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 _____	C 04/21/2016

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 and complaint survey started on 04/18/16 and completed on 04/21/16, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 3 of 21 sampled residents (Resident #3, #14, and #17). Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin placed these residents and all other residents at risk for abuse and mistreatment. Findings include: Review of the facility policy titled "Accidents and Incidents -- Investigating and Recording" occurred on 04/21/16. This policy, revised July 2015, stated, "POLICY: All incidents will be reported and investigated by the following procedure. PROCEDURE: 1. Reporting of Accidents/Incidents: a. Regardless of how minor	F 226	1. Bruise for resident #3 had resolved prior to the survey, unable to investigate further due to passage of time. Per resident #14, bruise was caused by a gait belt buckle accidentally bumping forehead upon removal. Investigation was completed for resident #17, resident left arm bumped on standing lift. 2. All residents have the potential to be affected by the practice. 3. Re-education will be provided to all staff on reporting and investigation of accidents, bruises, and injuries of unknown origin by the DON/designee on 5/12/16.	5/23/16

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

Electronically Signed | 05/12/2016

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F 226	Continued From page 1 an accident or incident may be, including injuries of an unknown source, it must be reported to the nurse on duty. An Incident Report must be completed on the shift that the accident or incident occurred for an injury of unknown origin; thoroughly complete all items on the incident report. . . . b. Incident reports are entered into Point Click Care Electronic Medical Record . . ." Review of Resident #3's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 03/12/16, identified extensive assistance of two staff members for bed mobility, transfers, and toileting. The current care plan stated, "Focus: I have impaired mobility related to joint pain, hx. [history] of fractures and hx. of joint replacements to shoulders, knees and hips secondary to osteoarthritis. . . . Interventions/Tasks . . . BED MOBILITY: Assist of 2 staff for bringing legs in and out of bed and repositioning side to side. . . . TRANSFERS: Pivot transfer with 2 staff assist. . . . Focus: I have a self-care deficit . . . Interventions/Tasks . . . 2 staff assist for toileting. . . ." Review of Resident #3's progress notes identified the following: * 02/24/16 at 6:44 p.m.: "Bruise on top of L) [left] hand. Resident has a quarter-sized dark purple bruise on the top of her left hand. Stated that she does not remember how she got it. Denies pain to the area. Observed. Will monitor for healing." * 02/26/16 at 4:41 p.m.: "Follow up to bruise - Resident has stated that she feels safe at Rosewood, stated that staff and other resident treat her very well." During an interview on 04/20/16 at 9:55 a.m. an	F 226	4. Complete an audit of bruises and injuries of unknown origin noted in progress notes for identified cause weekly for 4 weeks then quarterly for 1 year by DON/designee. Audits will be submitted to the QAA committee monthly for review.	

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F 226	Continued From page 2	F 226		

administrative nurse (#2) stated the facility failed to investigate Resident #3's bruise.

- During initial tour on 04/18/16 at 12:20 p.m., observation showed Resident #14 with a quarter size purple bruise near her left temple. Resident #14 stated the bruise happened when the buckle from a belt hit her.

Review of Resident #14's medical record occurred on April 18-21, 2016. The admission MDS for Resident #14, dated 02/26/16, identified severe cognitive impairment, clear speech, able to make self understood, and able to understand others.

A progress note stated, "Late Entry 4/4/2016 10:20 [a.m.]. Type: bruise. Data: Resident has a quarter size dark purple bruise on her left temple. Action: left open to air. Response: When asked about bruise resident states that was an accident." The medical record contained no other documentation regarding this bruise.

During an interview on 04/18/16 at 5:20 p.m., an administrative nurse (#11) identified no further documentation or investigation was available regarding the bruise on Resident #14's left temple. The administrative nurse (#11) stated Resident #14 "was hit in the head with a gait belt," it was an "accident" . . . "you can ask her [Resident #14]."

On the morning of 04/19/16, when asked about what caused the bruise on her left temple, Resident #14 stated, "I think I bumped myself. I don't remember."

