STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ON BROADWAY	1351 N BROADWAY FARGO, ND 58102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 04/01/14 and completed on 04/03/14, the sample included five (5) residents for complete review, 15 residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157** It is the practice of this facility to provide notification of any accident resulting in injury, significant change in resident condition, or changes in treatment to the resident's provider and family/legal representative. 1. Resident #9 and resident #14 family and medical providers were updated on resident condition. 2. All residents who have a change in condition, accident with an injury, or change in treatment have the potential to be affected. 3. Licensed Nurses will be re-educated on notification of resident's medical provider and family with accidents, significant	5/8/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 4/28/14

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to promptly notify residents' families and physicians of a change in condition for 2 of 5 sampled residents (Resident #9 and #14) who experienced a fall with fracture. Failure to notify physicians and families of the falls may result in delayed treatment, does not allow for participation in the residents' care, and is an infringement of the residents' rights. Findings include: Review of the facility policy titled "Notification of Change in Resident's Condition or Status" occurred on 04/03/14. This policy, revised 07/10/13, stated, ". . . Facility staff will promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status and document the notification in the progress notes of the residents [sic] chart. . . . Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's condition or status. . . ." Review of the facility policy titled "Falls Protocol" occurred on 04/03/14. This policy, revised 06/13/13, stated, ". . . Nursing will notify the family and provider after each fall unless otherwise indicated in the careplan. . . ."	F 157	change in treatment or condition. Report format updated and nurses educated to include Notifications that need to be completed on the next shift. 4. The Quality Nurse or designee will audit all residents with an accident resulting in injury for documentation that medical provider and family have been notified for 4 weeks then will audit 10 falls per month for 3 months. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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F 157	Continued From page 2 - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Nurses' notes stated the following: *06/28/13 at 11:09 p.m.: ". . . Notified by RA [resident assistant] that resident was on the floor. RA was making resident's bed at time of fall and resident was in the bathroom. Upon entering room resident was seen sitting on the floor. Resident was assessed and appeared to be at baseline. . . ." *06/29/13 at 2:49 p.m.: ". . . Resident alert . . . Poor weight bearing to right lower extremity. . . ." *06/30/13 at 1:32 p.m.: ". . . Called daughter . . . regarding recent fall on 06/28/2013 PM [evening] shift. Notified daughter that resident was having a hard time bearing weight to her right side. . . ." *06/30/13 at 7:00 p.m.: ". . . Res. [resident] having increased pain to R) [right] hip/leg. Res. not bearing weight to R) leg at all. . . . Daughter . . . was called and updated about above. . . . would like x-ray done tonight if possible. . . ." *06/30/13 at 7:10 p.m.: ". . . Physician Orders . . . PPX [portable x-ray] of R) hip d/t [due to] pain and not bearing weight on R) leg after fall. . . ." *06/30/13 at 10:10 p.m.: ". . . PPX here and did x-ray of R) hip at [8:00 p.m.]. X-ray results received and are as follows: . . . Right superior pubic ramus fracture [pelvic fracture]. . . ." The facility's incident report (investigation of the fall), dated 06/28/13 at 8:20 p.m., failed to identify notification of Resident #9's family or physician. Resident #9's medical record contained a communication form, sent to the practitioner and dated 06/30/13 (not timed), which stated, ". . . Fell	F 157		

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F 157	Continued From page 3 on PM shift 06/28/13. . . . Poor weight bearing to R) leg. . . ." Resident #9's medical record lacked evidence the facility notified Resident #9's family or physician of the fall until 06/30/13 (two days after the fall). - Review of Resident #14's medical record occurred on April 02-03, 2014 and diagnoses included Alzheimer's disease and dementia. Nurses' notes stated the following: * 10/11/13 at 9:50 p.m. (late entry progress note created on 10/15/13 at 3:52 p.m.) : " . . . Writer enter res room Res was sitting on the floor with both legs straight facing the hand washing sink. . . . Writer assess res for injury and pain upon assessment, No injuries noted. . . ." * 10/12/13 at 3:35 a.m. : ". . . Medication Administration Note, Tylenol . . . c/o [complaining of] left hip pain. Yelling." * 10/13/13 at 6:30 a.m. (late entry progress note): "Resident complaining of increased pain in left lef/hip [sic] about 0330 [3:30 a.m.] this morning. . . . PRN [as needed] tylenol was given at 0400 [4:00 a.m.]. . . ." * 10/14/13 at 7:00 a.m. : "Pain . . . right knee/hip . . . repositioning/PRN pain medication . . . slight relief." * 10/14/13 at 9:01 a.m. : "Call placed to daughter with update regarding residents complaint of pain to her right leg/knee/hip/buttocks. Informed daughter that resident states that she is having increased pain to her right side and that it has been that way for two days. Daughter states that she is going to be taking her to the walk in ortho clinic this afternoon to have right side checked." * 10/14/13 at 11:27 a.m. : " . . . continues to have pain. Family will be bringing her to the clinic to be	F 157		

