STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		4/9/16

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

Electronically Signed | 03/22/2016

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

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, facility staff failed to identify the location and/or date of the Care Area Assessment (CAA) documentation on Section V of the Minimum Data Set (MDS) for 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) reviewed. Failure to identify the location and/or date of the CAA documentation limits the ability of the interdisciplinary team to locate information related to the resident's complicating factors, risks, and any referrals for the CAA area. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, Chapter 3, page V-5, stated ". . . Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. . . . For each triggered care area, indicate the date and location of the CAA documentation in the 'Location and Date of CAA Documentation' column. . . ." Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10's medical records occurred on all days of survey. Review of the current comprehensive assessment for each resident identified MDS Section V (CAA Summary)	F 272	F 272 Comprehensive Assessments 1. Current comprehensive assessments for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 have been reviewed. The date and the location for the care area assessment documentation for triggered CAAs have been identified in the MDS Section V (CAA Summary) for the following assessments: Resident #1 □ Admission MDS, dated 11/19/15 Resident #2 □Annual MDS, dated 7/1/15 Resident #3 □ Significant Change MDS, dated 8/2/15 Resident #4 □ Admission MDS, dated 1/14/16 Resident#5 □ Admission MDS, dated 10/28/15 Resident #6 □ Admission MDS, dated 12/15/15 Resident #7 □ Significant Change MDS, dated 9/7/15 Resident #8 □ Significant Change MDS, dated 12/12/15 Resident #9 □ Admission MDS, dated 11/6/15 Resident #10 □ Significant Change MDS, dated 1/20/16 2. All current Resident records were reviewed for indication of a comprehensive assessment with Section V of the MDS, Any deficient Section V was updated to include date and location	

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F 272	Continued From page 2 "Location and Date of CAA Documentation" failed to indicate the date of the CAA information. The location for the care areas triggered for all the resident's stated "CAA WS [worksheet]." The following CAA Summaries (Section V0200A) lacked location and dates for the Care Areas triggered: *Resident #1 - Admission MDS, dated 11/19/15 *Resident #2 - Annual MDS, dated 07/01/15 *Resident #3 - Significant Change MDS, dated 08/02/15 *Resident #4 - Admission MDS, dated 01/14/16 *Resident #5 - Admission MDS, dated 10/28/15 *Resident #6 - Admission MDS, dated 12/15/15 *Resident #7 - Significant Change MDS, dated 09/07/15 *Resident #8 - Significant Change MDS, dated 12/12/15 *Resident #9 - Admission MDS, dated 11/06/15 *Resident #10 - Significant Change MDS, dated 01/20/16 During an interview on 02/24/16 at 11:00 a.m., an administrative nurse (#1) stated she was unaware staff needed to include the location and date of CAA documentation found under Section V of the MDS.	F 272	of documentation as indicated and submitted. 3. The MDS Nurses have been educated by the Certified RAC on identification and documentation of the date and location of care area assessment documentation for the triggered CAAs in Section V of the MDS. 4. Certified RAC will randomly audit MDS Section V of comprehensive assessments weekly X 4 weeks, Monthly X3 months and quarterly X 3 for inclusion of the date and location for the care area assessment documentation for triggered CAAs. Certified RAC will submit audit findings monthly to the QAA Committed for review and recommendations. 5. Compliance Date: 04/09/16	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		4/9/16

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F 278	Continued From page 3 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and resident and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 8 of 10 sampled residents (Resident #1, #3, #4, #5, #6, #7, #9, and #10). Failure to complete the correct MDSs after being discharged from the facility with return anticipated (Resident #3, #5, #6, and #7) and failure to accurately complete portions of the MDS, Section G (Activities of Daily Living) (Resident #3, #4, #5, #6, and #7), Section I (Active Diagnosis) (Resident #1 and #10),	F 278	F278 Assessment Accuracy 1. A modification or significant correction has been made to the inaccurately coded sections of the Minimum Data Sets for resident #1, #3, #4, #5, #6, #7, #9 and #10. Corrected MDSs have been submitted to the CMS QIES Assessment Submission & Processing System and the North Dakota Department of Human Services with billing adjustments made for those affecting payment. 2. Current MDSs of other residents in the facility have been reviewed for	

