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 _____	04/25/2013

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 04/22/13 and completed on 04/25/13, the sample included five (5) residents for complete review, 14 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**F225** It is the practice of this facility to ensure that all alleged incidents of neglect are reported to officials in accordance with State Law including the State survey and certification agency. 1. No further corrective action can be taken for Resident #13 because the timeline for reporting has passed. 2. All residents have the potential to be affected. 3. All incidents will be reviewed and investigated to identify whether failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness has occurred. If so,	5/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/16/13

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to report 1 of 1 alleged incident of neglect and/or abuse to the state survey and certification agency immediately (within 24 hours) and failed to report the result to the state survey and certification agency within five working days of the incident. Failure to report all alleged violations involving mistreatment, neglect, or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include: Review of the facility policy and procedure titled "Abuse, Neglect, and Misappropriation of Resident Property Prevention" occurred on 04/25/13. This policy, revised 03/01/13, stated, " . . . DEFINITIONS . . . 'Neglect' means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. . . . REPORTING All alleged violations involving mistreatment, neglect or abuse . . . will be reported immediately (within 24 hours) to the administrator and to other officials in accordance	F 225	an initial report within 24hrs will be made to the Department of Health with a follow-up report within 5 days stating what action was taken. 4. The Abuse Prevention Coordinator or designee will audit 5 incidents per month for 3 months to ensure compliance in reporting timely any incidents that meet the criteria for reporting allegations of neglect. 5-22-13 education provided to license nurses regarding ~~the~~ reportable events. Per conversation with administrator 5-23-13. JB	

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F 225	Continued From page 2 with state law through established procedures (including to the state survey and certification agency) via Initial Allegation of Abuse Reporting Form. The results of all investigations must be reported to the administrator or designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within 5 working days of the alleged incident." Review of Resident #13's medical record occurred on all days of survey. Diagnoses included a fractured right femur (leg), multiple sclerosis, degenerative joint disorder, and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 02/15/13, identified Resident #13 required extensive assist of two for bed mobility and transfers with a Hoyer (sling) lift. The care plan, dated 03/27/13, stated, "TRANSFER: Assist of 2 with hoyer. (R) [right] leg must be supported." Progress Notes, dated 02/25/13 at 9:10 p.m., stated, "Time of Fall: 1730 [5:30 p.m.]. Location: Resident's room. Description of Incident: This writer was called to Res. [Resident's] room via walkie talkie by . . . RA [Resident Assistant]. Upon arrival this writer saw the resident lying in bed crying and yelling. RAs . . . state the resident fell [less than] 6inches [sic] back in her wheel chair when the rear R) hoyer strap slipped out of the hook during transfer from the wheel chair to bed. This writer spoke with resident in private and resident confirmed RA report of incident. . . . Nursing assessment, Injuries, Action taken, and Vital Signs: . . . bandage covering R) knee was out of place. Resident reported 8/10 [Pain at an 8 on a pain scale of 0 to 10, 0 being no pain and 10 being the worst pain] R) leg pain. . . . Educated	F 225		

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F 225	Continued From page 3 staff to ensure good communication between each other and to ensure safe transfers (make sure all straps are completely secure)." Review of incidents of neglect/abuse and misappropriation reported to the state agency lacked a report of the 02/25/13 incident. During an interview on the afternoon of 04/24/13, an administrative staff member (#4) and administrative nurse (#5) confirmed the facility failed to notify the state agency regarding the above event.	F 225	**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 resident's plan of care. 1. Resident #20 expired on 3/14/13, so no corrective action is taken. 2. Residents with a change in condition have the potential to be affected. 3. Licensed Nurses will be re-educated on re-assessment of oxygenation and use of standing orders for providing oxygen to residents with low oxygen saturation levels as appropriate. 5-22-13 9 5-23-13 on 4. The Quality Nurse or designee will audit documentation of residents with a change of condition to verify that oxygen levels are re-checked and monitored with changes in condition as appropriate per standards of nursing practice. related to oxygen saturation for three months per conversation with administrator	5/30/13
F 309 SS=D	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: Based on record review, review of facility policy, professional reference review, and staff interview, the facility failed to provide the necessary care and services for 1 of 2 closed resident record (Resident #20) who required hospitalization. Failure to manage signs and symptoms of a low oxygen saturation level and administer oxygen in a timely manner may have contributed to Resident #20's hospitalization. Finding include:	F 309		

