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 _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	**1315 S UNIVERSITY DR FARGO, ND 58103**

(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 The standard Medicare/Medicaid recertification and complaint survey started on June 25, 2018 and concluded on June 28, 2018.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and	F 576		8/1/18

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

Electronically Signed | 07/26/2018

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F 576	Continued From page 1 video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on policy review, resident group interview and staff interview, the facility failed to provide mail delivery on Saturday for 7 of 7 interviewed residents (Resident A, B, C, D, E, F, and G). Failure to provide mail delivery on Saturdays infringes on the residents' rights. Findings include: Review of policy titled "Mail Distribution" occurred on 06/27/18. This policy, dated January 2013, stated, ". . . delivers mail to the patient within 24 hours of receipt to the center. . . ." The resident group interview occurred on 06/26/18 at 10:37 a.m.. The residents stated they did not receive mail on Saturday. During an interview on 06/27/18 at 1:45 p.m., an administrative staff member (#1) confirmed the expectation is for mail to be delivered on Saturday. She reported staff are responsible for passing out mail on Saturday.	F 576	1. Resident□s (A, B, C, D, E, F & G) mail has been delivered. 2.Residents who receive mail have the potential to be impacted. 3.Activity Staff and Managers on Duty were educated on the Mail delivery policy to include prompt delivery of mail and packages, including Saturdays by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4.Audit of mail delivery will be conducted 5 times per week for two months and randomly thereafter to insure proper practice. Administrator will meet with Resident Council to review mail delivery in August, November and randomly thereafter to insure that mail has been delivered on Saturdays. QAPI beginning July 27, 2018, Audit findings will be submitted to QAPI Committee by the Administrator for review for two months and randomly thereafter. 5. August 1, 2018	
F 644	Coordination of PASARR and Assessments	F 644		8/1/18

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F 644 SS=D	Continued From page 2 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #23) with a newly diagnosed mental illness since the facility completed the initial PASARR on admission. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with resident's needs. Findings include:	F 644	1. Resident #23 had a PASARR completed on July 10, 2018. 2. Current residents were reviewed to determine if there was a new diagnosis of a possible serious mental disorder, intellectual disability or related condition and PASARR requested as needed. 3.Education was provided to Nurse Managers, Social Services and Admissions on the need to complete a PASARR on an on-going basis when there is a new or changed diagnosis by August 1, 2018. New hires, leaves of	

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F 644	Continued From page 3 The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [name of contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #23's medical record occurred on all days of survey. The record showed an initial PASARR completed on 03/12/12 and identified dementia and no mental illness. The screening stated, ". . . The Level I Screen conducted for the above named individual determined that there was not evidence to suggest presence or known conditions of mental illness . . ." Resident #23's medical record identified diagnoses of dementia without behavioral disturbance (03/12/12), anxiety disorder (03/12/12), dsythymic disorder (03/12/12), and unspecified psychosis not due to a substance or known physiological condition (05/06/15). The record lacked evidence the facility completed a Level II assessment following the new diagnosis of psychosis.	F 644	absence and prn staff will not work until they have received education. 4.New admissions will be audited to insure that possible serious mental disorder, intellectual disability or related conditions have had proper PASARR documentation. Social Services Director or designee will complete random audits for five residents once a month for three months and randomly thereafter. QAPI, beginning July 27, 2018, audit results will be submitted by the Social Services Director to QAPI Committee for three months and randomly thereafter, for review and determination of need for additional audits. 5. August 1, 2018	

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F 644	Continued From page 4 During an interview on 06/28/18 at 8:40 a.m., a supervisory social service staff member (#3) confirmed the facility failed to submit a PASARR for Resident #23 following the additional diagnosis of psychosis.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 657	1.Care plan and task list were updated	8/1/18