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F 278	Continued From page 4 Section J (Health Conditions) (Resident #1 and #6), Section K (Swallowing/Nutritional Status) (Resident #1), Section M (Skin Conditions) (Resident #1, #4, #5, #7, and #9), and Section N (Medications) (Resident #5) does not allow each resident's assessment to reflect the resident's current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: ADMISSION ASSESSMENTS The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, Chapter 2, page 2-8, stated ". . . Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations: * when the resident has never been admitted to this facility before; OR * when the resident has been in this facility previously and was discharged return not anticipated; OR * when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge . . ." - Review of Resident #3's medical record occurred on all days of survey and identified a hospital stay from October 13-17, 2015. The facility completed a discharge assessment return	F 278	inaccurate coding with modifications to sections or significant corrections completed as indicated. If Documentation does not exist as to the status of a skin or Pressure Ulcer the MDS will not be corrected, going forward Documentation will be provided in the chart as to staging of Pressure Ulcers. All able to be corrected MDSs have been submitted to the CMS QIES Assessment Submission & Processing System and the North Dakota Department of Human Services with billing adjustments made for those affecting payment. 3. The Interdisciplinary Team (IDT), MDS nurses and others who complete sections of the MDS have been educated by the Certified RAC and or DON on completion of the MDS to include definitions related to Admission/Discharge Assessments, Activities of Daily Living, Urinary Tract Infections, Moisture Associated Skin Damage, Pressure Ulcers, Falls, Nutritional Approaches, and Medications; coding the MDS accurately, and required documentation in the medical record to justify the coding of the MDS. 4. Certified RAC will randomly audit MDS assessments for accuracy weekly X 4 weeks, monthly X3 Months and quarterly X3. The findings of the audits are submitted to the QAA Committee monthly for review and recommendations. 5. Compliance Date: 4/09//16	

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anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.

- Review of Resident #5's medical record occurred on February 23-24, 2016 and identified a hospital stay from December 09-24, 2015. The facility completed a discharge assessment return not anticipated assessment MDS and upon return from the hospital, incorrectly completed an admission MDS.

- Review of Resident #6's medical record occurred on February 23-24, 2016 and identified a hospital stay from December 23-30, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.

- Review of Resident #7's medical record occurred on all days of survey and identified a hospital stay from November 27, 2015 through December 21, 2015. The facility completed a discharge assessment return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.

ACTIVITIES OF DAILY LIVING

The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, Chapter 3, pages G-3-G-4, stated ". . . Activities of Daily Living Definitions . . . A. Bed mobility: how resident moves to and from lying position, turns side or [sic] side, and positions body while in bed or alternate sleep furniture. B. Transfer: how resident moves between surfaces including to or

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F 278	Continued From page 6 from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet . . . G. Dressing: how resident puts on, fastens and takes off all items of clothing . . . I. Toilet use: how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag . . . J. Personal hygiene: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) . . ." Page G-5 stated, ". . . Coding Instructions for . . . ADL [activities of daily living] Self-Performance . . . Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times: Weight-bearing support provided three or more times, OR Full staff performance of activity three or more times during part but not all of the last 7 days." Page G-6 stated, "Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period. . . ." Page G-24 stated, ". . . Code 3, physical help in part of bathing activity: if the resident required assistance with some aspect of bathing. Code 4, total dependence: if the resident is unable to participate in any of the bathing activity. . . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly	F 278		

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MDS, dated 01/17/16, identified total assistance of one person required with bathing.

The current care plan stated, ". . . Focus: ADL Self care deficit as evidenced by weakness related to disease process (Dementia) . . . Interventions/Tasks . . . hands on staff assist with bed mobility, transfers, toileting dressing and bathing. . . . Transfer with one assist with gait belt . . ." The MDS, dated 01/17/16, should have been coded for extensive assistance with bathing.

- Review of Resident #4's medical record occurred on February 23-24, 2016. The Prospective Payment System (PPS) 14 day MDS, dated 01/21/16, and the PPS 30 day MDS, dated 02/04/16, identified Resident #4 required extensive assistance of two or more staff members for transfers. The PPS 30 day MDS, dated 02/04/16, identified the resident required total assistance for bathing.

Review of the care plan, current at the time of both MDS assessments, stated, ". . . ADL self care deficit related to physical limitations . . . assist to bathe/shower as needed . . . assist with daily hygiene, grooming, dressing, oral care and eating as needed . . ."

During an interview on the morning of 02/23/16, Resident #4 stated staff transferred her with the full-body mechanical lift since admission and identified she can move her upper extremities and assist with washing her face, hands, etc.

The facility failed to identify Resident #4 required total assistance with transfers on both MDSs and incorrectly coded total assistance for bathing on

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F 278	Continued From page 8 the 02/04/16 MDS. - Review of Resident #5's medical record occurred on February 23-24, 2016. A PPS 14 day MDS, dated 01/07/16, and a PPS 30 day MDS, dated 01/23/16, identified the resident required extensive assistance for bed mobility, transfers, dressing, and toilet use. The care plan stated, ". . . Assist resident with ambulating to and from meals with FWW [front wheeled walker] with stand-by assist [assistance] [SBA] . . . Assist with daily hygiene, grooming, dressing, oral care and eating as needed . . ." Nursing progress notes identified the following: *01/04/16 - ". . . Pt [patient] is limited assist of one with transfers, bed mobility and toileting . . ." *01/05/16 - ". . . Pt is SBA assist with front wheeled walker to bathroom . . . Pt needs assist of 1 to get new pad when in bathroom if incontinent. Pt likes to be covered back up and pt is able to get legs in and out of bed per self. Pt needs assist sometimes to put O2 [oxygen] cannula back on also." *01/20/16 - ". . . Pt is limited assistance of one with all cares. Pt transfers with a FWW and uses a w/c [wheelchair] independently for long distances . . ." The facility incorrectly identified Resident #5 required extensive assistance for bed mobility, transfers, dressing, and toilet use on his 01/07/16 and 01/23/16 MDSs. - Review of Resident #6's medical record occurred on February 23-24, 2016. A PPS 14 day MDS, dated 01/16/16, and a PPS 30 day MDS,	F 278		