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F 157	Continued From page 4 evaluated." * 10/14/13 at 4:10 p.m. : "Admit to Hospital . . . L) [left] hip fx [fracture]." * 10/15/13 at 11:44 a.m. (late entry progress note) : " . . . We also discussed the fall that occurred on 10/11/13 at 10pm and [name of resident's daughter] wants to be notified at anytime of the day if her mom should have a fall, change in medication, or change in health status. . . ." The facility failed to notify Resident #14's daughter of her right hip pain until 10/14/13 (three days after the fall) and of the actual fall until 10/15/13 (four days after the fall). The facility's incident report completed after the fall failed to identify notification of Resident #14's family or physician. During an interview on 04/03/14 at 10:40 a.m., an administrative nurse (#12) stated staff did not notify Resident #14's family and physician immediately because the staff member on duty did not report the fall when it occurred.	F 157		
F 278 SS=D	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. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	**F278** It is the practice of this facility to accurately assess and document resident's status and correctly code the assessment on the MDS. 1. Reviewed documentation for Resident #16 for 10/2/13 and 1/2/14 MDS's. Correction made to E0100B on MDS dated 10/2/13. MDS Submitted to CMS and ND DHS.	5/8/14

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F 278	Continued From page 5 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 staff interviews, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 2 sampled residents (Resident #16) coded with delusions. Failure to accurately assess Resident #16 regarding delusions and code the MDS correctly does not reflect the resident's current status and may affect the accuracy of the care plan and the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated, ". . . E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code	F 278	2. Review all residents with E0100B coded as Yes on their most recent MDS assessment. 3. 2 Case Managers attended MDS training in Bismarck April 14-16, 2014. Review supporting documentation information from training at Case Management meeting. Documentation review for all residents with E0100B coded Yes on their most recent MDS. 4. The Quality Nurse or designee will review supporting documentation for all MDS's with E0100B coded as Yes weekly for the next 4 weeks then monthly for 3 months.	

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F 278	Continued From page 6 based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . ." Review of Resident #16's medical record occurred on April 02-03, 2014 and diagnoses included dementia and depression. The annual MDS, dated 01/02/14, and the quarterly MDS, dated 10/02/13, identified the resident had delusions. The resident's medical record lacked evidence to support the coding of the delusions on both MDSs. During interviews on 04/03/14, an administrative nurse (#15) and a case manager (#16) confirmed Resident #16's medical record lacked evidence to support the coding of the delusions on the annual MDS, dated 01/02/14, and the quarterly MDS, dated 10/02/13.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	**F309** It is the practice of this facility to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care for the resident. 1. Resident #1 had an acute condition which is resolved. Resident #14 was treated for fracture and it has healed. Residents #7, #15, #19 and #20 medication follow up is being monitored and education provided to staff. Care plan reviewed for non-medication interventions.	5/8/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 7 1. Based on record review, professional reference review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #1) transferred to the hospital emergency room by a transportation service. Failure to recognize the emergent situation, request emergency services (ambulance) instead of a transportation service, and continue oxygen therapy during the transfer, resulted in Resident #1 experiencing acute respiratory failure and requiring hospitalization. Findings include: Kozier and Erb's, "Fundamentals of Nursing, Concepts, Process, and Practice," ninth edition, Pearson Company, New Jersey, page 535, stated, ". . . Oxygen saturation is also commonly measured at the same time as the traditional vital signs. . . ." Page 567 stated, ". . . oxygen saturation . . . The pulse oximeter can detect hypoxemia (low oxygen saturation) before clinical signs and symptoms, such as a dusky color to skin and nail beds develop . . . Normal oxygen saturation is 95% [percent] to 100%, and below 70% is life threatening." Review of Resident #1's medical record occurred on all days of survey and identified a hospitalization from January 24-28, 2014 for acute respiratory failure. Resident #1's code level, at the time of the hospitalization, identified "Code Level 1" and stated, "All available reasonable technology is used in the event of cardiac or respiratory arrest." Review of Resident #1's progress notes identified the following: *01/23/14 at 11:22 p.m. - ". . .resident having hard	F 309	2. All residents have the potential to be affected. 3. Licensed Nurses will be re-educated on assessment of resident's status prior to transfer to the ER, monitoring resident status following an accident which may result in injury. Education will also be provided on monitoring and documentation of target behaviors as well as use of non-medication interventions prior to administration of PRN psychotropic medications. Review of supporting documentation to include in resident chart and careplanning non-medication interventions. 4. The Quality Nurse or designee will audit documentation of all residents who have been transferred to the ER for follow up for use of appropriate equipment during transport. All residents will be reviewed weekly for 4 weeks then 5 per month for 3 months. Audit 5 residents who have fallen for timely treatment of injuries following fall weekly for 4 weeks then monthly for 3 months then randomly for a year.	