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F 657	Continued From page 5 facility policy and staff interview, the facility failed to review and revise comprehensive care plans to reflect the resident's current status for 2 of 18 sampled residents (Resident #2 and #71). Failure to review/revise the care plan to reflect each resident's current status limited the staff's ability to communicate needs and ensure continuity of care for the residents. Findings include: Review of the policy titled, "Interdisciplinary Care Planning" occurred on 06/27/18. This policy, updated March 2018 stated, " . . . The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive . . . The care plan should include patient-specific measurable objectives . . . identifying risk versus benefits of the current interventions . . . incorporate the patient's personal and cultural preferences. . . ." - Review of Resident #2's record occurred on all days of the survey. The Quarterly Minimum Data Set (MDS), dated 05/31/18, identified Resident #2 as requiring the assistance of two staff for transfers and toileting, assistance of one staff for dressing and eating and only set up help with personal hygiene. The current care plan stated, ". . . activities of daily living (ADL) self care deficit . . . Assist with daily hygiene, grooming, dressing, oral care and eating as needed. . . ." The certified nursing assistant (CNA) care card showed, ". . . ADL assist-usually 2 person with minimum (min) level	F 657	for Resident #71 to reflect correct transfer status of minimal assist of 1 with gait belt. Resident #2 Care plan and task list were updated to reflect stand pivot with assist of one and a gait belt. 2.Residents who need assistance with transferring have the potential to be affected by this practice. Care plans and task lists updated and revised as needed. 3.DON or designee provided education to licensed nurses and CNAs on ensuring accuracy of care plans and task lists. Education included information on updating care plans and task lists, utilizing alert charting or 24hr report sheet, as well as notifying the nurse or nurse manager of any concerns noted when CNAs review task lists/Kardex prior to providing care and services by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4.The DON or designee will complete random audits three times weekly for four weeks, then monthly for three months and randomly thereafter. QAPI beginning July 27, 2018, the DON or designee will submit to the QAPI committee the audit results weekly, monthly and randomly thereafter, will be submitted by the DON or designee to the QAPI committee for review and recommendations. 5. Date of compliance is August 1, 2018.	

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F 657	Continued From page 6 of assist . . . provide assistance with toileting. . . ." Observation on 06/26/18 at 9:00 a.m., showed a CNA (#14) assisted Resident #2 from her wheelchair (WC) to her bed using a gait belt and a pivot transfer. Observation on 06/27/18 at 8:08 a.m., showed an unidentified CNA transferred Resident #2 from the toilet to her WC with a gait belt and pivot transfer. During an interview on 06/28/18 at 11:15 a.m., an administrative nurse (#2) stated Resident #2's care plan does not reflect the current ADL needs of the resident. - Review of Resident #71's record occurred on all days of the survey. The admission MDS, dated 06/14/18, identified Resident #71 required assist of two with bed mobility, transfers and toileting. The current care plan stated, ". . . ADL self care deficit as evidenced by assist of one to two to complete ADLs . . . Transfer with sit to stand mechanical lift (EZ stand) and 2 assist . . . Assist with daily hygiene, grooming, dressing, oral care and eating as needed. . . ." The CNA care card showed, ". . . ADL assist-usually 2 persons with maximum (max) level of assist . . . transfer with sit to stand mechanical lift (EZ stand) and 2 assist. . . ." Observation on 06/26/18 at 9:24 a.m., showed a CNA (#9) assisted Resident #71 from her WC to her bed using a gait belt and a pivot transfer.	F 657		

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F 657	Continued From page 7 During an interview on 06/28/18 at 10:50 a.m. , a CNA (#9) stated Resident #71, "transfers with a gait belt and assistance of one. No she does not use the EZ stand lift." The current care plan's failed to accurately reflect the level of assistance Resident #2 and #71 required for assistance with ADL's.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review of professional reference, and staff interview, the facility failed to administer medications in accordance with acceptable standards of practice for 1 of 1 resident (Resident #16) with a physician's order for a crushed medication. Failure to follow acceptable standards of practice for medication administration has the potential to result in medication errors and/or adverse reactions for the resident. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, Pearson, Boston, Massachusetts, page 776, states ". . . Administering Oral Medications . . . Preparation: . . . 2. Check the MAR [medication administration record]. Check for the drug name, dosage, frequency, route of	F 658	1.Resident #16□s medication list was reviewed and directions updated on Medication Administration Record. Nurse #12 was given 1:1 education on med pass policy. A Medication audit will be done with Nurse #12. 2. Residents who request or need to have medications crushed have the potential to be affected. 3. MARs were reviewed and revised as needed for residents needing medications crushed identified through audits and directions were updated on the Medication Administration Record. DON or designee will provide education to licensed nurses on medication administration and observing orders by August 1, 2018. New hires, leaves of	8/1/18