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F 278	Continued From page 9 dated 01/30/16, identified the resident required extensive assistance for bed mobility, transfers, and toilet use. The care plan stated, ". . . Assist with daily hygiene, grooming, dressing, oral care and eating as needed . . ." Nursing progress notes identified the following: *01/10/16 - ". . . Pt is limited assistance of one with all cares . . ." *01/26/16 - ". . . Patient is limited assist of one with all cares . . ." The facility incorrectly identified Resident #6 required extensive assistance for bed mobility, transfers, and toilet use on his 01/16/16 and 01/30/16 MDSs. During an interview on 02/24/16 at 11:00 a.m., an administrative nurse (#1) stated Resident #5 and #6 should not have been coded as extensive assistance. - Review of Resident #7's medical record occurred on all days of survey. A PPS 14 day MDS, dated 01/06/16, identified extensive assistance of two or more people required with transfers. A PPS 30 day MDS, dated 01/20/16, identified extensive assistance of two or more people required with transfers and total assistance of one person required with bathing. The current care plan stated, ". . . Focus: ADL Self care deficit related to disease process, physical limitations . . . Interventions/Tasks . . . Transfer with Hoyer [full body mechanical lift] lift and 2 assist. . . ."	F 278		

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Review of the progress notes identified the following:
* 01/20/16 at 2:40 p.m.: ". . . Resident does use mechanical lift for transfers. Resident can brush own teeth and wash face if given towels. Resident propels self in wheelchair around facility. . . ."
* 01/06/16 at 10:38 p.m.: ". . . is a hoyer transfer in and out of bed and w/c with assist of two."

The MDSs, dated 01/06/16 and 01/20/16, should have been coded for total assistance of two or more people with transfers. The MDS, dated 01/20/16, should have been coded for extensive assistance of one person with bathing.

During an interview on 02/23/16 at 3:13 p.m. an administrative nurse (#1) confirmed the MDSs were incorrectly coded and stated Resident #7 required a full body mechanical lift for transfers.

URINARY TRACT INFECTIONS

The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, Chapter 3, page I-8, stated ". . . Item I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days. Code only if all the following are met: 1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days, 2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., [example given] peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change

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in mental status, change in character of urine (e.g., pyuria), 3. 'Significant laboratory findings' (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 4. Current medication or treatment for a UTI in the last 30 days."

- Review of Resident #1's medical record occurred on February 23-24, 2016. A medical provider's note, dated 12/21/15, stated, ". . . Pt was on cipro for her UTI, urine C/S [culture and sensitivity] came back last Friday with [sic] showed resistance to levofloxacin. She was changed to Macrobid last Friday . . . Has been voiding on her own with no urinary symptoms . . . Diagnosis: . . . UTI associated with visual hallucination secondary to urinary retention . . ."

A PPS 60 day MDS, dated 01/09/16, failed to identify Resident #1 with a UTI as an active diagnosis (within 30 days).

- Review of Resident #10's medical record occurred on all days of survey and identified a hospital stay from January 01-13, 2016. During the hospitalization on 01/01/16, a physician performed laboratory tests, diagnosed, and treated the resident for a UTI. A PPS 30 day MDS, dated 02/10/16, identified a UTI as an active diagnosis.

During an interview on 02/23/16 at 2:23 p.m., an administrative nurse (#1) confirmed Resident #10's UTI was outside of the 30 day look back period.

MOISTURE ASSOCIATED SKIN DAMAGE

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The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2015, Chapter 3, page M-35, stated ". . . M1040H Moisture Associated Skin Damage (MASD) . . . is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown. . . ."

- Review of Resident #1's medical record occurred on February 23-24, 2016. A PPS 60 day MDS, dated 01/09/16, identified MASD. The medical record lacked evidence Resident #1 had MASD during the assessment reference period.

- Review of Resident #7's medical record occurred on all days of survey. A PPS 14 day MDS, dated 01/06/16, identified MASD. The medical record lacked evidence Resident #7 had MASD during the assessment reference period.

- Review of Resident #9's medical record occurred on February 23-24, 2016. A PPS 60 day MDS, dated 01/28/16, identified MASD. The medical record lacked evidence Resident #9 had MASD during the assessment reference period.

