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	355047	A. BUILDING _____ B. WING _____	05/10/2012

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

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 05/07/12 and completed on 05/10/12, the sample included 5 residents for complete review, 14 residents for focused review, and 3 closed records for review. The sample included 3 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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F156 It is the practice of this facility to post pertinent State client advocacy groups contact information. 1. The Medicaid Fraud Unit phone number posting has been corrected to read 800-472-2622. 2. All residents have the potential to be affected. 3. Verification of all required posted information has been completed and will be updated by the Case Management Coordinator or designee as the facility is aware or notified of changes.	6/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/8/12

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156		

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the correct telephone number for the Medicaid Fraud Control unit on 3 of 4 days of survey (May 7-9, 2012). Failure to post correct information to ensure that all residents and their families have access to state client advocacy groups is an infringement of residents' rights. Findings include: Observations from May 7-9, 2012 identified the	F 156		

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F 156	Continued From page 3 facility posted the incorrect telephone number for the Medicaid Fraud Control unit. The correct number was verified with an administrative staff member (#25) on the afternoon of May 9, 2012. The staff member stated they would update the facility's information to include the correct telephone number.	F 156	4. The Case Management Coordinator or designee will audit the required posting information every 6 months for accuracy.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the use of and continued need for physical restraints for 1 of 1 sampled resident (Resident #3) and 1 of 1 closed record resident (Resident #20) for whom staff used a one piece undergarment. Failure to assess, monitor, and re-evaluate the necessity of the devices limited the residents' access to their body and placed them at risk for increased episodes of incontinence, skin breakdown, and loss of dignity. Findings include: Review of the facility's policy and procedure titled "Restraints, physical, chemical and alarming devices" occurred on May 9-10, 2012. The policy, revised 04/24/12, stated, ". . . PHYSICAL RESTRAINTS are defined as any . . . material or equipment attached or adjacent to the resident's	F 221	F221 It is the practice of this facility to respect resident's rights to be free from any physical restraints that are not required to treat the resident's medical symptoms. 1. The one piece undergarment for Resident #3 has been discontinued. Resident #20 is no longer in the facility. 2. Residents that have a physical restraint have the potential to be affected. 3. The Interdisciplinary Team and Nursing staff have been re-educated on the use of a one-piece undergarment as a physical restraint. The Restraint Policy has also been updated to define a one-piece undergarment as a physical restraint device. 4. The Quality Nurse or designee will audit residents with a restraint weekly for 4 weeks and monthly thereafter for 2 months. Audits will be reviewed at the QA Meeting to ensure compliance.	6/18/12

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F 221	Continued From page 4	F 221		

body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body . . . The least restrictive alternatives must be exhausted and clearly documented in the resident's clinical record before a restraint is applied . . . The use of the restraining device, its risks, benefits and expected outcomes must be explained to the resident, family member, or legal representative and used only after receiving acknowledgement that this information has been reviewed and that they consent to the treatment plan . . . A physician's order is necessary for the use of a physical restraint . . . The nurse must contact the physician for specific orders detailing:

a) the type of restraint to be use
b) when it is to be used
c) how long it will be used, when it is to be released
d) the medical need for a restraint . . .

Evaluation of restraint usage will be individualized and re-assessed as indicated in the care plan but no less than quarterly. Assessment must include observation of changes in the resident's functional status related to restraint use, continued need for the restraint, effectiveness of non-restraint interventions. . . ."

- Observation during the initial tour of the facility, on 05/07/12 at 7:40 a.m. identified Resident #3 ambulating in the hall in the special care unit clothed in a one piece garment which zipped up the back. This design did not allow Resident #3 to remove the garment without assistance from staff.

On the morning of 05/07/12 the facility provided a list of residents using restraints. Resident #3's

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name did not appear on the list.

Review of Resident #3's medical record occurred on May 7-10, 2012 and identified a diagnosis of Alzheimer's Disease. Minimum Data Sets (MDSs), dated 07/13/11 and 04/07/12, identified the resident with severe cognitive impairment, required extensive assistance with toileting, and frequently incontinent of bladder and occasionally incontinent of bowel. MDSs, dated 07/13/11, 10/07/11, 01/07/12, and 04/07/12 identified Resident #3 used no physical restraints during the look back periods.

Resident #3's progress notes identified the following regarding the one piece garment:
* 09/22/11 at 5:00 a.m.: ". . . Resident in BR [bathroom] with attempts to self remove onsie [sic] clothing while seated on toilet . . . assisted him with removal of onsie [sic] . . . Resident was cleansed of inc [incontinent] BM [bowel movement] . . ."
* 09/27/11 at 5:16 a.m.: ". . . Observed resident standing by sink et [and] voiding . . . Upon assisting resident to BR . . . onsie [sic] was saturated with urine . . ."
* 10/12/11 at 3:22 p.m.: "Discussed with residents [sic] daughter [name] residents [sic] issues of urinating in innapropriate [sic] places. Discussed that he is cued and assisted regularily [sic] to use the toilet but this has not been enough to prevent this behavior. Action: [Daughter's name] is in agreement to try the one piece outfits."