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During an interview on the afternoon of 04/19/16, an administrative nurse (#1) confirmed the facility failed to investigate Resident #14's bruise on her left temple; and if Resident #14 had been hit in the head with a gait belt, the expectation would be for the staff member(s) to report the incident.

- Review of Resident #17's medical record occurred on April 20-21 2016. Diagnoses included dementia. The MDS, dated 04/09/16, identified extensive assistance of one staff member for transfers and toileting.

Nursing progress notes identified the following:
* 04/14/16 1:42 p.m. ". . . Data: Resident has a bruise to her left forearm that is 8 cm [centimeter] [by] 5 cm Action: Assessed area and applied ice for 20mins. [minutes] . . ."
* 04/16/16 9:38 a.m. " . . . Data: The bruise to her left forearm is a lighter purple than before. It has stayed inside the line that was drawn on her skin. . . ."

An undated typed note stated, "Follow Up to [Resident #17] left arm bruise . . . About [9:00 p.m.] [CNA name] was getting this resident [Resident #7] into the bath with the pal lift [sit-to-stand lift], resident refused to hold onto the bars of the pal lift and arms waving in the air. Resident stating 'I don't need help, I can do this by myself.' Resident placed on toilet still waving arms, [CNA name] locked the pal lift and stepped out of the bathroom so resident could use the toilet leaving the door slightly open. [CNA name] then helped the resident out of the bathroom with the pal lift and noticed a small black bruise on the left lower forearm area. [CNA name] thought the bruise was old looking. Education provided to

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F 226	Continued From page 4 [CNA name] . . ." During an interview on 04/21/16 at 9:15 a.m. an administrative nurse (#1) stated Resident #17 sustained a bruise when resistive to care. The investigation failed to state how Resident #17 sustained the bruise. The CNA identified the bruise as small, and the nursing progress notes stated eight centimeters by five centimeters.	F 226		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		5/23/16

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F 278	Continued From page 5 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 interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 4 of 21 sampled residents (Resident #10, #13, #15 and #17), and for 1 of 3 closed records reviewed (Resident #22). Failure to accurately code bowel patterns, active diagnoses, determination of pressure ulcer risks, and/or turning/repositioning programs does not allow the residents' assessments to reflect their current status/needs; and has the potential to affect the accurate development of a comprehensive care plan and to affect the care provided to these residents. Findings include: BOWEL PATTERNS The Long-Term Care Facility RAI User's Manual, revised October 2015, page H-12 and H-13 stated, "Bowel Patterns: Definition-Constipation: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements)." ". . . Steps for Assessment: 1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes,	F 278	1. For resident #10 with MDS ARD date 2/7/16 item M0100B will be corrected so the formal risk assessment is not marked. For resident #13 with MDS ARD date 3/3/16 MDS item H0600 will be correctly coded for constipation as the resident did not have constipation at the time of the MDS. Section I will also be corrected to remove the diagnosis of hemiplegia as it is not currently active. M0100B and M0100C will be correctly coded as not having a formal assessment or a clinical assessment for pressure ulcer development at time of the MDS. For resident #15 with MDS ARD date 2/22/16 MDS item M1200C will be correctly coded as not having a turning and repositioning program as there was not sufficient documentation to support the coding. For resident #17 with MDS ARD date 4/9/16 MDS item H0600 will be correctly coded for constipation as the resident did not have constipation at the time of the MDS. For resident #22 with MDS ARD of 1/4/16 MDS item M1200C was incorrectly coded for Turning and repositioning. This was a	