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F 278	Continued From page 13 PRESSURE ULCERS The Long-Term Care Facility RAI Manual, revised October 2015, pages M-5-M-7, stated, ". . . M0210: Unhealed Pressure Ulcer(s) . . . Code based on the presence of any pressure ulcer . . . in the past 7 days . . . Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300) . . . M0300: Current Number of Unhealed Pressure Ulcers at Each Stage . . . Steps for completing M0300A-G . . . 2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured that the depth of soft tissue damage cannot be observed, it is considered to be unstageable . . . Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage that what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item . . . Identify Unstageable Pressure Ulcers . . . Determine 'Present on Admission' For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home . . . " - Review of Resident #4's medical record occurred on February 23-24, 2016. Nursing progress notes identified the following: *01/14/16 - "Wound rounds completed today.	F 278		

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Resident was admitted with a wound to her buttocks which currently measures 2 cm [centimeters] by 1 cm. The wound is red and opened, draining serious fluid . . ."
*01/28/16 - ". . . She [Resident #4] does have a pressure ulcer to her buttock which she had when she was admitted to the hospital and to this facility . . ."

A PPS 14 day MDS, dated 01/21/16, and a PPS 30 day MDS, dated 02/04/16, failed to identify Resident #4 had a pressure ulcer during the assessment reference period of both MDSs.

During an interview on 02/24/16 at 11:00 a.m., an administrative nurse (#1) stated even though both nursing progress notes occurred the day before each MDS assessment reference period, the pressure ulcer would still have been present during the actual assessment reference period and should have been coded on each MDS.

- Review of Resident #5's medical record occurred on February 23-24, 2016. Nursing progress notes identified the following:
*01/07/16 - "Wound rounds completed today. Resident was admitted with bilateral wounds to his lower buttocks. Left buttock wound measures 1.2 cm by 1.2 cm. Wound is red, no drainage or odor. Right buttock would measures 1.2 cm by 1.9 cm and is red, no drainage or odor noted . . ."
*01/13/16 - "Wound rounds completed today. Resident has bilateral skin abrasions to his lower buttocks. Both wounds measure 2 cm by 1 cm, no odor or drainage . . ."
*01/27/16 - "Wound rounds completed today. Resident was admitted to the facility with skin abrasions to bilateral lower butt cheeks. Wounds

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F 278	Continued From page 15	F 278		

are currently healed, closed, and blanchable. Right buttock wound has slight bruise (purple and black colored) area. Resident tolerated dressing change well . . ."

A PPS 14 day MDS, dated 01/07/16, and a PPS 30 day MDS, dated 01/23/16, identified Resident #5 had unhealed pressure ulcers at a stage 1 or higher but staff failed to complete sections M300A-G (number of pressure ulcers at each stage and if present upon admission or reentry), M0700 (most severe tissue type for any pressure ulcer), M0800 (worsening in pressure ulcer status since prior assessment or last admission/entry or reentry), and if applicable, M0900 (healed pressure ulcers).

During an interview on 02/24/16 at 8:45 a.m., an administrative nurse (#1) stated after coding Resident #5's pressure ulcers on his 01/07/16 and 01/23/16 MDSs, she did not complete the rest of Section M due to the lack of a complete assessment, including staging, in the resident's record. The nurse (#1) agreed Resident #5's medical record lacked evidence of a wound assessment completed during the 01/23/16 assessment reference period. Refer to F314.

- Review of Resident #9's medical record occurred on February 23-24, 2016. Nursing progress notes identified the following:
*12/30/15 - "Wound rounds completed today. Resident has a pressure ulcer to his coccyx that measures 4.5 cm by 3 cm. It has a shiny pink color to the wound bed with a light purple/bruise-like border. No odor or drainage noted . . ."
*01/22/16 - "Wound rounds completed today.

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F 278	Continued From page 16 Resident was admitted with a pressure ulcer to his coccyx which currently measures 4.7 cm by 2.4 cm. Wound bed is light red with dry/flaky skin. No open areas noted or drainage . . ." A PPS 30 day MDS, dated 01/02/16, and a PPS 60 day MDS, dated 01/28/16, identified Resident #9 had unhealed pressure ulcers at a stage 1 or higher but staff failed to complete sections M300A-G (number of pressure ulcers at each stage and if present upon admission or reentry), M0700 (most severe tissue type for any pressure ulcer), M0800 (worsening in pressure ulcer status since prior assessment or last admission/entry or reentry), and if applicable, M0900 (healed pressure ulcers). During an interview on 02/24/16 at 8:45 a.m., an administrative nurse (#1) stated after coding Resident #9's pressure ulcers on his 01/02/16 and 01/28/16 MDSs, she did not complete the rest of Section M due to the lack of a complete assessment, including staging, in the resident's record. Refer to F314. FALLS The Long-Term Care Facility RAI Manual, revised October 2015, page J-30, stated, ". . . Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home . . . Code 0, no: if the resident has not had any fall since the last assessment . . . Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment . . . item (J1900) . . ." Page J-32	F 278		