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F 658	Continued From page 8 administration, . . . If the MAR is unclear or pertinent information is missing, compare the MAR with the prescriber's most recent written order. . . . Performance. . . . 3. Obtain the appropriate medication. Read the MAR and take the appropriate medication . . . Compare the label of the medication container or unit-dose package against the order on the MAR . . . 4. Prepare the medication. . . . While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: this second safety check reduces the chance of error. . . ." During an interview on 06/26/18 at 9:37 a.m., Resident #16 stated her digestive system problems cause some of her pills to "pass through without even dissolving, so the doctor said to crush those pills." Resident #16 stated "some nurses crush the pills, and others don't. It says it right on the record, but I have to keep telling staff." Review of Resident #16's medical record occurred on all days of survey. The physician's orders, dated 06/20/18, stated, "Change time of the Buspirone . . . and recommend crushing this med." Review of the June MAR on 06/27/18, identified the following: "6/20/18 Buspirone 30 mg [milligrams] po [by mouth] BID [two times a day] Crush." Observation of medication pass occurred on 06/28/18 at 7:54 a.m. The nurse (#12) placed 19 oral medications in a medication cup (for a total of 21 pills). The nurse (#12) stated one of the tablets needs to be crushed but she does not know which one and would need to ask the	F 658	absence and prn staff will not work until they have received education. 4. The DON or designee will complete random medication pass audits three times weekly for four weeks, then weekly for two months and randomly thereafter. QAPI beginning July 27, 2018, the DON or designee will review results of audits weekly and randomly thereafter to the QAPI committee for review and recommendations. 5. Date of compliance is August 1, 2018.	

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F 658	Continued From page 9 resident. The nurse emptied the pills from the medication cup into Resident #16's hand and asked the resident which of the pills needed to be crushed. Resident #16 initially expressed frustration and said she was not sure, but then began to identify each of the pills in her hand and found the two pills that should be crushed. The pills were identified as two 15 milligram tablets of Buspirone. The nurse went to the medication cart, crushed the medications, mixed them in applesauce, and administered them to the resident. During an interview on the afternoon of 06/28/18, two administrative staff members (#1) and (#2) confirmed the nurse should refer to the physician's orders and MAR regarding crushed medications and not ask the resident to identify the medications.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		8/1/18

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F 686	Continued From page 10 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/10/17 Based on information provided by the complainant, observation, record review, resident and family interview, and staff interview, the facility failed to provide the necessary care and services to prevent the development of pressure ulcers and promote healing, for 1 of 4 sampled residents (Resident #22) with pressure ulcers. Failure to evaluate risk factors that may impact the development/healing of a pressure ulcer, implement, monitor and modify interventions to reduce those risk factors, resulted in Resident #22 developing avoidable, facility acquired pressure ulcers and may result in the development of new ulcers. Findings include: The complainant identified Resident #22 was admitted to the hospital on 06/18/18 with multiple areas of skin breakdown. Review of Resident #22's medical record occurred on all days of survey. Diagnoses include benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, chronic kidney disease stage III, pain, and a hospital admission on 06/18/18 for volume depletion, urinary tract infection (UTI) and hyperglycemia (high blood sugar). During an observation on 06/26/18 at 9:45 a.m. two certified nursing assistants (CNAs), (8# and #9) assisted Resident #22 with perineal cares. While staff performed cares, Resident #22 called out in pain and moaned. His buttocks, peri area,	F 686	1. Resident #22 had a new Braden completed on 7/19/2018 to identify risks, topical treatments three times daily and prn to affected area, indwelling Foley catheter to reduce exposure to urine, lab work, Easy Air XL air mattress and Equagel wheelchair cushion. Skin is observed daily during cares & resident is repositioned routinely. 2. All residents at risk for pressure ulcers have the potential to be affected. 3. All residents were reassessed or had a new Braden Assessment completed to identify risk for the development of pressure ulcers. Patient□s with pressure ulcers medical records were reviewed to include a wound assessment, nutrition note, Braden and observation of pressure relieving devices in place per plan of care. Braden Assessments will be completed upon admission, weekly for three additional weeks and upon change of condition. The DON or designee will provide education to licensed staff and CNAs on risk identification with the use of Braden scale to prevent pressure ulcers, reporting changes in resident□s skin integrity to the nurse or nurse manager immediately and assuring skin interventions/pressure relieving devices are in place by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4. The DON or designee will complete	

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F 686	Continued From page 11 and scrotum were excoriated, his penis reddened and ulceration noted to the foreskin. He had an indwelling foley catheter. Current physician orders stated, ". . . Assess pain daily, weekly skin checks, mycostatin apply to affected area twice daily as needed, corona ointment to buttocks/coccyx q/shift(every shift) and as needed. . . ." A quarterly MDS (Minimum Data Set), dated 05/28/18 identified frequent incontinence of bowel and bladder, extensive assistance of two persons for bed mobility, toileting and total dependence for transfers. The current care plan stated, ". . . Self care deficit as evidenced . . . hands on staff assist with bed mobility, transfers, toileting . . . Skin care: . . . At risk for alteration . . . related to incontinence . . . barrier cream to peri area, buttocks . . . observe skin condition with ADL(Activities of Daily Living) care daily - report abnormality . . . . " Although Resident #22 was identified as frequently incontinent of bowel and bladder, his care plan failed to address his incontinence and provide specific interventions to prevent skin breakdown. Review of a Braden Scale (an assessment for predicting pressure sore risk), dated 05/04/18 and 06/05/18, identified a risk for pressure ulcers. A facility policy on skin conditions/pressure ulcers, was requested and the facility provided a "Skin Practice Guide Process Flowchart." Review of Resident #22's medical record identified facility staff failed to follow the process as indicated by the flowchart.	F 686	audits for implementation of risk identification and interventions per plan of care three times weekly for four weeks, then weekly for two months and randomly thereafter. QAPI beginning July 27, 2018, the DON or designee will submit the results of audits weekly and randomly thereafter to the QAPI committee for review and recommendation. 5. Date of compliance is August 1, 2018.	