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F 278	Continued From page 6 physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period. . . . Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. . . ." - Review of Resident #13's medical record occurred on April 18-21, 2016. The annual MDS, dated 03/03/16, identified the resident experienced constipation (item H0600 coded as 1. Yes) during the 7-day look-back period (February 26, 2016 - March 3, 2016), even though the bowel records showed frequent bowel movements and no difficulty in passing stool. During an interview on 04/19/16 at 5:30 p.m., a nurse (#3) confirmed the facility incorrectly coded constipation on Resident #13's annual MDS. - Review of Resident #17's medical record occurred on April 20-21 2016. The annual MDS, dated 04/09/16, identified constipation even though the bowel records indicated Resident #17 had more than two bowel movements and no difficulty in passing stool during the 7-day assessment period. During an interview on 04/21/16 at 8:00 a.m., a nurse (#3) confirmed the facility incorrectly coded constipation on Resident #17's annual MDS. ACTIVE DIAGNOSIS The Long-Term Care Facility RAI User's Manual, revised October 2015, page I-3 and I-4 stated, ". . . There are two look-back periods for this section: Diagnosis identification (Step 1) is a 60-day	F 278	closed record so correction will not be made. 2. All Residents have the potential to be affected by this practice. 3. MDS Coordinator will be attending the 3 day AANAC RAC Coordinator MDS Training May 17-19, 2016. 4. The DON/designee will complete an audit of 5 MDS's per week for 4 weeks then monthly for 3 months then quarterly for 1 year for appropriate coding of turning/repositioning, formal assessment and risk for pressure ulcers, Constipation, and appropriate diagnosis coding. Audit results will be reported to the QAA committee on a monthly basis for review.	

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look-back period. Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period . . . Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. . . ."

- Review of Resident #13's medical record occurred on April 18-21, 2016. The annual MDS, dated 03/03/16, identified Resident #13 with intact cognition, clear speech, able to make self understood; independent in bed mobility, transfers, and walking; and having an active diagnoses of hemiplegia (item I4900 checked) during the 7-day look-back period (February 26, 2016 - March 3, 2016), even though the medical record lacked evidence of this diagnosis being active.

During an interview on 04/19/16 at 5:30 p.m., a nurse (#3) confirmed the facility incorrectly coded hemiplegia as an active diagnosis on Resident #13's annual MDS.

DETERMINATION OF PRESSURE ULCER RISK

The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 page M-2 stated, ". . . Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the Braden Scale for Predicting Pressure Sore Risk. Other tools may be used.
Check C if the resident's risk for pressure ulcer development is based on clinical assessment. A

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F 278	Continued From page 8 clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Example of risk factors include the following: - impaired/decreased mobility and decreased functional ability - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; - drugs, such as steroids, that may affect wound healing; - impaired diffuse or localized blood flow. . . - resident refusal of some aspects of care and treatment; - cognitive impairment; - urinary and fecal incontinence; - under nutrition, malnutrition, and hydration deficits; and - healed pressure ulcers . . . " - Review of Resident #13's medical record occurred on April 18-21, 2016. The annual MDS, dated 03/03/16, identified the resident's risk for pressure ulcer development was based on a formal assessment (item M0100B checked) and a clinical assessment (item M0100C checked). The facility failed to code Resident #13's MDS accurately for items M0100B and M0100C, as the medical record lacked evidence of a formal and a clinical pressure ulcer risk assessment being completed during the look-back period (February 26, 2016 - March 3, 2016). During an interview on 04/19/16 at 5:30 p.m., a nurse (#3) confirmed the facility failed to complete a formal and clinical pressure ulcer risk	F 278		

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assessment during the look-back period.

- Review of Resident #10's medical record occurred April 18-21, 2016. An admission MDS, dated 02/07/16, identified the facility completed a formal assessment to determine pressure ulcer risk during the look back period (February 1-7, 2016). The resident's medical record failed to contain a formal risk assessment completed during the look back period.

During an interview on 04/21/16 at 10:45 a.m., an administrative nurse (#1) identified the facility failed to complete a formal pressure ulcer risk assessment for Resident #10 during the assessment period as identified by the MDS.

TURNING/REPOSITIONING

The Long-Term Care Facility RAI User's Manual, revised October 2015, Page M-38, stated, "DEFINITIONS Turning/Repositioning Program: Includes a consistent program for changing the resident's position and realigning the body. 'Program' is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. . . . The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention. . .

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- Review of Resident #15's medical record occurred on April 20-21, 2016. A quarterly MDS, dated 02/22/16, identified Resident #15 on a turning/repositioning program (item M1200C checked).