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F 309	Continued From page 4 Review of the facility policy titled "Blood Pressures/Vital Signs" occurred on 04/25/13. The policy, dated 2011, stated, ". . . PROCEDURE: . . . At the discretion of the nurse vital sign findings that are of concern will be retaken, compared to the baseline readings and brought to the attention of the practitioner." Kozier and Erb's, "Fundamentals of Nursing, Concepts, Process, and Practice," ninth edition, Pearson Company, New Jersey, page 535, stated, "The traditional vital signs are body temperature, pulse, respiration, and blood pressure. . . . Oxygen saturation is also commonly measured at the same time as the traditional vital signs. . . ." Page 567 stated, "A pulse oximeter is a noninvasive device that estimates . . . 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 #20's medical record occurred on April 24-25, 2013. Diagnoses included dementia and congestive heart failure (CHF). The physician's standing orders, dated 01/07/13, stated, ". . . Dyspnea [shortness of breath] - Oxygen at 2 liters/minute PRN [as needed] nasal cannula . . ." Review of Resident #20's progress notes identified the following: * 03/10/13 at 1:18 p.m.: ". . . Action: . . . V/S [vital signs] . . . O2 [oxygen] 88% on RA [room air]	F 309		

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F 309	Continued From page 5 (resident is mouth breathing) Response: Resident is lying in bed at this time sleeping, but is restless. He is groaning . . ." * 03/10/13 at 4:29 p.m.: ". . . Action: The resident vitals were taken. . . . O2 85% on room air. The resident has some wheezing noted . . . cough is non-productive. . . . not showing signs pulmonary distress. . . . not using his accessory muscle to breath, no pursed lip, or mouth breathing, and no dyspnea noted. . . . good capillary refill and lips are pink. Hospice was called and informed of resident health status. Hospice recommended giving him Morphine if he shows any signs of Dyspnea." * 03/11/13 at 11:29 a.m.: "Data: [Hospice nurse] visit: Pt [patient] in bed, minimally responsive. Pt did not open eyes or attempt to communicate . . . VS: . . . O2-82% on RA . . . Action: Phone call made to . . . NP [nurse practitioner] . . . She ordered . . . oxygen at 2lpm [2 liters per minute] nasal cannula if pt tolerates. . . ." * 03/11/13 at 3:46 p.m.: Transfer to . . . ER [emergency room] for evaluation per family request . . ." * 03/11/13 at 8:03 p.m.: "Type: Admit to Hospital . . . Admitting Diagnosis: Decrease O2 saturation, High sodium levels and Decrease level of consciousness." During an interview on 04/25/13 at 10:55 a.m., an administrative nurse (#) agreed facility staff should have administered oxygen when Resident #20's oxygen saturation continued to drop. Resident #20's oxygen saturation measured 88% on 03/10/13 at 1:18 p.m., and dropped to 85% by 4:29 p.m. The facility failed to check his oxygen saturation again until 03/11/13 at 11:29 a.m., 19	F 309		

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F 309	Continued From page 6 hours after the last oximeter reading. Failure of facility staff to administer oxygen per the physician's standing order in a timely manner may have contributed to Resident #20's decreased level of consciousness, restlessness, and hospitalization.	F 309	**F 323** It is the practice of this facility to provide an environment that remains as free of accident hazards as is possible.	5/30/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy and procedure, the facility failed to appropriately utilize a Hoyer lift (a full body mechanical lift) and failed to assess the resident for injuries prior to assisting to bed for 1 of 1 sampled resident (Resident #13) who fell from a Hoyer lift. Failure to ensure all sling straps were secure before transferring a resident and failure to wait for the nurse to assess a resident before moving placed Resident #13 and all residents at risk for falls and/or injury. Findings include: Review of the facility's procedure for the use of a Hoyer lift titled "Volaro lifts Series 4" occurred on 04/25/13. This policy, revised 11/01/12, stated, "Lifting from Chair to Bed . . . (NOTE: RAISE	F 323	1. Staff caring for Resident #13 has been re-educated to check that all hoyer lift straps are appropriately secured prior to moving the resident. 2. All residents who use a mechanical lift for transfers have the potential to be affected, as well as all residents having a fall have the potential to be affected. 3. Education has been provided to CNA's for the staff operating the lift to check all straps on the hoyer lift prior to lifting and double check after there is tension on the hoyer straps. Re-education has been provided on notification of nurse prior to moving resident to another position following the incident on 5-22-13. 4. The Quality Nurse or designee will audit 10 hoyer transfers per week for 4 weeks and monthly thereafter for 3 months to verify that straps are being hooked prior to transfer. The Quality Nurse will also review all Risk Management entries for falls to verify that the nurse has been notified prior to movement of the resident. All Risk Management entries for falls will be reviewed	on 5-26-13