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	355024	A. BUILDING _____ B. WING _____	C 06/28/2018

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F 686	Continued From page 12	F 686		

Resident #22's progress notes identified the following:
* "05/07/18 Groin is pink." Only documentation regarding skin condition for the month of May. The next entry, 33 days later identified:
* 06/10/18 "Open area on back of testicles, 1 cm(centimeters) x 1 cm. Open area on left buttocks returned."
* 06/17/18 "Excoriation on right and left buttocks. Skin red and firm. Redness blanchable. Redness and excoriation peeling. Some areas on excoriation has scant amount of thin/red drainage noted measuring approx 15 cm x 15 cm. Testicle red/firm/swelling. Redness blanchable. Wound located on right testicle 1 cm x 1 cm Edges approximated.
Second wound located on right testicle measuring 2.5 cm x 1 cm. Edges approximated. Black eschar noted [tissue that adheres firmly to the wound bed or ulcer edges]. Small open area on left testicle 1 cm x 1 cm. Edges approximated dark/pink/red tissue noted, scant amount of thin red drainage noted. Writer left Situation Background Assessment and Recommendation (SBAR) for Nurse Practitioner (NP) to assess areas. New order for ointment to apply topically 3 x/day and as needed (PRN) to buttocks, peri area and excoriation."
* 06/18/18 "Resident transferred to emergency department (ED). Blood sugar (BS) of 1085 and Sodium (Na) of 126."
* 06/23/18 "Resident returned from hospital. Wound recommendation was put in for wound on back of penis/testicle. Resident continent of bowel and bladder (B&B). Has a foley catheter. Uses a bedpan. Is incontinent of B&B at times."
* 06/24/18 the progress note showed: "1) Open

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F 686	Continued From page 13 area right testicle- 1 cm x 1 cm, yellow slough present. 2) 2nd open area right testicle 3.5 cm x 2 cm. 3) open area left testicle 1 cm x 1 cm. 4) Excoriation noted left buttocks. 5) Rash noted on right and left groin - raised bumps zero drainage. 6) Open wound on top of penis/foreskin - 2 cm x 2 cm yellow slough present - scant amount red/thin drainage." * 06/24/18 "Resident requested to stay in bed all shift, was repositioned at routine intervals." During an interview on 06/26/18 at 4:28 p.m., Resident #22's wife stated she is aware of him being left on a bed pan for an hour. She stated it happened about a month ago. She also indicated he was hospitalized on 06/18/18 for high blood sugar and an infection. During an interview on 06/28/18 at 11:15 a.m., Resident #22, who has a Brief Interview for Mental Status (BIMS) of 15 [cognitively intact], reported sometimes he is on the bed pan for a long time because he falls asleep and staff failed to check on him after they put him on the bed pan. During an interview on 06/28/18 at 4:00 p.m. regarding Resident #22's pressure ulcers/skin breakdown, the administrative nurses (#1) and (#2) provided no further information.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		8/1/18

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F 692	Continued From page 14 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, observation and staff interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for 1 of 1 sampled resident (Resident #22) hospitalized for volume depletion and urinary tract infection (UTI). Failure to frequently offer fluids placed residents at risk for dehydration, UTI, and fluid/electrolyte imbalances. Findings include: Review of the facility's "Hydration Practice Guide Flowchart," dated 2012, stated: "Prompting patients to consume fluids and hydrate themselves is the single most effective approach in maintaining fluid balance . . . prompting to drink fluids is paired with toileting activities. . . ." Review of Resident # 22's medical record	F 692	1.Resident #22 was assessed with no clinical indications of dehydration observed. Resident #22 continues to be independent in his ability to obtain fluids. Fluids are offered at meals and available in between meals. 2.All residents have the potential to be affected. 3.Fluids continue to be offered at meals and are available in between meals. Assessments were completed for residents needing assistance with no identified issues. DON or designee will provide education to nursing staff regarding offering fluids at meals, with cares and following guidelines for hydration management as outlined in the Hydration manual by	