The above conversation with Resident #3's daughter occurred three weeks after the record identified staff first used the one piece garment

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for Resident #3, not prior to use, as facility policy states. The discussion failed to identify alternatives (other than cueing) attempted prior to implementing the restraint or the risks and benefits of the restraint. The notes on 09/22/11 and 09/27/11 indicated the use of the one piece garment may have contributed to urinary and bowel incontinence due to the resident's inability to remove the garment without assistance.

Resident #3's medical record lacked an assessment prior to implementation of the restraint, lacked quarterly assessments after implementation, and lacked a physician's order which included the medical need for the restraint.

During an interview on the morning of 05/08/12 an administrative nurse (#6) agreed the one piece garment did meet the definition of a restraint by limiting the resident's access to his body.

- Review of Resident #20's closed record occurred on May 9-10, 2012. The resident's diagnoses included dementia with behavioral disturbances and urinary incontinence. The MDS, dated 08/10/11, identified the resident sometimes makes self understood or rarely/never understands others, short-term and long-term memory problems, and extensive assistance transferring, locomotion on unit, toileting, and personal hygiene. The MDS failed to identify the use of a one-piece garment with rear closure restraint.

Review of Resident #20's care plan, initiated on 05/31/11, stated:
"Focus: I can't always express that I need to use

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F 221	Continued From page 7 the toilet or find it and urinate on the floor . . . ." "Intervention: Assist me with wearing one piece outfits. I will wear one outfit for 24 hr [hour] period unless soiled. . . ." Review of Resident #20's progress note identified the use of a one-piece garment restraint: * 05/31/11, 2:51 p.m. - "Data: [Resident] has been urinating in inappropriate places on a daily occurrence. Staff have been offering toilet at least every 2 hours and sometimes every 1 1/2 hours. Action: Above information shared with daughter ... Staff will replace white toilet seat with black seat to help [Resident] see the toilet better. Also suggested trialing one piece outfits to prevent [Resident] from removing clothing. Response: [Resident's daughter] in agreement with above." * 06/12/11, 11:55 a.m. - ". . . Has 2 one piece outfits he currently wears to help decrease the amount of times he urinates inappropriately. . . ." * 10/30/11, 5:30 p.m. - ". . . Staff used extra care with application of "new onsie. . . ." Resident #20's medical record lacked an assessment prior to implementation of the restraint, lacked quarterly assessments after implementation, and lacked a physician's order which included the medical need for the restraint. During an interview on the afternoon 05/09/12, administrative nursing staff members (#3 and #6) confirmed staff should have assessed the one-piece garment and obtained a physician's order for its use. A staff member (#6) confirmed the garment remained inappropriately in place following Resident #20's decline in his ability to transfer and ambulate.	F 221		
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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F 241 SS=D	Continued From page 8 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in manner that promoted each resident's dignity and self respect for 3 of 19 sampled residents (Resident #3, #12, and #15). Failure to provide privacy with toileting (Resident #12), change soiled clothing (Resident #3 and #12), and cover a catheter bag when transporting the resident in a public area (Resident #15) failed to enhance the residents' dignity and self-respect. Findings include: - Observation on 05/07/12 at 2:15 p.m., showed two certified nursing assistants (CNAs #13 and #14) assisted Resident #12 to toilet. An aide obtained a belt for the resident's pants from outside the bathroom leaving the door open. Resident #12 sat on the toilet exposed in full view of the resident's roommate. The room lacked a privacy curtain to pull around the roommate. During an interview on 05/09/12 at 4:55 p.m., an administrative nursing staff member (#6) confirmed CNAs should bring needed items into the bathroom before beginning cares. - Observation on 05/09/12 from 2:15 p.m. - 5:30	F 241	F241 It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. 1. Resident #12's bathroom door is closed and privacy curtain pulled during toileting. Resident #12's and #3's pants have been replaced because the stains wouldn't come out. Resident #15's catheter leg bag is covered by pant leg. 2. Any resident requiring assistance could be affected. 3. Nursing staff will be re-educated on the identified privacy/dignity issues by the Director of Nursing or designee. 4. Privacy/dignity audit rounds will be conducted by Director of Nursing or designees three times per week for four weeks, once weekly for the next two months and as needed thereafter. Audits will be reviewed at the Q A Meeting for continued compliance.	6/18/12