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F 309	Continued From page 8 time breathing sats [saturation] low, O2 [oxygen] started . . . wife called to notify her of his condition . . . wife stated she would like to come up and see resident before notifying oncall physician." *01/23/14 at 11:35 p.m. - " . . . Writer alerted by RA [resident assistant] that resident had an emesis. Writer went to assess resident and resident was wheezing throughout. Coughing thick clear to light yellow sputum. O2 sats 77% on room air. O2 started and sats went to 82-90 on 2L/NC [2 liters per nasal canula]. Resident continues to have labored breathing . . . Notified wife . . ." *01/24/14 at 12:25 a.m. - ". . . Order: send resident in via transit [to emergency room] . . . Reason for order: Dyspnia, wheezing throughout. O2 sats down to 77% or [sic] room air O2 started sats at 80% on 2L/NC. Coughing thick clear/white sputum . . ." *01/24/14 - "@ [at] 12:50 a.m. . . . Transferred resident to [name of hospital] ER [emergency room] for assessment via [name of transportation service] via stretcher. All papers sent with resident, et [and] wife will meet over in ER." During an interview on 04/03/14 at 10:45 a.m., two administrative staff members (#1 and #2) stated Resident #1 was transferred without oxygen. *01/24/14 - "@ 1:40 a.m. Received phone call from [name of facility] ER nurse RE: choice of transportation use as resident's status was poor. Informed . . . ER nurse that wife was thinking of not having resident sent to ER to be assessed. Staff encouraged wife to have resident be assessed due to ? aspiration as resident was coughing et had an emesis. Wife was in agreement to have resident transferred per [name of transportation service] stretcher." *01/24/14 at 4:22 a.m. - Received phone call from	F 309	Audit will also be done for residents who take antianxiety medications PRN for documentation of non-medication approaches and monitoring or target behaviors prior to administration of PRN medication. Review 5 residents weekly for 4 weeks then monthly for 3 months then audit randomly for a year. All audits will be completed and reviewed at our monthly QAPI meeting to determine ongoing follow up and audit frequency.	

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[name of doctor] from [name of hospital] with questions of how resident was before emesis et after emesis. If he's used oxygen here or not on routine or @ all . . ."

Resident #1's "Hospital History and Physical", dated 01/24/14, stated, ". . . patient was brought in to the emergency department on room air. On arrival, nursing staff in the emergency department report that the patient had desaturated into the low 70's (on room air) was in a fair amount of respiratory distress. Patient was apparently febrile as well [had a temperature of 102.5 degrees Fahrenheit] . . ."

Resident #1's "Discharge Summary," dated 01/28/14, identified discharge diagnoses of acute hypoxic respiratory failure likely from aspiration.

During an interview on 04/03/14 at 10:00 a.m., when asked how the facility determines which mode of transportation should be used when transferring residents to the emergency room, an administrative nurse (#3) stated the facility utilizes "a [name of a transportation service] for non-acute conditions, such as a fractured limb, and an ambulance for acute conditions, such as cardiac or respiratory distress."

During an interview on 04/03/14 at 10:45 a.m., two administrative nurses (#1 and #2) agreed, an ambulance should have been called for the transfer to the emergency room because of Resident #1's acute respiratory condition.

Failure of the facility to call emergency services to transfer Resident #1 to the emergency room and failure to continue oxygen therapy during the transfer resulted in acute respiratory failure and

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F 309	Continued From page 10	F 309		

hospitalization.
2. Based on record review, review of facility policy, and staff interview the facility staff failed to provide appropriate care and services following a fall for 1 of 1 sampled resident (Resident #14) who obtained a fracture with the fall. Failure to report Resident #14's fall resulted in delayed treatment.

Findings include:

Review of the facility policy titled "Falls Protocol" occurred on 04/03/14. This policy, dated 06/13/13, stated, ". . . PROCEDURE: . . . 8. Nursing will notify the family and provider after each fall unless otherwise indicated in the careplan. . . ."

Review of Resident #14's medical record occurred on April 02-03, 2014 and diagnoses included Alzheimer's disease, dementia, and osteoporosis.

Nurses' notes stated the following:
* 10/11/13 at 9:50 p.m. (late entry progress note created on 10/15/13 at 3:52 p.m.): " . . . Writer enter [sic] res [resident] room Res was sitting on the floor with both legs straight facing the hand washing sink. . . . Writer assess [sic] res for injury and pain upon assessment, No injuries noted. . . ."
* 10/12/13 at 3:35 a.m.: ". . . Medication Administration Note, Tylenol [given] . . . c/o [complaining of] of left hip pain. Yelling."
* 10/13/13 at 6:30 a.m. (late entry progress note): "Resident complaining of increased pain in left lef/hip [sic] about 3:30 a.m. this morning. . . . PRN [as needed] tylenol was given at 4:00 a.m. . . ."
* 10/14/13 at 7:00 a.m.: "Pain . . . right knee/hip . .

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ROSEWOOD ON BROADWAY	1351 N BROADWAY FARGO, ND 58102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 . repositioning/PRN pain medication . . . slight relief." * 10/14/13 at 9:01 a.m.: "Call placed to daughter with update regarding residents complaint of pain to her right leg/knee/hip/buttocks. Informed daughter that resident states that she is having increased pain to her right side and that it has been that way for two days. Daughter states that she is going to be taking her to the walk in ortho clinic this afternoon to have right side checked." * 10/14/13 at 11:27 a.m.: " . . . continues to have pain. Family will be bringing her to the clinic to be evaluated." * 10/14/13 at 4:10 p.m.: "Admit to Hospital . . . L) [left] hip fx [fracture]." The facility failed to have Resident #14's right hip pain evaluated until 10/14/13 (four days after the fall). Review of the hospital discharge summary, dated 10/18/13, indicated an acute traumatic fracture of the left hip. This summary identified Resident #14 underwent open reduction, internal fixation of the left hip fracture on 10/15/13. During an interview on 04/03/14 at 10:40 a.m., an administrative nurse (#12) stated the staff member on duty did not report and document the fall at the time it occurred. Failure to report Resident #14's fall resulted in unnecessary pain, delayed treatment, and investigation of possible neglect. 3. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 4 of 5 sampled residents (Resident #7, #15, #19, and #20) who received as needed (PRN) medications. Failure to identify target behaviors, assess the	F 309		

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reason/causative factor(s) for behaviors, implement appropriate interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential for these residents to not obtain their highest practicable physical, mental, and psychosocial well-being.