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F 692	Continued From page 15 occurred on all days of survey. Diagnoses included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, chronic kidney disease stage III and a hospital admission on 06/18/18 for volume depletion, UTI, and hyperglycemia. Current physician orders showed Resident #22 required assist with feeding, safe swallow strategies, small bites/sips, slow rate, no straws, honey-like liquid at meals and thin liquid between meals. Current medications included furosemide (diuretic) 20 milligram (mg) 1 tablet daily by mouth. The resident's care plan identified, ". . . Risk for alteration in hydration related to diuretics, disease process/conditions, . . . times of pain, times of dry mouth, states he doesn't drink enough water, . . . dysphagia with thickened liquids at meals and thin liquids between meals per physician/mid-level order, . . . offer encourage and assist patient with fluids and between meals as needed. . . . " Observation on 06/26/18 at 9:45 a.m. showed two certified nursing assistants (CNAs) (#8 and #9) assisted Resident #22 with perineal cares, however, failed to offer fluids upon completion of cares. Observation on 06/27/18 at 11:39 a.m. showed two CNAs (8# and #7) assisted Resident #22 with perineal cares, however, failed to offer fluids upon completion of cares. During an interview on 06/28/18 at 4:00 p.m., an	F 692	August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4. The DON or designee will complete random audits for compliance with assistance with fluid intake, that during cares and intake at meals fluid is being offered will be completed three times weekly for four weeks and then monthly for two months and randomly thereafter. QAPI beginning July 27, 2018, the Director of Nursing or designee will submit results of audits weekly, monthly and randomly thereafter to QAPI committee for review and recommendations. 5. Date of compliance is August 1, 2018.	

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F 692	Continued From page 16 administrative nurse (#2) stated the staff are to offer fluids with cares and throughout the day.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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 facility policy and procedure, resident interview, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 1 of 2 sampled residents (Resident #63) receiving hemodialysis outside the facility. Failure to assess the hemodialysis vascular access site (central venous catheter) can result in complications with access function, infection, and possible loss of the access site. Findings include: Review of the facility policy/procedure titled "Dialysis Guidelines" occurred on 06/28/18. This policy, dated November 2017, stated, ". . . Guidelines: . . . A coordinated comprehensive care plan for dialysis treatments is developed with input from both the interdisciplinary team (IDT) and dialysis facility staff. . . . Both the center and the dialysis facility are responsible for shared communication regarding patients receiving dialysis served, either onsite or offsite. . . . Collaborative communication includes	F 698	1. Resident #63 Care Plan and task list were updated to reflect the dialysis port to her right chest. 2. All residents who receive dialysis have the potential to be affected. 3. The DON or designee will provide education to licensed staff on care planning and assessing dialysis ports by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4. The DON or designee will complete audits of all residents with dialysis orders and will be audited for monitoring and care plan of their ports. Audits will be completed weekly x4 monthly x2 and randomly thereafter. QAPI beginning July 27, 2018 and DON or designee will submit weekly, monthly and randomly thereafter the audit findings to QAPI committee for review and determination of need for additional audits.	8/1/18

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F 698	Continued From page 17 information regarding: . . . Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring including those related to the vascular access site . . . " During an interview on 06/25/18 at 4:04 p.m., Resident #63 stated he/she has a dialysis catheter (a tube placed in a large central vein in the chest) and a fistula (an artery and a vein connected together under the skin to provide access to the blood) in his/her arm for dialysis. Observation showed a central venous catheter (CVC) with a dressing on Resident #63's upper right chest and a dressing over his/her left arm fistula. Review of Resident #63's medical record occurred on all days of survey. Resident #63's medical conditions are such that he/she requires treatment for kidney disease. Resident #63's current care plan failed to identify his/her central venous catheter, or the risks/complications, or care of the catheter. During an interview on the afternoon of 06/27/18, a supervisory nurse (#6) stated the nurses would assess the catheter during the weekly skin assessments. Review of the nursing progress notes and skin assessments failed to show evidence nursing staff monitored Resident #63's central venous catheter site.	F 698	5. Date of compliance is August 1, 2018.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		8/1/18