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F 241	Continued From page 9 p.m., showed Resident #12's pant leg contained a white-colored stain visible on his dark pants. During an interview on 05/09/12 at 4:55 p.m., an administrative nursing staff member (#6) stated facility staff should have changed the resident's pants. - Observation, on 05/08/12 at 9:30 a.m., showed a CNA (#7) assisted Resident #3 to ambulate from the common area to his room. Observation showed Resident #3 clothed in khaki pants with a red stain approximately two inches by one inch on the front of his pants, near the zipper. The CNA (#7) assisted Resident #3 to use the bathroom and ambulate back to the common area without changing the stained pants. On 05/08/12 at 3:30 p.m. observation showed Resident #3 seated in a recliner near the nurse's station wearing the stained khaki pants. A CNA (#8) assisted the resident to ambulate down the hall and use the bathroom. The CNA then assisted him back to the common area without changing his stained pants. - Observation on 05/08/12 at 4:40 p.m. showed a CNA (#10) assisted Resident #15 into the elevator and to the dining room on a lower floor for the evening meal. Observation identified the lower half the resident's catheter leg bag, partially filled with urine, protruding from Resident #15's pant leg. The CNA failed to cover the bag prior to transporting Resident #15 to the dining room.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

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F 250	Continued From page 10 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident group interview, individual resident interview, and staff interview, the facility failed to provide medically-related social services to resolve roommate concerns for 1 of 1 sampled resident (Resident #4) who expressed concerns with her roommate. Failure to attempt to resolve the concerns contributed to Resident #4 experiencing an increase in mood symptoms. Findings include: A group interview occurred on 05/07/12 at 1:00 p.m. During the interview, Resident #4 stated, at night, staff turn on room lights and talk in regular tones when assisting her roommate. These actions by the staff awaken Resident #4 on a nightly basis. An individual resident interview with Resident #4 occurred on 05/07/12 at 3:00 p.m. During the interview, Resident #4 stated she has asked facility staff to move her to another room because her roommate has a "hygiene problem." Resident #4's record, reviewed on all days of survey, identified diagnoses including episodic mood disorder. The record showed Resident #4 received Celexa (an antidepressant) 10 milligrams (mg) daily. An admission Minimum	F 250	F250 It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable well-being of each resident. 1. Resident #4 was moved to a different room and has a new roommate. 2. All residents are identified as having potential to be effected. 3. Procedure on Room Change requests has been revised to include the development of care plan interventions to address roommate situations. Care plan team members have been educated to procedure changes by Case Management Coordinator or designee. 4. Current residents Room Change Request List will have care plans audited for presence of interventions by the Case Management Coordinator or designee for presence of interventions. Audit will be presented at QA meeting.	6/18/12

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F 250	Continued From page 11 Data Set (MDS), dated 01/10/12, identified the resident as cognitively intact and having no mood symptoms. A quarterly MDS, dated 04/04/12, identified, during the 14 day assessment period, Resident #4 experienced the following mood symptoms: * little interest or pleasure in doing things - 7 to 11 days * feeling down, depressed, or hopeless - 2 to 6 days * trouble falling or staying asleep, or sleeping too much - 2 to 6 days * feeling tired or having little energy - 2 to 6 days The above mood symptoms resulted in a severity score of five, indicating mild depression. Resident #4's progress notes identified the following: * 04/04/12 at 2:11 p.m.: "Resident scored 5/27 on her PHQ-9 [resident mood interview] assessment which indicates mild depression. This is a decline since last assessment. During interview resident mentioned that she has been feeling down, and is unable to stay asleep at night because of activity her roommate is doing. She also stated that as a result of this she feels more tired through out the day and has less interest in activities she usually enjoys . . ." * 04/23/12 at 7:43 p.m.: "PHQ-9 score of 6/27, indicating mild depression. She reported that she feels down and depressed about the conflict she has with her roommate, and that she overeats most days. This is a slight decline since last assessment. She says that she has been sleeping well other than when her roommate wakes her up . . . Staff have noticed that she has been spending more time in her room, and less socializing in the dining room this review period.	F 250	Subsequently, as residents are added to Room Change Request List, the care plan will be reviewed by the Case Management Coordinator or designee for presence of interventions addressing request to move.	

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F 250	Continued From page 12 When writer asked her why, she reported that she 'can't stand being by her roommate' who usually is out in the dinning [sic] room during the day. She can make very hurtful comments towards her roommate. Writer discussed with her about keeping these comments to herself when she is around her roommate." Resident #4's care plan failed to identify the roommate concerns. The record lacked evidence staff considered a room change for Resident #4 or her roommate, and lacked approaches to resolve the conflict, which resulted in Resident #4's mood decline. During interviews on 05/08/12 at 10:20 a.m. and 1:15 p.m., a case manager (#9) confirmed Resident #4's care plan should have addressed the roommate concerns.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	F274 It is the practice of this facility to complete a comprehensive assessment for residents who experience significant changes in their physical and mental status. 1. A Significant Change in Status Assessment (SCSA) was completed for Resident #1 and #4. 2. All residents have the potential to be affected. 3. MDS Coordinator will review medical record and complete assessment for significant change if indicated, prior to completion and transmission of MDS. Computer software will alert need for significant change in status assessment. Interdisciplinary team will be educated on the completion of accurate MDS assessments by the MDS Coordinator or designee.	6/18/12