Findings include:

- Review of Resident #7's medical record occurred during all days of survey. Diagnoses included dementia, anxiety, depression, psychosis, and sleep disorder. The quarterly Minimum Data Set (MDS), dated 02/15/14, identified moderate cognitive impairment, delusions, and hallucinations.

Review of Resident #7's current plan of care identified, "Focus: I use anti-anxiety medications related to my Anxiety Disorder . . . Interventions: . . . Give anti-anxiety medication ordered by physician. Monitor/document side effects and effectiveness. . . ." The care plan failed to identify non-pharmacological interventions staff should attempt prior to administering her as needed (prn) anti-anxiety medications.

The physician's order, dated 06/07/13, identified "Lorazepam [an antianxiety medication] 2 MG/ML [milligrams/millileters] Concentrate By mouth . . . PRN ANXIETY STATE . . ."

Review of Resident #7's Progress Notes identified the following:
* 09/09/13 at 11:53 a.m., "Lorazepam . . . Restless agitated, standing up in w/c [wheelchair], striking out at staff," and at 1:43 p.m., "Sleep."
* 09/11/13 at 4:53 p.m., "Lorazepam . . . resident

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F 309	Continued From page 13 restless and agitated," and at 9:14 p.m., "resident sitting in recliner, content." * 09/13/13 at 11:02 a.m., "Lorazepam . . . Agitated, standing up striking out at staff," and at 12:33 p.m., "Sleeping." * 09/14/13 at 5:34 p.m., "Lorazepam . . . increased restlessness and attempts to self transfer," and at 6:33 p.m., "res [resident] is resting quietly in her wheelchair." * 09/15/13 at 7:14 p.m., "[Lorazepam] given due to restlessness and agitation, combative with staff," and at 9:28 p.m., "Cooperative and pleasant." * 10/05/13 at 5:24 p.m., "Lorazepam . . . Resident restless, agitated, crying, and feisty," and at 8:45 p.m., "Resident became less restless and agitated after receiving the med [medication] at 5:15 p.m." * 10/06/13 at 7:20 p.m., "Lorazepam . . . Resident restless and agitated," and at 8:13 p.m., "Resident calm and relaxing in chair." * 10/09/13 at 6:21 p.m., "Lorazepam . . . Resident agitated, restless and being aggressive," and at 8:07 p.m., "Resident calmed down and resting comfortably in chair." * 10/11/13 at 7:45 p.m., "Lorazepam . . . Given at 6 p.m. for agitation and aggression, kicking, pinching and hitting staff," and on 10/12/13 at 1:15 a.m., "Quieter and cooperative." * 10/13/13 at 12:31 a.m., "Lorazepam . . . Resident up in chair crying becoming increasingly agitated slapping at staff," and at 2:26 a.m., "Resident is in bed at this time is still wide awake and restless." * 10/14/13 at 6:04 p.m., "Lorazepam . . . Given at 5:20 p.m. for agitation and combativeness . . ." * 10/19/13 at 6:18 p.m., "Lorazepam . . . agitated, crying and restless," and at 7:12 p.m., "Resident is calmer and less restless."	F 309		

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F 309	Continued From page 14 * 10/20/13 at 5:12 p.m., "Lorazepam . . . Resident is combative, restless, kicking, hitting, pulling hair, and biting," and at 6:50 p.m., "Resident calmed down." * 10/23/13 at 6:40 p.m., "Lorazepam . . . Resident restless, combative and agitated at 3:55 p.m.," and at 4:39 p.m., "Resident is calm, not combative and sitting in her chair." * 10/29/13 at 12:19 a.m., "Lorazepam . . . anxious, trouble going to sleep," and at 6:46 a.m., "f/u [follow-up] able to sleep." * 11/06/13 at 3:41 a.m., "Lorazepam . . . f/u resident had reduced anxiety." The Medication Administration Record (MAR) failed to show facility staff administered this dose of Lorazepam. * 11/11/13 at 5:30 p.m., "Lorazepam . . . resident combative, hitting staff," and at 8:39 p.m., "f/u resident resting in recliner." * 11/12/13 at 4:59 p.m., "Lorazepam . . . resident combative with transport team, med given to help calm her," and at 9:26 p.m., "Was calming as transport team took her to ER [emergency room]." * 11/17/13 at 5:53 p.m., "Lorazepam . . . woke up crying because she didn't have the house clean and her parents were coming," and at 6:54 a.m., f/u relaxed and went back to sleep." * 01/03/13 at 4:29 p.m., "Lorazepam . . . Agitated and weeping," and at 6:55 a.m., "f/u became more relaxed, less muttering." * 01/04/13 at 9:36 a.m., "Lorazepam . . . increased restlessness, attempts to self transfer, combative," and at 10:18 a.m., "res. is sleeping in her chair." * 03/01/13 at 4:56 p.m., "Lorazepam . . . attempting to transfer out of chair and unable to redirect," and at 7:08 a.m., "res. calmed down and rested in recliner."	F 309		

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* 03/15/13 at 4:34 p.m., "Lorazepam . . . res. kicking, grabbing out at staff and residents, attempting to self transfer, and yelling," and at 6:10 p.m., "res. is calmly sitting in her chair no further agitation noted."