The facility failed to code Resident #15's MDS accurately for item M1200C, as the medical record lacked evidence of a turning/repositioning program during the look-back period. The interventions stated, "Repositioning: Every 2 hrs [hours] throughout the day. I wish to be repositioned at 2 am, 5 am, & 6:30am [sic] during the night shift." The turning/repositioning program lacked specific approaches and interventions for changing the resident's position and realigning the body (e.g., reposition on side, pillows between knees); and the medical record lacked documentation by staff to support the program was implemented and monitored.

During an interview on the afternoon of 04/20/16, an administrative nurse (#1) confirmed the medical record for Resident #15 failed to contain evidence of a turning/repositioning program being provided in accordance with the Long-Term Care Facility RAI User's Manual.

- Review of Resident #22's medical record occurred April 20-21, 2016. An admission MDS, dated 01/04/16, identified a turning and repositioning schedule. Resident #22's care plan for bed mobility stated, ". . . Assist of 2 with repositioning . . ." The resident's medical record failed to identify an individualized turning and repositioning program.

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F 278	Continued From page 11 During an interview on 04/20/16 at 5:28 p.m., an administrative nurse (#1) indicated the medical record lacked documentation to support an individualized turning schedule for Resident #22.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 provide care in accordance with professional standards for 1 of 5 sampled resident (Resident #1) reviewed with a suspected head injury. Failure to complete neurological assessments has the potential for a head injury to go undetected. Findings include: Review of the facility policy titled "Accidents and Incidents -- Investigating and Recording" occurred on 04/21/16. This policy, revised July 2015, stated, "PROCEDURE . . . 3. Medical Attention: The charge nurse shall . . . d. Any time an individual has an injury to the head or suspected injury to the head, either by a blow to the head or by falling and striking the head, regardless of whether they receive medical attention or not, a neurological assessment needs to be done. Many times when a person sustains a head injury there are no immediate signs or symptoms of internal injury. The nurse	F 281	1. On 4/28/15, CNP noted "no significant neuro changes per staff" for resident #1. No further interventions ordered by CNP. 2. All residents with a suspected head injury have the potential to be affected by this practice. 3. Re-education will be provided to nursing staff on the initiation and completion of neurological checks per facility policy at the All Staff meeting on 5/12/2016. 4. The DON/designee will complete an audit for all suspected head injuries (resident bumps head or has bruising to head) for completion of neurological checks per facility policy for 1 year. Audit will be submitted to the QAA committee for review monthly.	5/23/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12	F 281		

will complete a neurological assessment completed on the neurological assessment form. . . . The person with a suspected head injury should be assessed: *Every 30 minute checks X2 [two times] = [equals] 1 hour *Hourly checks X2 = 2 hours *Every 4 hour checks = 4 hours *Every 8 hour checks X2 = 16 hours . . ."

Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease.

Review of an incident report, dated 04/23/15 at 11:45 a.m., identified the following, "[Name of a certified nursing assistant (CNA)] approached me after brunch stating that he had been in toileting [Resident #1] . . . and that res [resident] had tipped to her left while on the toilet and may have bumped her head on the clothes hamper in the bathroom. I immediately assessed [Resident #1] for any injury . . . No injury noted. Checked again in the afternoon when staff was getting [Resident #1] up and still no abraision [sic], bruising or other injury noted. . . ."

Review of an incident report, dated 04/24/15 at 2:48 a.m., identified the following, "During 1 o'clock rounds R.A.'s [resident assistants] stated that they found resident to have a bruise on the left side of her face. Assessed resident and found triangular shaped dark purple bruise (point of triangle pointing up to hair line). No bruising or edema at that time. Bed is kept in the lowest position with fall matts [sic] in place at night. There are no pull bars on her bed. She is a two person transfer, not a hoyer. . . ." The incident report failed to include a neurological assessment.