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F 274	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident interview, the facility failed to complete a comprehensive assessment for 2 of 2 sampled residents (Resident #1 and #4) who experienced significant changes in their physical and mental status. Failure to complete a comprehensive assessment when Resident #4 experienced a decline in mood resulted in lack of care planning for the decline. Failure to complete a comprehensive assessment when Resident #1 experienced improvement in mood and physical functioning may interfere with the resident's goal of returning home. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, pages 2-20 through 2-23 states, "Significant Change in Status Assessment (SCSA) . . . is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain . . ."	F 274	4. The MDS Coordinator or designee will audit a random sample of current MDS assessments weekly for 5 weeks and monthly thereafter for 3 months to ensure significant change assessments are completed if indicated. The audits will be reviewed at the QAMeeting to ensure compliance.	

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Resident #4's record, reviewed on all days of survey, identified a diagnosis of episodic mood disorder. An admission Minimum Data Set (MDS), dated 01/10/12, identified the resident as cognitively intact, had no mood symptoms, and frequently incontinent of bowel and bladder.

A quarterly MDS, dated 04/04/12, identified, during the 14 day assessment period, Resident #4 experienced the following mood symptoms:
* little interest or pleasure in doing things - 7 to 11 days
* feeling down, depressed, or hopeless - 2 to 6 days
* trouble falling or staying asleep, or sleeping too much - 2 to 6 days
* feeling tired or having little energy - 2 to 6 days
The above mood symptoms resulted in a severity score of five, indicating mild depression.
The MDS further identified Resident #4 as continent of both bowel and bladder.

Resident #4's progress notes, dated 04/06/12 at 11:17 p.m., stated, "Quarterly MDS completed . . . MDS indicates significant improvement in ADL's. Consult with IDT [Interdisciplinary Team] indicates [Resident #4] frequently fluctuates in ADL assistance needs. Will not proceed with significant change MDS." The note failed to address Resident #4's mood decline and improvement in continence status, which also indicated a need for a SCSA. Failure to complete the SCSA resulted in Care Area Assessments not completed and care plan interventions not developed for Resident #4's decline in mood.

- Review of the medical record for Resident #1 occurred May 7-10, 2012. Comparison of the

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F 274	Continued From page 15 admission MDS, dated 10/13/11, with the quarterly MDS, dated 03/15/12, identified the resident as cognitively intact and showed improvement in the following areas: For each MDS the facility assessed the resident's mood symptom frequency for two weeks: * "Feeling down, depressed, or hopeless; [and] trouble falling or staying asleep, or sleeping too much" decreased from "12-14 days (nearly everyday)" to "2-6 days (several days)." * "Little interest or pleasure in doing things" decreased from "several days" to "never or 1 day." * "Feeling tired or having little energy; [and] moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual" decreased from "nearly everyday" to "never or 1 day." * "Mood: Total severity score" decreased from "19" to "10". For each MDS the facility assessed the resident's functional status for ADLs in the areas of self performance and staff support for the past seven days: * "Bed mobility" improved from "extensive assistance [with] two+ [plus] persons physical assist" to "independent [with] set up help only." * "Transfer" improved from "extensive assistance [with] one person physical assist" to "independent [with] set up help only." The Care Area Assessment (CAA) Summary regarding cognitive loss/dementia, dated 10/17/11, stated, "Residents goal is to get strong enough to go home. Resident is able to do some cares each morning (brush teeth, comb hair, wash face)."	F 274		

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F 274	Continued From page 16 Observation of Resident #1 on 05/07/12 at 5:10 p.m., showed the resident independently positioned himself from a laying to a sitting position on the edge of the bed when staff brought his meal tray to his room. Other random observations on all days of survey showed Resident #1 to be independent in his room.	F 274		
F 314 SS=G	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, record review, resident interview, staff interview, and review of facility policy, the facility failed to provide necessary treatment and services to prevent the occurrence and promote the healing of pressure ulcers for 2 of 5 sampled residents (Resident #6 and #7) identified with pressure ulcers. Failure to provide timely and appropriate interventions and ensure staff consistently implemented existing interventions resulted in the development of a new pressure area and the deterioration of an existing facility-acquired pressure area for Resident #6, and may resulted in the reoccurrence of pressure areas for Resident #7.	F 314	F314 It is the practice of this facility to provide the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. 1. Resident #6's physician was notified, order received for treatment to pressure area. Dietary assessment was updated with interventions indicated on the Medication Administration Record (MAR). Repositioning continues as resident allows. Pressure areas are improving. Resident #7 is using the prevalon boots and wedge as care planned.	6/18/12