During an interview on 04/03/14 at 10:00 a.m., a managerial nurse (#3) confirmed facility staff failed to attempt non-pharmacological interventions prior to administering Resident #7's prn Lorazepam, and confirmed this is required.

Failure to attempt non-pharmacological interventions and monitor the effectiveness of those interventions prior to administering an anti-anxiety medication does not allow staff to evaluate what interventions would be most effective to manage Resident #7's behavior.

- Review of Resident #19's medical record occurred April 3, 2014. Diagnoses included dementia, anxiety state, and depression. A significant change MDS, dated 02/04/14, identified severe cognitive impairment, on current hospice services, and the use of a daily antidepressant. Current medications included lorazepam (Ativan) 0.25 mg every three hours prn for anxiety and restlessness, and Trazodone HCL (hydrochloride) (an antidepressant) 12.5 mg every four hours prn for anxiety and restlessness.

The current care plan for Resident #19 stated, "Focus I will be at Rosewood for long term. In the past, I enjoyed visiting. used to like to attend activities,but now I prefer to spend my free time in my room. I can become anxious at times. I was recently re-admitted to Hospice. . . Interventions: Allow me to assist in decision making and to participate in my plan of care as best as I am

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able. I am of Lutheran faith and I may like to attend chapel services. I may also attend Catholic Mass as I was raised Catholic as a child. I can obsess about many different things. try to get my mind off of these things by inviting me to activities, visiting with me, taking me for a walk or wheelchair ride, etc. I prefer to spend most of my free time in my room. This is a recent change for me as I used to like to attend most activities. You may ask me to attend activities, but most likely I will decline. I have a television in my room. I love to watch [specific show and channel] on Sundays at 7:00 p.m. I have difficulty hearing when not in a quiet setting. Speak clearly and at times, close to my ear, when talking to me. I wear bilateral hearing aides, make sure they are in working order when putting them in my ears. . . . I may need cueing, re-orientation, and/or reminders from time to time. I may not always respond to it. My daughter, [daughter's name], will assist me with decision making or will make the decision for me if I am unable. She is my contact person. Call her any time with emergencies and between 9A-9P [9:00 a.m. through 9:00 p.m.] for non-emergencies. You may leave a message. My family will visit me often. They may also attend activities with me if I choose to go. When I am anxious or have anxiety, spend some one-on-one time with me. Reassure me that everything will be all right. I also have an order for Trazodone for my anxiety. Offer me the prn dose when I am anxious and am having difficulty in calming down. . . . Focus: I have a history of anxiety. I have a history of feeling like I need to use the bathroom very frequently. Some times [sic] I get anxious about coming out of my room. Sometimes I call out 'help' repeatedly. . . Interventions A suggestion to help me when you are providing cares and I am anxious is to have me count. This

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seems to provide me with something to concentrate on. Assess level of anxiety and restlessness. Always use a calm and consistent approach when working with me. I like to be told I am doing a good job. I respond well to being told I am doing the best job I can. Some of the things that help when I am anxious are playing cards, folding wash cloths [sic] and having you massage me [sic] neck/shoulders, hands and feet. I like you to spend 1:1 [one to one] time with me when I am anxious. I say just holding my hand or touching me helps me feel better. Medication as ordered."

Review of the PRN MAR, from December 1, 2013 to March 30, 2014 identified Resident #19 received PRN Trazodone HCL on 41 occasions, and PRN Ativan on 11 occasions.

During interview on 04/03/14 at 11:35 a.m.. an administrative nurse (#3) confirmed staff are to document non-pharmacological interventions attempted prior to the administration of a PRN dose of Trazodone HCL or Ativan.

The medical record lacked evidence the facility staff attempted non-pharmacological interventions prior to the administration of the PRN Trazodone HCL and Ativan and failed to consistently identify/document the actual behavior exhibited by Resident #19 that resulted in the administration of the medications.

- Review of Resident #15's medical record occurred on April 2-3, 2014. Diagnoses included dementia, anxiety, and delusional disorder. Current medications included Ativan 0.25 mg up to three times daily prn and Ultram (a pain medication) 25 mg every four hours prn. The