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	355047	A. BUILDING _____ B. WING _____	C 04/21/2016

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F 281	Continued From page 13 The progress notes identified the following: * 04/24/15 at 10:59 a.m.: "Dark purple triangle shaped bruise to left side of forehead with point toward the hairline. RA reported that she observed a bruise to the left side of the resident's forehead at 3 o'clock rounds. Assessed site. At 0300 was dark purple bruise of approximately 5.5 cm [centimeters] along the base and 3 cm high, the tip of the triangle was 3 cm across. At 0830 [8:30 a.m.] purple bruise was lighter and had spread out to the right of the triangle for approximately 2 cm and was pink in that area. Edema was from the left side of the bruised area to approximately the middle of the forehead for length of 10 cm. . . . Resident alert and following staff with eyes." * 04/24/15 at 11:27 a.m.: "Bruise noted to left side of forehead/temple on night shift Area was assessed by night nurse - see documentation follow up with staff re: [regarding] origin of bruise. Evening nurse stated that resident was observed to have a red mark on the left side of her forehead after supper. She was observed with her head laying on the table at that time. Per staff reports, resident was sleepy and her daughter had to wake her several times during supper meal. Bruise origin is from resident laying her head down on the table, resident was assisted to bed following observation. Resident was very sleepy and appears to have hit her head on the table when laying her head down." * 04/24/15 1:23 p.m.: "Bruise on Lt [left] side of forehead Observed area, Neuro [neurological] checks done and vitals No c/o [complaints of] of [sic] discomfort when resting." The progress notes failed to include neurological assessments.	F 281		

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F 281	Continued From page 14 The facility failed to complete a neurological assessment following Resident #1's suspected head injury.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide treatment and services to prevent the development of pressure ulcers for 1 of 3 sampled residents (Resident #5) with heel pressure-relieving interventions. Failure to consistently implement interventions as care planned may result in worsening pressure ulcers or the development of new ulcers. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's, neuropathy, and a history of reddened calloused heels. The current Minimum Data Set (MDS), dated 03/23/16, identified extensive assistance from two or more people for bed mobility. The resident's current	F 314	1. Re-education to CNA's caring for resident #5 was completed to float his heels while in bed as careplanned. 2. All residents with careplanned pressure relieving interventions have the potential to be affected. 3. Re-education will be done at the All Staff meeting on 5/12/2016 to review Kardex for interventions for reducing pressure and implement as careplanned. 4. Audits will be completed for 5 residents with careplanned interventions for pressure relief by the QA Nurse/designee weekly for 4 weeks; then monthly for 3 months and quarterly	5/23/16

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F 314	Continued From page 15 care plan stated, ". . . I have potential for impairment to skin integrity or pressure ulcers r/t [related to] decreased mobility, age, occasional incontinence. . . . Interventions/Tasks . . . Apply lotion BID [twice a day] to bilateral heels. Float heels when in bed. . . ." Observation on 04/19/16 at 10:56 a.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #5 to lie down in bed. The CNA failed to float the resident's heels. Observation showed the resident remained in bed with his heels resting directly on the mattress until 1:03 p.m. when a CNA (#4) assisted him out of bed. Observation on 04/20/16 at 7:40 a.m. showed Resident #5 in bed with his heels resting directly on the mattress. At 8:42 a.m., a CNA (#5) assisted the resident with morning cares. As the CNA removed his gripper socks, the resident flinched and stated, "My heel is sensitive." The CNA stated, "Your skin is dry on your feet," and applied lotion. Failure to float Resident #5's heels while in bed as care planned may result in skin breakdown and/or the development of pressure ulcers.	F 314	thereafter for 1 year. The audits will be reviewed at the monthly QAA meeting for compliance.	
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.	F 323		5/23/16