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F 278	Continued From page 17 stated, ". . . Determine the number of falls that occurred since admission/entry or reentry or prior assessment . . . code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury . . ." - Review of Resident #1's medical record occurred on February 23-24, 2016. A PPS 60 day MDS, dated 01/09/16, identified the resident experienced a fall without injury since the prior assessment. Resident #1's record showed no falls since 11/21/15 (additional MDSs completed from date of fall and 01/09/16 MDS). During an interview on 02/23/16 at 2:20 p.m., an administrative nurse (#1) stated a fall should not have been coded on Resident #1's 01/09/16 MDS. - Review of Resident #6's medical record occurred on February 23-24, 2016. A PPS 14 day MDS, dated 01/16/16, identified no falls since the prior assessment. A PPS 30 day MDS, dated 01/30/16, identified the resident experienced one fall without injury since the prior assessment. Nursing progress notes identified the only falls for Resident #6 occurred on 01/12/16 (skin tear to elbow) and 01/13/16 (no injury). The 01/16/16 MDS failed to identify Resident #6 had one fall without injury and one fall with a minor injury. The 01/30/16 MDS incorrectly identified the resident fell since the last MDS. On 02/24/16 at 11:00 a.m., a nurse (#1) confirmed Resident #6 should have been coded for two falls on his 01/16/16 MDS and none on	F 278		

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F 278	Continued From page 18 his 01/30/16 MDS. NUTRITIONAL APPROACHES The Long-Term Care Facility RAI Manual, revised October 2015, page K-11, stated, ". . . K0510: Nutritional Approaches . . . Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period . . . Check all that apply. If none apply, check K0510Z, None of the above . . . K0510A, parenteral/IV [intravenous] feeding . . . K0510B, feeding tube . . . K0510C, mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) . . . K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol) . . ." - Review of Resident #1's medical record occurred on February 23-24, 2016. A PPS 60 day MDS, dated 01/09/16, identified the resident's nutritional approaches during the last seven days included a feeding tube and therapeutic diet. Review of Resident #1's physician's orders identified a feeding tube, low-sodium cardiac diet, and mechanical soft diet with nectar-thick liquids. A nurse's note, dated 01/05/16, identified the resident received nutrition via tube feeding at night and by mouth during the day. A dietary order, dated 01/06/16, identified regular texture foods and thin liquids. The 01/09/16 MDS failed to identify Resident #1 received a mechanically altered diet, in addition to a feeding tube and therapeutic diet, during the seven day look back period.	F 278		

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F 278	Continued From page 19 MEDICATIONS The Long-Term Care Facility RAI Manual, revised October 2015, pages N-5-N-6 stated, ". . . N0410: Medication Received . . . 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home . . . N0410A, Antipsychotic . . . N0410B, Antianxiety . . . N0410C, Antidepressant . . . N0410D, Hypnotic . . . N0410E, Anticoagulant . . . N0410F, Antibiotic . . . N0410G, Diuretic . . ." - Review of Resident #5's medical record occurred on February 23-24, 2016. A PPS 30 day MDS, dated 01/23/16, identified the resident received an antipsychotic, an antianxiety, an antidepressant, a hypnotic, an anticoagulant, an antibiotic, and a diuretic each of the seven days of the assessment reference period. Review of the resident's medication administration record during the 7-day look-back period of the MDS identified the resident only received a diuretic. During an interview on 02/24/16 at 9:50 a.m., an administrative nurse (#1) stated Resident #5's MDS, dated 01/23/16, should have identified a diuretic only.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		4/9/16

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F 309	Continued From page 20 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 07/09/15. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 1 sampled resident (Resident #3) who did not have a bowel movement (BM) for five days. Failure to monitor the resident's bowel status and provide as needed (PRN) laxatives to relieve constipation has the potential to cause discomfort and may have attributed to Resident #3's hospitalization. Findings include: Review of Resident #3's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated 08/02/15, identified constipation present in the look back period. The medical record identified Resident #3 was hospitalized from 10/13/15 to 10/17/15 for ileus (inability of the intestine to contract normally and move waste out of the body). Review of the October 01-13, 2015 Medication Administration Record (MAR) showed Resident #3's scheduled medications to manage	F 309	F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Resident #3 has discharged from the facility. 2. Residents who have episodes of constipation have the potential to be affected by this practice. Review of bowel records was completed upon survey exit and interventions provided when indicated. 3. The DON or designee will provide education to unit managers and licensed nurses on bowel management, including bowel assessments and use of routine or PRN medications to manage constipation. Education provided to CNAs on proper documentation of bowel movements. 4. Unit managers will complete random audits of bowel management practices weekly for four weeks, then monthly for three months and then quarterly times three. Results of audits will be submitted to the QAPI committee for review and	