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F 309	Continued From page 18 resident's current MDS, dated 02/05/14, identified severely impaired cognition, hallucinations, delusions, and no behavioral symptoms. Resident #15's current care plan stated, ". . . I use anti-anxiety medications (Ativan prn) r/t [related to] Anxiety disorder, Adjustment issues. [date initiated 2/11/2013]. . . . Interventions . . . Monitor/record/occurrence of for [sic] target behavior symptoms (pacing, wandering, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. . . . I have a mood problem(s) r/t dementia, Delusional Disorder, Psychosis. . . . I am resistive to cares and medications when anxious. . . . [date initiated 04/01/13] . . . Interventions . . . Allow me time and encourage me to express feelings . . . Reaproach [sic] or try different staff if refusing cares/meds. [medications]. . . . When anxious: Get my mind on something else, sit outside with me, listen to music, ride up and down the hall in w/c [wheelchair]. . . ." Resident #15's nurses' notes stated the following: *January 2014: *01/02/14 at 1:18 a.m.: ". . . Ativan - Give 0.25 mg up to 3x [3 times] daily as needed for anxiety/restlessness: very anxious and tearful as she was talking to her self and given much comfort." *01/02/14 at 1:20 a.m.: ". . . ultram - Give 50 mg . . . every 4 hours PRN: resident crying et [and] talking loudly to self with much anxiety? pain? attempted to self remove from bed when staff comforting her. . ." *01/04/14 at 12:46 a.m.: ". . . Ativan . . . Resident very anxious about where her father is et [and] therapeutic fibs given with very mild	F 309		

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F 309	Continued From page 19 success. . . ." *01/04/14 at 12:47 a.m.: ". . . ultram . . . resident rubbing legs et c/o [complains of] aching with tears in eyes. . . ." *01/04/14 at 1:25 a.m.: ". . . F/U [follow up] resident sound asleep in recliner by nurses station et calm. . . ." *01/12/14 at 11:44 p.m.: ". . . ultram . . . @ 11:15 PM resident very restless with grimace about face ? pain . . ." *01/12/14 at 11:45 p.m.: ". . . Ativan . . . resident continues to be vwery [sic] restless et 'antsy.' . . ." *Facility staff administered a pain medication and an anti-anxiety medication at close intervals, which does not allow staff to determine if one medication alone would have been effective. In addition, the record lacked evidence staff attempted non-pharmacological measures prior to administering Ativan and Ultram. *Nurses' notes also identified the administration of prn Ativan on 01/18/14 and 01/23/14. The notes lacked identification of target behaviors present that would warrant the use of prn Ativan, as well as identification of non-pharmacological interventions attempted prior to administration. *February 2014: *02/06/14 at 1:42 a.m.: ". . . ultram . . . Resident moaning et self removing herself from bed. ? pain. . . ." *02/06/14 at 2:55 a.m.: ". . . Ativan . . . Resident in less pain but continues to talk of having to do this et that, given warmed towels @ 2:30A. Continues to fret et unable to calm resident. . . ." *The record lacked evidence of non-pharmacological interventions attempted	F 309		

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F 309	Continued From page 20 prior to administering a pain medication and an anti-anxiety medication approximately one hour apart. *02/13/14 at 8:05 a.m.: ". . . Ativan . . . Given this am [morning] thirty minutes before cares to promote calm . . ." *02/15/14 at 7:37 a.m.: ". . . Ativan . . . given thirty minutes before cares to promote calm . . ." *The record lacked evidence of agitation or resistance to cares prior to the administration of prn Ativan on 02/13/14 and 02/15/14, and also lacked identification of non-pharmacological interventions attempted if Resident #15 resisted cares (i.e. reapproaching or trying different staff as per the resident's care plan). *The medication administration record (MAR) also identified the administration of prn Ativan on 02/02/14 at 8:42 a.m., 02/11/14 at 8:33 a.m., 02/16/14 at 7:46 a.m., 02/25/14 at 8:13 a.m., 02/27/14 at 8:57 a.m., 03/14/14 at 9:13 a.m., and 03/15/14 at 2:41 p.m. *Nurses' notes lacked identification of target behaviors present that would warrant the use of prn Ativan, as well as identification of non-pharmacological interventions attempted prior to administration. - Review of Resident #20's medical record occurred on 04/03/14. Diagnoses included Alzheimer's disease, dementia, and anxiety. Medications included Ativan 0.25 mg by mouth twice a day; Ativan 0.5 mg by mouth every four hours PRN for anxiety; and Ativan Gel 0.5 mg applied to the inner wrist every 4 hours if the resident refused the oral PRN Ativan. Resident #20's care plan stated, "Focus: I have a hx [history] of depression and sometimes feel sad and confused because I am not home . . .	F 309		

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F 309	Continued From page 21 Interventions: *Encourage me to spend time out of my room. Ask me if I would like to watch television in the south lounge area or listen to music in the chair outside my room. * I have a picture book of my family that I like to look at. Do not ask me who anybody is, as I may not always remember who they are. This may upset me. *When I am anxious or agitated, spend one-on-one time with me or check on me every 15 minutes. *When I am anxious or upset, I may calm down when I watch the Coronation of the Fargo Bishop. It is kept in the south nurse's station. *When I appear sad or worried, talk with me and offer me comfort and support. Reassure me that everything will be all right. Use therapeutic fibbing as it may be helpful." Review of the PRN MAR from January 01, 2014 to April 03, 2014 identified Resident #20 received PRN Ativan on 38 occasions. The medical record lacked evidence the facility staff attempted non-pharmacological interventions prior to the administration of the Ativan for 35 of the 38 occasions. Failure to identify target behaviors, assess the reason/causative factor(s) for the behavior, and implement appropriate interventions (including non-pharmacological interventions) prior to administering PRN medications does not allow staff to evaluate what interventions would be most effective to manage the behavioral symptoms of Resident #7, #15, #19, and #20.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 It is the practice of this facility to provide assistance necessary to prevent accidents for residents.	5/8/14