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F 314	Continued From page 17 Findings include: Review of the facility policy titled "Pressure Ulcer Treatment" occurred on 05/10/12. This policy, revised September 2011, stated, ". . . Key Procedural Points . . . 2. The staff nurse will initiate a care plan and initiate the PUSH tool [used to monitor the size and stage of pressure ulcers] to monitor the healing process. . . . 3. Signs of healing . . . should be evident after 2 to 4 weeks of treatment. Notify physician or mid-level practitioner if any evidence of deterioration is noted. . . . 4. The diet of the resident with a pressure ulcer should contain nutrients adequate to support healing such as increased protein. . . . 6. Avoid positioning the resident on a pressure ulcer. Use positioning devices to raise a pressure ulcer off the support surface. . . . 13. Dressings should keep the ulcer tissue moist while keeping the surrounding intact skin dry. Use the prescribed dressing type. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses include obstructive chronic bronchitis with exacerbation, osteoarthritis, and generalized muscle weakness. The admission Minimum Data Set (MDS), dated 04/01/12, identified intact cognition and no pressure ulcers. The medical record indicated Resident #6 was hospitalized from April 16-23, 2012 with pneumonia. Review of skin assessments prior to this hospitalization revealed the following: *04/05/12 (the first indication that pressure ulcers were present): 2 pressure ulcers present on the resident's left buttock. The first area measured 1	F 314	2. Residents identified as at risk for skin breakdown have the potential to be affected. 3. Certified Nursing Assistants (CNAs) and licensed nurses were re-educated on the provision of skin care which included timely notification to the health care provider, ensuring prompt and appropriate treatment, dietary interventions, timely repositioning and use of pressure relieving interventions by the Director of Nursing or designees. 4. The Quality Nurse or designee will audit 3 residents weekly for 4 weeks and monthly thereafter for 3 months to verify the presence of treatment and preventative measures if applicable. The audits will be reviewed at the QA Meeting for continued compliance. Additional audits will be conducted at the direction of the QAA Committee.	

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centimeter (cm) by 1.2 cm, the second area measured 1 cm by 0.9 cm.
*04/13/12: 2 left buttock ulcers, both Stage II, the first area measured 0.6 cm by 0.4 cm, the second area measured 1.4 cm by 0.6 cm.

An admission MDS (completed after Resident #6's return from the hospital), dated 04/30/12, identified extensive assistance from two or more people for bed mobility and transfers, the presence of two Stage II pressure ulcers, short term memory problems, and modified independence with daily decision-making.

Resident #6's current care plan stated, "Focus . . . I have the potential for and actual impairment to skin integrity r/t [related to] presence of 2 open areas to (R) [right] medial buttock (present upon admission to facility 4/23/12); alteration in mobility; require assist with transfers, ambulation, bed mobility, toileting. *4/30/12 open area (R) buttock, (L) buttock, & slit in coccyx area. *05/07/12 open areas continue in all three previously noted areas. . . . Interventions . . . I have a pressure-relieving mattress & w/c [wheelchair] cushion. . . . Reposition every 2 hrs. [hours] side to side. . . . Treatment per E-TAR [electronic treatment administration record] . . . Focus . . . I need increased protein in my diet to aid in healing my skin . . . Interventions . . . Please provide activia yogurt QID [four times per day] with med [medication] pass. . . . Please provide choc [chocolate] milk and juice with fiber BID [twice per day] with meals. . . ."

The care plan initially identified the presence of 2 open areas to Resident #6's left buttock. A supervisory nursing staff member (#4) revised the

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care plan on the afternoon of 05/07/12 to indicate 2 open areas to the right buttock. The staff member also made the additions, dated 04/30/12 and 05/07/12, at that time.

During Resident #6's hospital stay, a wound care nurse completed an assessment, dated 04/16/12, which stated: "Left medial buttock with two open areas 0.7 x [by] 1.2 cm and 0.5 x 0.5 cm . . . Coccyx has nonblanchable erythema. Hydrocolloid dressing was removed as it was rolled up at edges. Will stop this and use xenaderm [a type of ointment used to treat pressure ulcers]. . . ."

Upon readmission to the facility on 04/23/12, nursing staff completed an initial assessment which identified two pressure areas to the right buttock, one measuring 1.4 cm by 0.4 cm, and one measuring 0.2 cm by 0.2 cm. The assessment identified no further pressure areas.

During an interview on 05/08/12 at 4:00 p.m., a supervisory nursing staff member (#4) stated she was unsure as to why the facility's readmission nursing assessment conflicted with the skin assessment performed by the wound care nurse, as well as the facility's assessments prior to Resident #6's hospitalization. She also stated that it is facility policy to initiate a PUSH tool when staff discover pressure areas, and staff should have initiated one on 04/23/12.

A skin assessment, dated 04/30/12, identified three pressure ulcers in three different locations: *Right buttock: 1.2 cm x 1.2 cm reddened area. Open area inside reddened area which measured 0.5 cm.