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F 757	Continued From page 18 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure each resident's medication regimen was free of unnecessary drugs for 1 of 14 sampled residents (Resident #9) identified as having severe/moderate pain. Failure to ensure adequate indications for increasing the dosage of the drug limited Resident #9's ability to reach or maintain her highest practicable mental, physical, and psychosocial well-being. Findings include: Observation on 06/25/18 at 3:22 p.m. and 06/26/18 at 4:22 p.m. showed Resident #9 sleeping in her bed. Observation on 06/27/18 at 11:15 a.m. showed resident sleeping in her	F 757	1.Resident #9 was assessed and plan of care was reviewed and revised as needed. 2.All residents with increases in pain medications have the potential to be affected. 3. Medication Regimens were reviewed and revised as needed. A pain assessment was completed for patients on controlled pain medications. The DON or designee will provide education to licensed staff and CNAs on adequate pain assessments and proper documentation reflecting the need for increased pain medications and charting	

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F 757	Continued From page 19 wheelchair with her head down. Observation on 06/26/18 at 12:25 p.m., showed Resident #9 in the dining room slowly eating independently. The resident fell asleep numerous times throughout the meal. Observation on 06/27/18 at 8:37 a.m. and 06/27/18 at 12:31 p.m. showed the resident asleep with food in front of her at the dining table. Observation on 06/27/18 at 11:17 a.m., showed two certified nursing assistants (CNAs) (#10 and #11) attempted to wake Resident #9, who was asleep in her wheelchair in her room. The CNAs were unable to fully wake the resident. The resident did not open her eyes or lift her head. Resident #9 responded with groans when asked if she wanted to transfer to the toilet. A CNA (#10) stated, "Recently, she is hard to wake up sometimes. If she does not wake up, instead of transferring her to the toilet, we check and change her in the bed." The CNAs transferred the resident to the bed and provided cares. The resident did not open her eyes or respond verbally while cares were done. The resident followed commands and groaned. Review of Resident #9's medical record on 06/27/18 showed a daily pain assessment documented as "0" for all of May 1-31, 2018. "Pain/Pain Assessment in Advanced Dementia Evaluation," entered on 05/09/18, indicated pain level of "0." The quarterly Minimum Data Set, dated 04/08/18, identified no presence of pain. A review of the physician's orders stated, " . . . Tramadol 25 milligrams (mg) twice daily. . . . (was discontinued 05/16/18) . . . Increase Tramadol to 50 mg twice daily 5/16/18. . . ."	F 757	to baseline by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4. The DON or designee will complete audits of residents on pain medications for adequate pain control three times a week for four weeks, then monthly for two months and randomly thereafter. QAPI beginning July 27, 2018, the DON or designees will submit results of audits weekly, monthly and randomly thereafter to QAPI committee for review and recommendations. 5. Date of compliance is August 1, 2018.	

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F 757	Continued From page 20 Review of a progress note, dated 04/17/18, written by an activities staff member, stated ". . . Care conf. [conference] held. [sic] in [Resident #9's] room. This writer present. [Resident #9] is alert, smiling and talkative through out. Dietary: 4/16 128.8# [pounds]. Has had significant weight loss. Intakes vary on alertness, but recently downgraded to dysphagia mech. [mechanical] soft. Activities: Cont. [continue] to attend act. [activities] such as religious services, exercise, and socials. Often falls asleep requiring cues to stay awake and engage in activity. Nsg [nursing]: A/O [alert/oriented] to self only. Vitals WNL [within normal limits]. No pain issues. . . ." A provider note, dated 05/16/18, stated, "[Resident #9] is a 100 year old female who is seen today at the request of staff for concerns of a rash on her lower legs and for increased pain, not controlled by her current regime. I do not see a rash on her lower legs. She does appear uncomfortable and I did increase tramadol to 50 mg twice daily. . . ." In an interview on 06/28/18 at 1:41 p.m., an administrative nurse (#6) stated she could not find documentation of increased pain for Resident #9.	F 757		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804		8/1/18

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F 804	Continued From page 21 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, group interview, resident interview, and staff interview, the facility failed to serve food at palatable and appetizing temperatures for 7 of 7 residents attending the group interview (Resident A, B, C, D, E, F, and G) and 4 of 11 sampled residents (Resident #16, #25, #35, and #65) interviewed. Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Food Temperatures at Point of Service" occurred on 06/28/18. This policy, dated September 2014, stated, "The regulation that addresses food temperatures at point of service to the patient . . . 'each patient receives and the facility provides: (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature.' The intent . . . states that 'Food should be palatable, attractive and at the proper temperature as determined by the type of food to ensure patient's satisfaction.' . . . A temperature or range of temperatures at point of service is not defined in the regulation or Guidance to Surveyors. Patient acceptance is used as a guide and consideration is given to the time the food sits at temperatures between 135 [degrees] Fahrenheit (F) and 41 degrees F. . . ." The resident group interview occurred on	F 804	1.For resident #65 and the group, extra silverware and condiments are placed on the meal delivery carts so that staff does not have to go back to the kitchen to obtain. Resident #16 was offered and chose to change dining locations. The weights for resident #35 were reviewed and there is no weight loss. For resident #25 and group, meal preparation procedures have been changed to insure that meals are on-time and served at the proper temperature. 2.Current residents have the potential to be affected. 3.Education was provided to Nurses, Nursing Assistants, Cooks and Dietary Aides on the importance of serving palatable meals on a timely basis by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. Condiment/silverware caddies will go out with each non-dining room cart as a backup. The process to expedite tray line and keep food covered to maintain temperatures has been refined. 4.The DSM or designee will audit food temperatures through test trays placed on different carts for different meals. Test tray will be the last tray delivered with food temperatures documented. This process will occur 3 times weekly for one	