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F 323	Continued From page 22 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of professional reference, and staff interview, the facility failed to provide supervision and assistance necessary to prevent accidents for 1 of 1 sampled resident (Resident #9) with an unattended fall in the bathroom. Failure to provide adequate supervision resulted in Resident #9 experiencing a fall with a pelvic fracture. Findings include: Dugan's "Successful Nursing Assistant Care," 2nd ed., Hartman Publishing, Inc., New Mexico, page 187, stated, ". . . Toileting Transfers . . . Do not leave residents alone if you feel it is unsafe or if residents require assistance. . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, a history of falls, and a history of pelvic fracture. The resident's Minimum Data Set (MDS) (in effect at the time of the fall), dated 04/18/13, identified short and long term memory problems, fluctuating inattention, extensive assistance from two or more people for toileting and transfers, and limited assistance from two or more people for ambulation. Resident #9's care plan (in effect at the time of the fall) stated, ". . . I am cognitively impaired and	F 323	1. Resident #9 care plan was updated on 6/29/13 after fall for resident not to be in restroom unattended. Staff education on gait belt use for residents completed on 4/3/14. 2. All residents requiring assistance have the potential to be affected. 3. Education has been provided to CNA's on providing supervision to residents in the bathroom per care plan. Assessment will be done on all residents with diagnosis of dementia to determine if resident requires supervision in restroom. Re-education has been provided on use of gait belts. Nurse and CNA in-services will be held on 5/5/14 and 5/6/14 to review fall prevention strategies and appropriate gait belt use. 4. The Quality Nurse or designee will audit 10 transfers per week for 4 weeks and monthly thereafter for 3 months to verify that gait belt is used appropriately during transfer. Assessment for supervision in restroom will be audited initially for completion and care plan update based on assessment. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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	355047	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 23 so I need cuing and supervision while doing cares. . . . I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Alzheimer's and can be combative with cares and toileting at times. . . . Interventions . . . Toileting: Assist of 1. May need assist of 2 when I'm upset. Can be extensive at times and up to 3 assist, due to dementia. Please assist me to the restroom every 2 hours. . . ." Resident #9's medical record identified three falls which occurred on 02/14/13 at 4:15 a.m., 04/17/13 at 6:30 a.m., and 05/30/13 at 5:15 a.m. All three falls occurred from the resident's bed and staff found Resident #9 incontinent of stool on all three occasions. Record review further identified a fall which occurred on 06/28/14 at 8:20 p.m. while the resident was alone in the bathroom. Nurses' notes stated the following: *06/28/13 at 11:09 p.m.: ". . . Notified by RA [resident assistant] that resident was on the floor. RA was making resident's bed at time of fall and resident was in the bathroom. Upon entering room resident was seen sitting in the floor. Resident was assessed and appeared to be at baseline. . . ." *06/29/13 at 2:49 p.m.: ". . . Resident alert . . . Poor weight bearing to right lower extremity. . . ." *06/30/13 at 1:32 p.m.: ". . . Called daughter . . . regarding recent fall on 06/28/2013 PM [evening] shift. Notified daughter that resident was having a hard time bearing weight to her right side. . . ." *06/30/13 at 1:45 p.m.: ". . . Tylenol - 650 mg [milligrams] PO [by mouth] PRN [as needed] . . . administered per family request for pain management. Pain upon weight bearing to right leg. Stated 'Uff.' . . ."	F 323		

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F 323	Continued From page 24 *06/30/13 at 6:50 p.m.: ". . . Res. having increased pain to R) [right] hip/leg during transfer. Res. not bearing any weight to R) leg and sticking R) leg out in front of body during transfer. Facial grimacing noted during transfer. . . ." *06/30/13 at 7:00 p.m.: ". . . Res. having increased pain to R) hip/leg. Res. not bearing weight to R) leg at all. . . . Daughter . . . was called and updated about above. . . . would like x-ray done tonight if possible. . . ." *06/30/13 at 7:10 p.m.: ". . . Physician Orders . . . PPX [portable x-ray] of R) hip d/t [due to] pain and not bearing weight on R) leg after fall. . . ." *06/30/13 at 10:10 p.m.: ". . . PPX here and did x-ray of R) hip at [8:00 p.m.]. X-ray results received and are as follows: . . . Right superior pubic ramus fracture [pelvic fracture]. . . ." *06/30/13 at 10:26 p.m.: ". . . Physician Orders . . . Keep comfortable in bed through night. . . . NP/PA [nurse practitioner/physician's assistant] to see in AM and refer to orthopedics as needed. . . ." *07/01/13 at 4:19 p.m.: ". . . Resident was sent to [facility name] ER for evaluation. Resident given Keflex [an antibiotic] for treatment of UTI [urinary tract infection], Hydrocodone [a pain reliever] for pain management. Order weight bearing as tolerated d/t pelvic fracture. . . ." During an interview on 04/03/14 at 10:45 a.m., a supervisory nurse (#12) stated if residents need assistance to toilet, staff should stay with them in the bathroom. She stated the facility did not have a policy stating this, but that it is an unwritten standard of care. Failure to ensure Resident #9 (who required toileting assistance, experienced previous falls, and had Alzheimer's disease) received adequate	F 323		