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F 309	Continued From page 21 constipation included Colace daily and Senna-Plus daily. PRN medications included Bisacodyl suppository daily as needed. Review of Resident #3's bowel records identified a BM on 10/06/15 and not again until 10/12/15 (five days without a BM). The MAR failed to show Resident #3 received any PRN medications to manage constipation. During an interview on 02/24/16 at 12:30 p.m., an administrative nurse (#3) stated the facility does not have a bowel policy. Her expectations are on day three with no bowel movement facility staff should perform a bowel assessment and offer PRN medications. On day four with no bowel movement facility staff should offer milk of magnesia and on day five with no bowel movement facility staff should offer a suppository and possibly an enema.	F 309	recommendation. 5. Date of compliance is 04/09/16.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, and staff interview, the facility failed to perform	F 314	F 314 SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL	4/9/16

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F 314	Continued From page 22 routine comprehensive assessments, including staging, for 3 of 3 sampled residents (Resident #4, #5, and #9) identified by the facility as having a pressure ulcer in the past 90 days. Staff failure to stage pressure ulcers as part of the wound assessment does not allow facility staff to assess for changes over time and results in inaccurate and incomplete coding of the Minimum Data Set (MDS). Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 838, stated, ". . . Pressure Ulcers, When a pressure ulcer is present, the nurse notes the following . . . Location of the ulcer . . . Size of the ulcer in centimeters. Measure greatest length, width, and depth . . . Presence of undermining or sinus tracts . . . Stage of the ulcer . . . Color of the wound bed and location of necrosis (dead tissue) . . . or eschar (dead tissue) . . . Condition of the wound margins . . . Integrity of surrounding skin . . . Clinical signs of infection, such as redness, warmth, swelling, pain, odor, and exudate (fluid draining from wound) (note color of exudate) . . ." - Review of Resident #4's medical record occurred on February 23-24, 2016. A patient admission/readmission skin assessment, dated 01/07/16, stated, ". . . Right buttock . . . pressure ulcer 4.5 x 1.4 . . ." Nursing progress notes identified the following wound assessments: *01/14/16 - "Wound rounds completed today. Resident was admitted with a wound to her	F 314	PRESSURE SORES 1. Resident #5 has discharged from the facility. Resident #4, and #9s medical records were reviewed and both pressure sores are currently resolved. 2. Current residents with pressure ulcers have the potential to be affected. Medical records were reviewed with a wound assessment completed. 3. DON or designee provided education to unit managers on staging of pressure ulcers and documentation of wound assessments. 4. DON and or Designee will complete audits of weekly wound round documentation to validate staging is included in documentation. Audits will be completed weekly for four weeks, then monthly for three months and then quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. 5. Date of compliance is 04/09/16.	

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buttocks which currently measures 2 cm [centimeters] by 1 cm. The wound is red and opened, draining serious fluid . . ."
*01/28/16 - ". . . She [Resident #4] does have a pressure ulcer to her buttock which she had when she was admitted to the hospital and to this facility . . ."
*02/11/16 - "Late entry for 2/10/16: Wound rounds completed today. Resident was admitted with a wound to her right buttock which currently measures 2.1 cm by 1.4 cm and is light red in color. Would [sic] is opened but has no drainage or odor . . ."
*02/17/16 - "Wound rounds completed today. Resident was admitted to the facility with a pressure wound to her coccyx. Her wound currently measures 1.2 cm by 2 cm. Area is light red in color, not opened, but non-blanchable . . ."

A Prospective Payment System (PPS) 14 day MDS, dated 01/21/16, and a PPS 30 day MDS, dated 02/04/16, failed to identify Resident #4 had a pressure ulcer during the assessment reference period of both MDSs.