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F 314	Continued From page 20 *Left buttock: 1 cm x 0.5 cm area of white slough tissue. *Intergluteal cleft: 4 cm x 0.1 cm, not staged. *Staff initiated a PUSH tool for all three areas on 04/30/12. A skin assessment completed on 05/07/12 identified the three pressure ulcers as follows: *Right buttock: 1 cm x 2 cm, Stage II *Left buttock: 1.2 cm x 0.8 cm, Stage II *Coccyx: 0.5 cm x 0.3 cm, Stage II *Skin surrounding the three areas is reddened During an interview on 05/08/12 at 8:06 a.m., a licensed nurse (#20) stated the intergluteal cleft and the coccyx are the same, and that the pressure ulcer is "right on the coccyx." The above assessments identify a deterioration in the right and left buttock ulcers, and also the development of a Stage II coccyx ulcer that was identified as a "slit" on the resident's care plan, dated 04/30/12. Observation on 05/07/12 at 1:52 p.m. showed Resident #6 seated in her wheelchair and propelled by staff to an activity. Observations throughout the afternoon until approximately 5:40 p.m. showed Resident #6 seated in her wheelchair. Facility staff failed to reposition the resident every two hours as care planned, which resulted in direct pressure to Resident #6's buttocks/coccyx area for nearly four hours. Observations showed Resident #6 lying in bed on her back and not positioned on her side as care planned as follows: *05/08/12 from 7:55 a.m. to 9:49 a.m.	F 314		

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F 314	Continued From page 21 *05/09/12 from 7:45 a.m. to 9:45 a.m. Observation on 05/08/12 at 9:49 a.m. showed two certified nursing assistants (CNAs) (#21 and #22) assisted Resident #6 with morning cares. Observation identified an open area surrounded by reddened tissue to the resident's left buttock, right buttock, and coccyx. The areas lacked any type of dressing. As the CNAs performed perineal cares, Resident #6 stated, "Can you put some cream on that [indicating her buttocks]? It's sore." Observation showed no cream available in the resident's room, and a CNA (#21) left to obtain some. A CNA (#22) then applied skin barrier cream to the resident's buttocks and coccyx areas. Observation on 05/08/12 at 2:22 p.m. showed Resident #6 lying in bed on her back. At 3:10 p.m. observation showed the resident sat in her wheelchair in the lounge area. The resident remained in her wheelchair until approximately 6:00 p.m. when observation showed the resident lying on her back in bed. The staff failed to reposition Resident #6 every two hours as care planned, which resulted in direct pressure to Resident #6's buttocks/coccyx area for nearly three hours. Observation on 05/09/12 at 9:45 a.m. showed two CNAs (#23 and #24) assisted Resident #6 with morning cares. Observation showed an open area surrounded by reddened skin the resident's left buttock, right buttock, and coccyx. The areas lacked any type of dressing. The CNA (#23) applied "Eucerin Dry Skin Treatment" to the resident's buttocks and coccyx area. The resident stated, "Ouch," and the CNA (#23) asked, "Does	F 314		

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that hurt [Resident name]?" Resident #6 replied, "Yes. Oh, yes it does!"

During an interview on 05/09/12 at 4:45 p.m., a supervisory nursing staff member (#4) stated Eucerin cream was for "dry skin" and not an appropriate treatment for pressure ulcers.

Physician's orders, as well as medication administration records (MARs) and treatment administration records (TARs) for the months of April and May 2012 failed to identify treatments for Resident #6's pressure ulcers.

The Care Area Assessment (CAA), dated 04/30/12, indicated staff applied duoderm dressing to the pressure areas during the reference period (seven days). However, treatment records and physician's orders failed to identify the use of any dressing. During an interview on 05/08/12 at 8:06 a.m., a licensed nurse (#20) stated staff are not applying a dressing to the ulcers, only moisture barrier cream. The CAA completed on 04/30/12 conflicts with medical record review, observation, and staff interview.

During an interview on 05/10/12 at 10:20 a.m., a supervisory nursing staff member (#4) stated a staff nurse reported the pressure areas to the physician, who recommended no treatment. However, record review showed no documentation of physician notification. The staff member (#4) agreed staff should have documented the conversation and was "surprised" that no dressing or treatment was in place.

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Dietary Progress Notes revealed the following:
*04/04/12: ". . . She prefers not to have milk with meals . . ."
*04/30/12: ". . . Protein: . . . Increased needs to aid in past low Alb [albumin] and to aid in healing skin . . . She likes to take her meds with Activia yogurt BID . . . [Resident name] has preferred not to have milk with meals. Will speak with [Resident name] about dietary interventions to provide increased protein. . . ."
*05/02/12: ". . . Spoke with [Resident name] and her daughter this morning regarding diet plan. She is receiving yogurt QID with med pass and she would now like choc milk BID with meals. . . ."