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F 323	Continued From page 25 supervision and assistance while in the bathroom resulted in an avoidable fall with pelvic fracture. 2. Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure adequate use of assistive devices to prevent accidents for 3 of 12 sampled residents (Resident #1, #2, #12) and 1 supplemental resident (Resident #24) who transferred with a gait belt. Failure to properly use a gait belt increased the risk of falls, pain, or injury to the residents. Findings include: Review of the facility policy titled "Moving a Resident, Bed to Chair" occurred on 04/03/14. This policy, revised May 2013, stated, "Purpose: . . . to provide for safe transferring of the resident . . . Steps in the Procedure . . . j. Support the resident by placing a belt around the resident's waist for you to hold and steady the resident. . . ." - Review of Resident #2's medical record occurred on April 02-03, 2014 and diagnoses included quadriplegia, cerebral palsy, and osteoarthritis. The annual Minimum Data Set (MDS), dated 03/13/14, identified the resident required extensive assistance of two or more staff members for transfers. The current care plan stated, ". . . I have a Self Care Deficit . . . TRANSFERS: Assist of 2 for stand-pivot transfer to bed from w/c [wheelchair], and to w/c from bed. Assist of 3 for stand-pivot on/off commode and to/from tub chair for cleansing and brief placement. Use hoyer as needed if res. [resident]	F 323		

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F 323	Continued From page 26 feeling weak or tired. . . ." Observation on 04/02/14 at 8:50 a.m. identified three Certified Nursing Assistants (CNAs) (#8, #9, and #10) transferred Resident #2 from his bed to his wheelchair using a gait belt. During the transfer, one CNA (#8) held on to the gait belt with one hand and lifted under the resident's left arm with her other hand. Observation on 04/02/14 at 11:00 a.m. identified three CNAs (#8, #10, and #11) transferred Resident #2 from the commode to his wheelchair using a gait belt. During the transfer, one CNA (#11) held on to the gait belt with one hand and lifted under the resident's left arm with her other hand. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Parkinson's disease. The quarterly MDS, dated 02/04/14 identified the resident required extensive assistance of one staff member for transfers. The current care plan stated, "Transfers: Assist of 1 with FWW [front wheeled walker]." Observation on 04/02/14 at 8:50 a.m. showed the CNA (#5) applied a gait belt to Resident #1's waist. The CNA lifted the resident to a standing position with one hand on the gait belt and the other hand under his arm. The CNA (#5) failed to use the gait belt correctly. - Review of Resident #12's medical record occurred on April 02-03, 2014 and diagnoses included osteoarthrosis. The quarterly MDS, dated 01/15/14, identified the resident required extensive assistance of two or more staff	F 323		

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F 323	Continued From page 27 members for transfers. The current care plan stated, " . . . Transfers: Assist of 1 . . ." Observation on 04/02/14 at 9:00 a.m. showed two CNAs (#13 and #14) transferred Resident #12 from her bed to a standing position using a gait belt. During the transfer, both CNAs (#13 and #14) held on to the gait belt with one hand and lifted under the resident's arm with their other hand. - During a random observation on 04/02/14 at 8:41 a.m., Resident #24 asked the nurse (#7) for assistance to stand from a dining room chair. The nurse (#7) assisted Resident #24 to stand by pulling up on his right upper arm. Review of Resident #24's current care plan on 04/03/12 showed an approach, which stated, "TRANSFERS: . . . If you feel I need assistance, I need to wear a gait belt. . . ." The nurse (#7) failed to use a gait belt as care planned. During an interview on 04/03/14 at 10:00 a.m., an administrative nurse (#4) stated staff should avoid pulling/lifting on residents' arms and only grasp the gait belt during transfers.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	**F356** It is the practice of this facility to post facility staffing. 1. Posting of staffing had no impact on care to a resident. 2. Resident care is not directly affected by posting of staffing.	5/8/14

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F 356	Continued From page 28 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post, at the beginning of each shift, the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care on 3 of 3 days of survey (April 1-3, 2014). Findings include: Observations throughout the survey, April 1-3, 2014, showed the posting of staff directly responsible for resident care and the resident census in a display case in two public elevators. The posting identified the total number of staff,	F 356	3. The Staffing Nurse will post staffing daily for the am and pm shifts when she is in the facility. When the staffing nurse is not available a designated staff nurses will be responsible to update the resident census and staffing changes and post at the beginning of each shift. 4. The Quality Nurse or designee will audit posting of staffing and that staffing changes and resident census updates are made at the beginning of each shift with random audits performed 5times per week for 1 month than 10 times per month for 3 months then randomly thereafter.	

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F 356	Continued From page 29 the actual hours scheduled, and the resident census for the morning, evening, and night shifts. During an interview on 04/02/14 at 4:20 p.m., an administrative staff member (#6) stated she completes the staffing and census information at the start of each day and posts the list for the day. This staff member (#6) stated she prepares the weekend postings on Friday and the receptionist posts them on Saturday and Sunday. When asked, this staff member (#6) stated the facility does not have a system to update the listings if staffing changes, or if the resident census changes over the weekend or between shifts. Failure to post the nurse staffing data on a daily basis at the beginning of each shift does not allow for accurate up-to-date data regarding staffing and resident census.	F 356		