323	Continued From page 45 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 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 adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #9) care planned for use of footrests during wheelchair (w/c) transport. Failure to utilize footrests during wheelchair transport placed Resident #9 at risk for falls and/or injury. Findings include: Review of the facility policy, titled, "Standard of Care" occurred on 05/11/17. This policy, revised October 2016, stated, ". . . At least 1 footrest of the wheelchair must be used for the resident's feet when pushing the resident's wheelchair. . . ." Review of Resident #9's medical record occurred on all days of survey. Medical diagnoses included back/bilateral knee pain, impaired mobility, and history of falls. The quarterly MDS, dated 03/11/17, identified impaired cognition and extensive assistance of one person required for locomotion on/off the unit. The certified nursing assistant (CNA) care card further identified, ". . . Make sure when we are pushing his w/c his foot pedals are on. . . ."	F 323	F 323 Free of Accident Hazards/Supervision/Devices 1.) Resident 9 was reassessed for proper wheelchair transport. Footrests will be used with all wheelchair transports as care planned. 2.) All residents who require wheelchair transport with footrests have the potential to be affected. 3.) All Nursing staff will be educated prior to June 15, 2017 on appropriate use of wheelchair with footrests. 4.) The DON or designee will be responsible to monitor wheelchair transports to ensure the safety of the residents. QA monitoring was implemented on 5/26/17. The DON or designee will monitor weekly for a month, monthly for three months, and then random audits as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 46 Observations showed the following: * On 05/09/17 at 7:52 a.m., a CNA (#10) transported Resident #9 down the hall in his wheelchair. Resident #9's feet/shoes caught and bounced on the flooring as the staff member transported him. * On 05/09/17 at 11:27 a.m., a CNA (#10) transported Resident #9 down the hall in his wheelchair. Resident #9's feet/shoes slid along the surface of the flooring as the staff member transported him. * On the morning of 05/11/17, after completing his morning cares, the CNA (#11) asked Resident #9, "You can hold your feet up, right?" She then transported Resident #9 down the hall in his wheelchair. Resident #9's left heel slid along the surface of the flooring as the staff member transported him. The staff members failed to cue Resident #9 to lift his feet and/or apply footrests during transport. During an interview on the morning of 05/11/17, two administrative staff members (#1 and #4) confirmed staff should place footrests on Resident #9's wheelchair prior to transporting him to a different location.	F 323	5.) Date of Correction: June 15th, 2017	
F9999	FINAL OBSERVATIONS Based on record review, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		