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F 323	Continued From page 16 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/13/15. GAIT BELT TRANSFERS Based on observation, record review, policy review, and staff interview, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 9 sampled residents (Resident #7) observed transferred with a gait belt. Failure to properly use a gait belt placed the resident at risk for sustaining a fall or injury. Findings include: Review of the facility policy titled "Gait Belts" occurred on 04/21/16. This policy, dated April 2016, stated, "A gait belt will be utilized with all residents who require assistance with transfers and ambulation. . . . 2. Place the gait belt around the residents waist and fasten snug enough so it won't slip up around ribs. . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included spastic quadriplegic cerebral palsy and osteoarthritis. The current care plan stated, " . . . I have self care deficit R/T [related to] cerebral palsy . . . Interventions: Transfers: Assist of 3 to transfer on and off commode. Two using the gait belt to lift and one to manage my pants and brief. Transfer with 2 assist from bed to chair and chair to bed. . . ."	F 323	1. PT evaluation was completed for resident #7 on 4/25/16 for transfers with gaitbelt. Re-education provided to CNA's on placement of gaitbelt for resident #7. The water mixing valve was adjusted by to ensure safe water temperatures for resident care units (1st and 2nd floor Berg Unit). 2. All residents needing assistance with transfers have the potential to be affected. All residents may be affected by using water on resident care units (1st and 2nd floor Berg Unit). 3. Re-education will be provided on the use of gaitbelts to Nursing staff at staff meeting on 5/12/16. The water mixing valve will be adjusted if needed to ensure safe water temperatures for resident care units (1st and 2nd floor Berg Unit). 4. The Quality Nurse or designee will audit 5 transfers per week for 4 weeks and monthly thereafter for 3 months to verify that gaitbelt is used appropriately during transfer. Audits will be reviewed at the facility QAPI meeting for continued	

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F 323	Continued From page 17 Observation on 04/19/16 at 7:55 a.m. showed a certified nursing assistant (CNA) (#6) and a nursing student transferred Resident #7 from the bed to the wheelchair. The CNA (#6) assisted the resident by lifting under the resident's axilla and pulled on the back of the resident's pants. Resident #7 said "ouch" during this transfer. Observation on 04/19/16 at 1:38 p.m. showed two CNAs (#6 and #7) and a licensed nurse (#8) assisted Resident #7 from the wheelchair to the bedside commode. During the transfer, the gait belt slid up near the resident's axilla requiring the CNA (#6) and the nurse (#8) to lift under Resident #7's axilla while holding onto the gait belt. After using the commode, the CNA (#6) and licensed nurse (#8) transferred Resident #7 into bed. During the transfer, the gait belt slid up near the resident's axilla requiring the CNA (#6) and the nurse (#8) to lift under Resident #7's axilla while holding onto the gait belt. The resident complained of left arm pain after the transfer. The licensed nurse assessed and briefly massaged the left arm. During an interview on 04/20/16 at 5:00 p.m., a supervisory nurse (#8) stated she expected staff to readjust the gait belt and avoid lifting under the resident's arm. HOT WATER TEMPERATURES 2. Based on observation, review of professional literature, review of facility water temperature log, and staff interview, the facility failed to maintain safe water temperatures at hand washing sinks in resident rooms on 2 of 8 resident care units (1st and 2nd floor Berg Unit). Failure to ensure	F 323	compliance. Six random water temperature audits will be conducted by the Environmental Services Coordinator/designee daily on the Berg Addition for 2 weeks; then weekly for 3 months and monthly thereafter. The audits will be submitted to the QAA Committee monthly to ensure compliance.	

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F 323	Continued From page 18 safe water temperatures may result in injury/burns to residents of the facility. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding hot water temperatures which states water may reach hazardous temperatures in hand sinks, showers, and tubs. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. Third degree burns can occur after five minutes of exposure to water at 120 degrees Fahrenheit (F), and three minutes of exposure at 124 degrees F. Review of the facility "Domestic Water Temperature and Laundry Wash Water" monthly logs occurred on 04/19/16. This log stated, "Domestic Water at 110 [degrees] maximum" During initial tour on 04/18/16 at approximately 11:45 a.m., a surveyor noted the water in the bathroom of room 253 and 255 as hot to touch. On the morning of 04/19/16, between 8:50 a.m. and 11:30 a.m. the water temperatures measured in residents' bathroom sinks revealed the following: * Room 154 - 118.3 degrees F * Room 172 - 118.5 degrees F * Room 252 - 121.3 degrees F	F 323		

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F 323	Continued From page 19 * Room 253 - 118.1 degrees F * Room 255 - 121.5 degrees F * Room 272 - 121.6 degrees F The Domestic Water Temperature and Laundry Wash Water monthly log recorded by the facility staff revealed the following water temperatures in resident rooms: * 02/10/16 Room 253 - 120.1 degrees F * 02/25/16 Room 175 - 115.8 degrees F * 03/16/16 Room 268 - 120.1 degrees F * 03/31/16 Room 154 - 121.1 degrees F During an interview on 04/21/16 at 8:10 a.m. an environmental supervisor (#7) stated an environmental assistant monitors water temperatures monthly and adjusts the temperature as needed. The facility failed to provide evidence of adjustments made to the water temperature.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325		5/23/16