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F 804	Continued From page 22 06/26/18 at 10:37 a.m. The residents who attended group reported the food is always at least 30 minutes late, can be as late as 90 minutes, and the food is always cold. - During an interview, the morning of 06/25/18, Resident #65 stated that his food is sometimes cold because his tray will come without silverware or condiments, and by the time they bring the items to him, the food is cold. - During an interview on 06/26/18 at 9:47 a.m., Resident #16 stated she is the last person to get served her meal tray and the "food is cold when I get it." - During an interview on 6/26/18 at 10:55 a.m., Resident #25 stated the "food is not served on time" and the temperature of the food is "fair." - During an interview on 06/26/18 at 1:30 p.m. Resident #35 stated the "food is bad" and thinks he is losing weight. Observation of tray-line occurred on 06/26/18 at 12:24 p.m. Observation showed one dietary staff member dishing the food on the plates and setting them on top of the counter. Observation showed up to 4 uncovered plates at a time on top of the counter waiting to be placed on a tray and covered with an insulated cover. During an interview on the morning of 06/28/18, an administrative dietary staff member (#12) acknowledged a problem with late meals and confirmed the plates should not sit on the counter uncovered.	F 804	month and weekly for two months and randomly thereafter. QAPI beginning July 27, 2018, the DSM or designee will submit audit findings weekly, monthly and randomly thereafter to QAPI committee for review and determination of need for additional audits. 5.August 1, 2018	

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	355024	A. BUILDING _____ B. WING _____	C 06/28/2018

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F 804	Continued From page 23 Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, resident group interview, and staff interview, the facility failed to provide meals in a timely manner according to resident needs, preferences, and requests for 5 of 11 sampled residents interviewed (Resident #6, #16, #25, #31, and #35) and for 7 of 7 residents attending the resident group interview (Resident A, B, C, D, E, G, and F). Failure to provide timely meal service and snacks can negatively impact the	F 809	1. DSM or designee followed up with Residents #6, #16, #25, #31 and #35 to assess frequency of meals and snacks. Resident #6 states that he is getting meals. Resident #16 was offered and chose to change dining locations. For all residents interviewed, the group and resident #25, meal preparation procedures have been changed to insure that meals are on-time and served at the	8/1/18

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F 809	Continued From page 24 dining experience and has the potential to cause adverse reactions for residents receiving medications such as short acting insulin. Findings include: Review of the facility policy titled "Meal Schedules," occurred on 06/28/18. This policy, dated September 2014, stated, ". . . Guidelines: 1. Requests for different meal times for individual patients are reviewed and accommodated as possible. . . . 6. According to the Investigative Protocol for Dining and Food Service from the Survey Procedures for Long Term Care Facilities, meals should arrive no later than 30 minutes past the scheduled meal time. . . ." The facility meal times for Dakota Dining were as follows: * Breakfast at 8:00 a.m. * Lunch at 12:00 p.m. * Dinner at 6:00 p.m. Observation of the noon meal in the Dakota Dining room occurred on 06/25/18 between 12:00 p.m. and 1:10 p.m. and showed numerous residents commenting about the food being late. Meal service started 45 minutes after the scheduled 12:00 p.m. meal time. During an interview on 06/25/18 at 4:06 p.m., Resident #6 reported he missed lunch today due to an appointment, and he returned to the facility at 2:30 p.m. Resident #6 was currently eating ice cream for an afternoon snack, but stated staff did not offer him a meal. Resident #6 stated this is not the first time this has happened.	F 809	proper temperature. Resident #31 states meals are on time. Resident #35 has been educated on the snacks available when he is hungry. 2. Residents residing in the facility have the potential to be affected by this practice. 3. Nurses, Certified Nursing Assistants, Cooks and Dietary Aides were educated on the importance of serving meals on time, passing snacks to all residents and offering a meal when residents miss a meal due to an appointment by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. A Dietary Communication form was implemented to indicate which residents have an appointment that will affect meal time and if a tray should be saved. Additional food items are stocked in the South Nourishment Room for anyone who misses a unexpected meal or requests a more substantial snack after kitchen staff has left. The South Nourishment Room refrigerator will be checked Monday, Wednesday and Friday by administrative dietary staff or designees to insure that the area is stocked. The DON or designee will provide education to nursing staff on providing snacks every shift. CNAs will be educated on obtaining sack meals for residents leaving for dialysis by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education.	