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F 323	Continued From page 7 UNTIL THERE IS TENSION ON THE STRAPS, THEN DOUBLE CHECK TO MAKE SURE SLING LOOPS ARE NESTED INTO THE BOTTOM OF THE HOOKS PROPERLY.) . . . General Procedure: . . . 12. Attach straps on sling to lift with the strap 'nesting' in the bottom of the hook. . . 13. Tell assistant to guide resident as you begin to lift them from the bed using 'up' button on hand control or up button at handle grips. Once there is slight tension on the straps check to make sure all four loops are still nested in the bottom of the hooks before lifting." Review of the facility's policy and procedure titled "Accidents and Incidents--Investigating and Recording" occurred on 04/25/13. This policy/procedure, revised 07/19/12, stated, ". . . An employee witnessing an accident or incident involving a resident, . . . must report such occurrence to the nurse on duty as soon as possible. . . . Do not move the victim until he/she has been examined for possible injuries." Review of Resident 13's medical record occurred on all days of survey. Diagnoses included a fractured right femur (leg), multiple sclerosis, degenerative joint disorder, and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 02/15/13, identified Resident #13 required extensive assist of two for bed mobility and transfers with a Hoyer lift. The care plan, dated 03/27/13, stated, "TRANSFER: Assist of 2 with hoyer. (R) [right] leg must be supported." Resident #13's Progress Notes, dated 02/25/13 at 9:10 p.m., stated, "Time of Fall: 1730 [5:30 p.m.]. Location: Resident's room. Description of Incident: This writer was called to Res.	F 323	for 4 weeks then 10 falls per month will be reviewed for 3 months. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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F 323	Continued From page 8	F 323		

[Resident's] room via walkie talkie by . . . RA [Resident Assistant]. Upon arrival this writer saw the resident lying in bed crying and yelling. RAs . . . state the resident fell [less than] 6 inches back in her wheel chair when the rear R) hoyer strap slipped out of the hook during transfer from the wheel chair to bed. This writer spoke with resident in private and resident confirmed RA report of incident. . . . Nursing assessment, Injuries, Action taken, and Vital Signs: . . . bandage covering R) knee was out of place. Resident reported 8/10 [Pain at an 8 on a pain scale of 0 to 10, 0 being no pain and 10 being the worst pain] R) leg pain. . . . administered 5mg [milligram] of oxycodone which was effective bringing pain to 3/10. . . obtained orders . . . to have . . . x-rays of R) femur/knee to rule out any injury. . . . Educated staff to ensure good communication between each other and to ensure safe transfers (make sure all straps are completely secure)."

Review of the medical practitioner's note, dated 02/26/13 at 7:09 p.m. stated, ". . . Fall on 2/25/13. xray shows questionable new change in right leg. . . . was being transferred via a hoyer lift and somehow . . . slid out of the hoyer. . . . has some pain of the right leg and this leg has been previously fractured. . . . PLAN: . . . send . . . to radiology for xray of right knee - I have asked ortho to compare with previous xrays to see if there are any acute or chronic changes." The right knee x-ray report, dated 02/27/13, stated, "IMPRESSION: . . . No new fractures are evident."

The facility failed to utilize the Hoyer lift appropriately to transfer Resident #13 and, after

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F 323	Continued From page 9 the fall, failed to wait for a nurse to conduct an assessment before moving this resident.	F 323		