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F 325	Continued From page 20 Based on observation, record review, and staff interview, the facility failed to provide interventions to prevent weight loss and maintain nutritional status for 1 of 3 residents (Resident #6) observed during meals in the Special Care Unit (SCU). Failure to provide interventions to prevent weight loss and constipation as care planned may result in avoidable weight loss, continued constipation, and inadequate nutritional intake. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, vitamin B and D deficiency, constipation, and adult failure to thrive. The resident's current care plan stated, ". . . My intake varies 0-100%. . . . I often drink better than I eat. . . . I need extra calories to prevent further weight loss. . . . I need dietary interventions in my diet to manage my bowels. . . . Interventions/Tasks . . . Provide 4 oz [ounces] Ensure + and 4 oz choc [chocolate] milk w/ [with] brunch & dinner. . . . Provide me with Ensure + qd [every day] with siesta snack . . . Provide me with fiber in juice BID [twice per day] with meals. Provide prune juice qd with brunch. . . ." Dietary notes stated the following: *03/23/16 at 10:17 a.m.: ". . . continues to lose weight. 3/20/16 wt. [weight] 86.5 lbs [pounds], 0.5 lb loss- 1 month, 5 lb loss - 6 months, BMI [body mass index] 14.8 (low). Goal is to prevent weight loss as much as possible. . . . 4 oz Ensure + BID with meals, 4 oz choc milk BID with meals . . . 8 oz Ensure + with siesta snack . . ." *03/03/16 at 12:15 p.m.: ". . . Bowels: . . . She is	F 325	1. Resident #6 is receiving care-planned dietary supplements daily. 2. All residents receiving high calorie or high fiber beverages have the potential to be affected. 3. Education will be provided to nursing and dietary staff by the Director of Nursing/designee to ensure residents receive all care-planned high calorie and high fiber beverages on 5/12/16. 4. Audits will be completed on 25% of residents identified by the Director of Nursing/designee weekly for 4 weeks; then monthly for 3 months and quarterly thereafter for 1 year. The audits will be reviewed at the monthly QAA meeting for compliance.	

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F 325	Continued From page 21 provided with fiber in juice BID with meals and add prune juice with brunch. . . . Calories: . . . She prefers milk with cereal only. . . ." *01/21/16 at 11:44 a.m. : ". . . Will add Ensure + BID with siesta and HS [bedtime] snacks to promote weight gain. . . ." Mealtime observations of Resident #6 showed the following: *04/19/16 at 10:30 a.m. (brunch): Staff served Resident #6 4 oz orange juice and 8 oz Ensure +. Staff failed to provide prune juice and chocolate milk as care planned. *04/19/16 at 1:38 p.m. (siesta snack): Staff served Resident #6 8 oz juice but failed to provide the resident Ensure + as care planned. *04/19/16 at 4:45 p.m. (dinner): Staff served Resident #6 4 oz chocolate milk and 8 oz regular milk. An unidentified dietary staff member identified the drinks as chocoloate milk and regular milk. Staff failed to provide the resident Ensure + and fiber juice as care planned. *04/20/16 at 10:34 a.m. (brunch): Staff served Resident #6 4 oz chocolate Ensure and 8 oz strawberry Ensure. Staff failed to provide the resident chocolate milk, fiber juice, and/or prune juice as care planned. A certified nursing assistant (CNA) (#5) identified the kitchen staff send chocolate Ensure, but the resident does not like the chocolate, so the CNAs offer strawberry instead. The CNA stated Resident #6 is offered Ensure once on the day shift. Failure to consistently implement existing interventions, evaluate their effectiveness, and modify interventions as needed may result in continued weight loss and repeated episodes of constipation.	F 325		

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F9999	FINAL OBSERVATIONS Based on observation, record review, policy and procedure review, family interview, resident interview, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		