- Review of Resident #5's medical record occurred on February 23-24, 2016. A patient admission/readmission skin assessment, dated 12/24/15, stated, ". . . Left buttock . . . covered with Mepilex, open area 1.5 x 1 . . . Right buttock . . . covered with Mepilex, open area 1.5 x 1 . . ."
Nursing progress notes identified the following wound assessments:
*01/07/16 - "Wound rounds completed today. Resident was admitted with bilateral wounds to his lower buttocks. Left buttock wound measures 1.2 cm by 1.2 cm. Wound is red, no drainage or odor. Right buttock would measures 1.2 cm by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 1.9 cm and is red, no drainage or odor noted . . ." *01/13/16 - "Wound rounds completed today. Resident has bilateral skin abrasions to his lower buttocks. Both wounds measure 2 cm by 1 cm, no odor or drainage . . ." *01/27/16 - "Wound rounds completed today. Resident was admitted to the facility with skin abrasions to bilateral lower butt cheeks. Wounds are currently healed, closed, and blanchable. Right buttock wound has slight bruise (purple and black colored) area. Resident tolerated dressing change well . . ." A PPS 14 day MDS, dated 01/07/16, and a PPS 30 day MDS, dated 01/23/16, identified Resident #5 had unhealed pressure ulcers at a stage 1 or higher but staff failed to complete sections M300A-G (number of pressure ulcers at each stage and if present upon admission or reentry), M0700 (most severe tissue type for any pressure ulcer), M0800 (worsening in pressure ulcer status since prior assessment or last admission/entry or reentry), and if applicable, M0900 (healed pressure ulcers). During an interview on 02/24/16 at 8:45 a.m., an administrative nurse (#1) stated after coding Resident #5's pressure ulcers on his 01/07/16 and 01/23/16 MDSs, she did not complete the rest of Section M due to the lack of a complete assessment, including staging, in the resident's record. The nurse (#1) agreed Resident #5's medical record lacked evidence of a wound assessment completed during the 01/23/16 assessment reference period. - Review of Resident #9's medical record occurred on February 23-24, 2016. Nursing	F 314		

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	355024	A. BUILDING _____ B. WING _____	02/24/2016

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F 314	Continued From page 25 progress notes identified the following wound assessments: *12/16/15 - "Wound rounds completed today. Resident was admitted to the facility with a pressure related wound to his coccyx and it measured 3.5 cm by 4 cm. Wound is reddened and raised with a white surrounding border. No drainage or odor noted . . ." *12/23/15 - "Wound rounds completed today. Resident has a coccyx wound that measures 5.2 cm by 3.7 cm. Wound is red in color with a bruise-like surrounding border (purple in color) and has a small opened area at the center if [sic] it. Scant amount of serosanguinous drainage noted to previous dressing . . ." *12/30/15 - "Wound rounds completed today. Resident has a pressure ulcer to his coccyx that measures 4.5 cm by 3 cm. It has a shiny pink color to the wound bed with a light purple/bruise-like border. No odor or drainage noted . . ." *01/07/16 - "Wound rounds completed today. Pressure ulcer to coccyx measures 5.2 cm by 3.2 cm. Wound bed is light pink in color and has a shiny appearance to it. Edges are blanchable and surrounding skin appropriate . . ." *01/13/16 - "Wound rounds completed today. Pressure ulcer to coccyx measures 5.9 cm by 4.6 cm with an open area measuring 0.5 cm by 0.6 cm . . ." *01/22/16 - "Wound rounds completed today. Resident was admitted with a pressure ulcer to his coccyx which currently measures 4.7 cm by 2.4 cm. Wound bed is light red with dry/flaky skin. No open areas noted or drainage . . ." A PPS 30 day MDS, dated 01/02/16, and a PPS 60 day MDS, dated 01/28/16, identified Resident	F 314		

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F 314	Continued From page 26 #9 had unhealed pressure ulcers at a stage 1 or higher but staff failed to complete sections M300A-G (number of pressure ulcers at each stage and if present upon admission or reentry), M0700 (most severe tissue type for any pressure ulcer), M0800 (worsening in pressure ulcer status since prior assessment or last admission/entry or reentry), and if applicable, M0900 (healed pressure ulcers). During an interview on 02/24/16 at 8:45 a.m., an administrative nurse (#1) stated after coding Resident #9's pressure ulcers on his 01/02/16 and 01/28/16 MDSs, she did not complete the rest of Section M due to the lack of a complete assessment, including staging, in the resident's record.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		4/9/16

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F 441	Continued From page 27 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, professional reference review, and staff interview, the facility failed to follow accepted infection control practices for 2 of 6 sampled residents (Resident #3 and #4) observed during personal cares. Failure to follow contact precautions for a resident with Clostridium difficile (C. Diff) (bacterium that causes diarrhea and inflammation of the colon) and complete hand hygiene after perineal cares has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Transmission Based Precautions" occurred on 02/24/16. This policy, dated May 2013, stated, ". . . Contact	F 441	F441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Staff caring for residents #3 and #4 were educated on infection control practices related to perineal care. Resident #3 has been discharged from the facility. Resident #4 was assessed for current C-diff infection. The C-diff signs and symptoms have resolved and this resident is no longer on precautions. 2. Residents requiring assistance with perineal care have the potential to be affected by this practice. Residents have been assessed for signs and symptoms	