Observations of meals on the evening of 05/07/12, morning and evening of 05/08/12, and morning and evening of 05/09/12 identified Resident #6 received four ounces of chocolate milk with her meals. Upon completion of the meals, the milk remained untouched by Resident #6.

Observation on the afternoons of May 7-9, 2012 identified staff failed to offer Resident #6 yogurt with her afternoon medication pass as care planned. Observation showed the dietary intervention of offering yogurt with medication pass was not listed on either the MAR or the TAR.

During an interview on 05/09/12 at 3:32 p.m., Resident #6 stated she has "never really drank milk" and does not like milk, chocolate or otherwise. The resident stated, "I like my ice water and maybe tomato juice once in awhile [with meals]." The resident also indicated the pressure ulcers to her buttocks and coccyx were

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F 314	Continued From page 24 "sore" and "sometimes" caused her pain. Failure to ensure staff consistently implemented existing pressure ulcer interventions (e.g. repositioning and providing yogurt with medication pass), ensure the timely notification of the health care provider and prompt treatment, ensure appropriate treatment (i.e. the use of moisture barrier cream, which is not a prescribed treatment for Stage II pressure ulcers), ensure dietary interventions were consistent with Resident #6's likes and dislikes, and ensure the accuracy of the measurements/assessments of pressure areas resulted in the deterioration and development of facility-acquired pressure ulcers, and also resulted in Resident #6 experiencing pain and discomfort. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included diabetes mellitus, stress incontinence, and diastolic heart failure. The current MDS, dated 04/10/12, identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment; extensive assistance from two or more people for bed mobility and transfer; frequent urinary and bowel incontinence; one State II pressure area; and one unstageable pressure area. Resident #7's current care plan stated, ". . . Focus . . . I have a (R) heel ulcer present on admission (resolved); & a stage 2 ulcer on (R) buttock present on admission (resolved); I have a pressure ulcer to my (L) heel (resolved). . . . Interventions . . . Reposition side to side every 2 hrs. and as needed. . . . I must wear my prevalon boots at all times. . . . Focus . . . I have an ADL	F 314		

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F 314	Continued From page 25 [activities of daily living] Self-Care Performance Deficit . . . BED MOBILITY: . . . Place wedge up near her shoulder and overlap it with a pillow about half way down to position res. [resident] way up on her hip to prevent pressure on bottom. . . ." During an interview on 05/08/12 at 8:04 a.m., a nursing staff member (#20) stated Resident #7 currently had no open areas. She stated the resident's coccyx ulcer had recently healed, and the resident's right heel ulcer healed in April. Observation during the initial tour of the facility on 05/07/12 at 7:42 a.m. showed Resident #7 lying on her bed with a pillow under her calves. A pair of Prevalon boots and a wedge cushion were located on a recliner in the corner of the room. The pillow was not large enough to ensure Resident #7's heels remained off the bed; as a result, the resident's heels rested directly on the mattress. Observation on 05/08/12 at 7:58 a.m. showed Resident #7 lying on her back in bed, and the wedge cushion located on the recliner. Observations on the morning of 05/09/12 showed Resident #7 lying on her back in bed, and the wedge cushion located on the recliner. During an interview on 05/08/12 at 4:45 p.m., a supervisory nursing staff member (#4) stated Resident #7 is supposed to have Prevalon boots on at all times, and the resident's coccyx area is still fragile, so it is important to have the wedge cushion in place.	F 314		

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F 314	Continued From page 26 Failure to ensure the consistent implementation of pressure-relieving interventions (e.g. Prevalon boots, wedge cushion) may result in the reoccurrence of Resident #7's pressure ulcers.	F 314	F315	6/18/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure the continued use of a catheter remained medically necessary for 1 of 3 sampled residents (Resident #6) with a catheter. Failure to ensure catheter placement remained appropriate after readmission to the facility placed Resident #6 at risk for urinary tract infections (UTIs), urethral damage, and discomfort. Findings include: Review of Resident #6's medical record occurred on all days of survey and identified a diagnosis of obstructive chronic bronchitis with exacerbation. Resident #6 was hospitalized from April 16-23, 2012 with pneumonia. Resident #6's orders upon	F 315	It is the practice of this facility to prevent urinary tract infections and to restore as much normal bladder function as possible. 1. Resident #6 had catheter discontinued. 2. Any resident admitted or returned from the hospital with a catheter has the potential to be affected. 3. Re-education has been provided to licensed nurses regarding the appropriate use of catheter by the Director of Nursing or designee. 4. The Quality Nurse or designee will audit any new admission or hospital return for the use and appropriateness of catheter placement for the next 4 weeks if applicable. Audits will be reviewed at the QA Meeting.	

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F 315	Continued From page 27	F 315		

her discharge from the hospital included "Bed Rest with Bathroom Privileges."