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F 809	Continued From page 25 Observation on 6/26/18 at 8:24 a.m. showed Resident #31 in his room waiting for his breakfast tray, and 8:50 a.m. he received his breakfast tray. The resident group interview occurred on 06/26/18 at 10:37 a.m. All residents who attended group reported the food is always at least 30 minutes late, and can be as late as 90 minutes. They stated evening snacks are not always served and the facility runs out of food such as yogurt, bananas, and peanut butter. One resident stated he/she gets snacks in the evening about 2-3 times per week and states if you miss a meal "they do not offer a meal when you return." -During an interview on 06/26/18 at 9:47 a.m., Resident #16 stated she is the last person to get served her meal tray and the "food is cold when I get it." Resident #16 stated she received her lunch at 1:20 p.m. yesterday and the night before her tray arrived at 7:20 p.m. She stated the trays usually arrive after 7:00 p.m. and the facility runs out of food. - During an interview on 6/26/18 at 10:55 a.m., Resident #25 stated the "food is not served on time and the noon and supper meals are the worst." - On 6/26/18 at 4:21 p.m., Resident #31, who eats meals in his room, stated "I have to wait for for my food sometimes, it depends on the day." - During an interview on 06/26/18 at 1:30 p.m. Resident #35 stated that he is hungry most of the time and that the "aids" (certified nurse	F 809	4. The DMS or designee will audit the time the carts leave the kitchen for each meal. This audit will take place 3 time weekly for one month, weekly for the two months and randomly thereafter. The DON or designee will complete random audits for compliance with timely meals and snack pass will be completed three times weekly for one month, then weekly for two months and randomly thereafter. QAPI beginning July 27, 2017, the DMS and DON or designees will submit audit findings weekly, monthly and randomly thereafter to QAPI committee for review and determination of need for additional audits. 5. Date of compliance is August 1, 2018.	

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F 809	Continued From page 26 assistants) told him he is not allowed more food due to his special diet. He stated he gets snacks about fifty present of the time. During an interview on the morning of 06/28/18, a administrative dietary staff member (#12) acknowledged a problem with late meals and delivery of meals.	F 809		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		8/1/18

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F 880	Continued From page 27 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, observation, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 3 sampled residents (Resident #6) on contact precautions. Failure to follow appropriate infection control practice related to disinfecting equipment may result in the spread of infection within the facility. Findings include: Review of the policy titled "Transmission Based Precautions" occurred on 06/28/18. This policy, dated May 2013, stated, ". . . Patient Care Equipment . . . Clean and disinfect equipment between patients. . . ." Review of Resident #6's medical record on 06/26/18 indicated the resident was on contact precautions due to Methicillin-resistant Staphylococcus aureus in the resident's abdominal wound. Observation on 06/26/18 at 2:10 p.m. showed two Certified Nursing Assistants (CNAs) (#4 and #5) removed a Hoyer Lift from Resident #6's room and placed it across the hall in the equipment room. The CNAs failed to disinfect the lift prior to the next use. During an interview on 06/26/18 at 2:15 p.m. with two CNAs (#4 and #5), they stated staff disinfect lifts daily. During an interview on 06/28/18 at 3:20 p.m., an administrative nurse (#6) stated she expected	F 880	1. The lift was cleaned when deficient practice report. CNAs #4 and #5 caring for resident #6 were educated on infection control practices related to cleaning of equipment. 2. Residents requiring use of mechanical lifts for transfers have the potential to be affected. 3. Residents have been assessed for signs and symptoms of infection. DON or designee provided education to licensed nurses and CNAs on infection control practices and isolation precautions by August 1, 2018. New hires, leaves of absence and prn staff will not work until they have received education. 4. Random observations of staff utilizing equipment shared between residents will be completed three times weekly for one monthly, then monthly for two months and randomly thereafter. QAPI beginning July 27, 2018, the DON or designee will submit audit results weekly, monthly and randomly thereafter to the QAPI committee for review and recommendation. 5. Date of compliance is August 1, 2018.	

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F 880	Continued From page 29 staff to disinfect lifts after every use when used on a resident on contact precautions.	F 880		