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F 441	Continued From page 28 Precautions, Contact transmission is the most important and frequent mode of transmission of healthcare associated infections. It is divided into two subgroups: direct and indirect contact transmission . . . Gloves and Hand Hygiene, Wear gloves during the course of providing patient care . . . Remove gloves before leaving the patient's room and immediately wash hands with an antimicrobial agent . . . Gown, Wear gown only when clothing anticipated to come in contact with the patient, environmental surfaces or items in room contaminated with organism, Remove gown before leaving room and immediately wash hands with an antimicrobial agent . . . Patient Care Equipment . . . Clean and disinfect equipment between patients . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 614, stated, ". . . If there is visible dirt or matter, or if C. difficile may be present, alcohol-based rubs will not be sufficient, and soap and water washing is necessary . . ." Review of the facility policy titled "Incontinence Care" occurred on 02/24/16. This policy, revised August 2014, stated, ". . . Procedure: . . . 4. Perform hand hygiene. 5. Apply latex free non-sterile gloves. 10. Cleanse peri-area and buttocks with cleansing agent or disposable wipe wiping from front of perineum toward rectum . . . 12. Apply skin protectant products, if needed . . . 13. Remove and discard gloves. 14. Perform hand hygiene. 15. Apply clean linen or brief . . . 16. Reposition for comfort with call light in reach and provide additional care needs requested by patient. 17. Return equipment to designated area	F 441	of infection related to infection control practices with perineal care. 3. DON or designee provided education to licensed nurses, nurse managers, and CNAs on infection control practices, hand hygiene, and isolation precautions. 4. Random observation audits of adherence to perineal care and isolation procedures to include practices related to hand hygiene, glove and PPE, including cleaning and disinfecting of non-dedicated patient equipment will be completed weekly for four weeks, then monthly for three months and then quarterly times three. Results of audits will be submitted to the QAPI committee for review and recommendation. 5. Date of compliance is 04/09/16.	

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F 441	Continued From page 29 and clean/dispose as indicated . . ." - Observation of Resident #4's room occurred on all days of survey and identified an isolation cart in the corridor outside of the resident's room and a sign on her door stating, "Stop and see nurse for instructions." On the evening of 02/22/16 a nurse (#6) stated the facility placed Resident #4 on contact isolation precautions related to a diagnosis of C. Diff. Resident #4's care plan stated, ". . . 02/01/16 . . . Infection of GI [gastrointestinal] tract: C-diff . . . maintain precautions as indicated . . ." During an observation on 02/22/16 at 5:13 p.m., a certified nursing assistant (CNA) (#5) entered Resident #4's room, and without washing his hands and donning a gown, applied gloves and assisted the resident with incontinence cares. The CNA (#5) cleansed stool from the resident's buttocks and perineal area. Visible stool soiled the dressing on Resident #4's coccyx. The CNA (#5) removed his gloves, and without washing his hands, exited the resident's room to find a nurse to change the resident's dressing. During an observation on 02/23/16 at 10:55 a.m., two CNAs (#7 and #8) transferred Resident #4 from her bed to her wheelchair using a full-body mechanical lift. The CNAs (#7 and #8) removed their gowns, washed their hands, and without disinfecting the mechanical lift, exited the room and placed the lift in the corridor. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . Focus: ADL Self care deficit as	F 441		

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F 441	Continued From page 30 evidenced by weakness related to disease process (Dementia) . . . Interventions/Tasks . . . hands on staff assist with bed mobility, transfers, toileting dressing and bathing. . . ." Observation on 02/23/16 at 2:00 p.m. showed a CNA (#2) performed perineal care for Resident #3, who was incontinent of bowel. The CNA removed her gloves, and without performing hand hygiene donned gloves, put Resident #3's pants on, pulled his shirt down, and removed her gloves. Then the CNA (#2) donned gloves and emptied Resident #3's catheter leg bag, removed her gloves, and washed her hands. The CNA (#2) failed to perform hand hygiene prior to completing other tasks.	F 441		
F 493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to establish and implement policies regarding the staff member (job title) responsible for completing each section of the Minimum Data Set (MDS), including submission and completion of the MDS schedule, and how staff accomplished the Care	F 493	F493 Governing Body 1. The center has established and implemented procedures to identify the staff member (job title) responsible for completing each section of the Minimum Data Set (MDS), including submission	4/9/16

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F 493	Continued From page 31 Area Assessment (CAA) process and care planning. Failure to establish and implement policies related to all aspects of the MDS may result in inaccurate resident assessments and incomplete care plans. Findings include: During an interview on 02/23/16 at 1:30 p.m., an administrative staff member (#4) confirmed the facility lacked policies and procedures related to the staff person (job title) responsible for completing each section of the MDS, including submission and completion of the MDS schedule, and how staff accomplished the CAA process and care planning.	F 493	and completion of the MDS schedule, the Care Area Assessment (CAA) process and care planning. 2. The IDT, MDS nurses have been educated on the MDS processes by the Administrator to include identification of staff members (job title) responsible for completing each section of the MDS, submission and completion of the MDS schedule and how staff accomplishes the CAA process and care planning. 3. The procedure has been submitted to the QAA Committee for review, recommendations and approval. Social Services will randomly audit for compliance with the established processes. The findings of the audits are submitted to the QAA Committee monthly for review and recommendations. 4. Compliance Date: 04/09/16	