The current Minimum Data Set (MDS), dated 04/30/12, identified an indwelling catheter, the presence of two Stage II pressure ulcers, short term memory problems, and modified independence with daily decision-making. The Care Area Assessment (CAA), dated 04/30/12, stated, ". . . Res [resident] states foley cath [catheter] was put in place during her hospital stay to keep skin dry so pressure ulcers to bilateral buttocks will resolve without complications. . . ."

Resident #6's admission MDS, dated 04/01/12, identified intact cognition, occasional urinary incontinence, and no pressure ulcers. The CAA, dated 04/01/12, stated, ". . . Incontinent x1 [one time] during the reference period [seven days]. Require extensive assistance for toileting. . . . Resident believes incontinence is an isolated incident and while she may dribble some she does not feel she is incontinent. Plans for a short rehab [rehabilitation] stay and then discharge to her own home with her husband. . . ."

Observations throughout the survey showed Resident #6 with a Foley catheter in place.

Observation on 05/08/12 at 2:22 p.m. showed two certified nursing assistants (CNAs) (#21 and #22) transferred Resident #6 to bed. The resident stated she needed to use the bed pan.

Resident #6's medical record lacked a comprehensive assessment which included factors to support the medical justification for the

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F 315	Continued From page 28 continued use of her catheter and lacked development of a plan for removal. During an interview on 05/08/12 at 4:00 p.m., a supervisory nursing staff member (#4) stated she was uncertain as to the reason Resident #6's catheter remained in place, since Resident #6 was continent prior to her hospitalization. The staff member also agreed there was not an indication for its continued use and stated the catheter was "usually one of the first things they [facility staff] discontinue" after readmission. On 05/09/12 at 2:09 p.m., a supervisory nursing staff member (#4) stated she contacted Resident #6's health care provider who gave an order to discontinue the catheter.	F 315		
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 observation, record review, and staff interview, the facility failed to implement the fall intervention of transferring the resident from a wheelchair to dining chair during meals for 1 of 3 sampled resident (Resident #12) identified as having falls. Failure to transfer the resident from a wheelchair to a dining room chair for meals	F 323	F323 It is the practice of this facility to provide each resident adequate supervision and assistance devices to prevent accidents. 1. Assessment was completed on Resident #12 and determined that the resident may sit in his wheelchair or dining room chair for all meals. 2. All residents that transfer to a dining room chair have the potential to be affected. 3. Re-education was provided to CNAs and licensed nurses to follow the care plan interventions for falls. 4. The Nursing Service Manager or designee will audit 6 care plans with fall interventions weekly for 4 weeks and monthly thereafter for 2 months.	6/18/12

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increased the risk of further falls and potential injury.

Findings include:

Review of Resident #12's medical record occurred May 7-10, 2012. The resident's diagnoses included hemiplegia/hemiparesis (paralysis of one side of body), and debility. The record identified the resident had a history of falls. The Minimum Data Set (MDS), dated 03/29/12, identified extensive assistance with transfers and supervision with eating.

Review of Resident #12's care plan showed the following fall intervention initiated on 04/14/12:
"Focus: I am at risk for falls r/t [related to] Hx [history] of stroke, weakness, and history of falls"
"Goal: [Resident] will be free of falls through the review date."
"Intervention: When I am up to the table eating make sure I am out of my wheelchair and in a regular chair."

Review of Resident #12's nurses' notes revealed the following falls while dining:
* 04/18/12, 7:40 a.m. - "Location: In hallway adjacent to kitchen area. Description of Incident: Resident had been sitting at the kitchen table in his w/c [wheelchair] (brakes locked) eating continental breakfast. Nurse heard him yelling out for help. Nurse found him in the hallway adjacent to the kitchen area laying on the floor on his left side. He had a fork in his right hand and napkins were laying on the floor next to him. His wheelchair was about 2 feet from him. . . ."
* 04/28/12, 4:16 p.m. - "Location: South prairie dinner [sic] area. Description of Incident: Resident

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F 323	Continued From page 30 was sitting in his wheelchair for supper and resident slid from his wheelchair to the floor. . . . " Observation showed Resident #12 seated in a wheelchair and not a dining room chair during 4 of 6 meals/snacks: * 05/08/12, 8:35 a.m., breakfast meal * 05/08/12, 2:30 p.m., siesta snack * 05/09/12, 7:40 a.m., breakfast meal * 05/09/12, 3:00 p.m., siesta snack During an interview on the afternoon of 05/09/12, an administrative nursing staff member (#6) confirmed staff should seat Resident #12 in a dining room chair to prevent him from standing, rolling back his wheelchair, and falling. Failure of facility staff to transfer Resident #12 from his wheel chair to a dining room chair, as indicated on his care plan dated 04/14/12, resulted in the resident falling on 04/18/12 and 04/28/12. Observations during the survey of the Resident #12 in his wheel chair for meals placed the resident at risk for further falls and injury.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and review of manufacturer's specifications, the facility failed to ensure a medication error rate of less than five percent during observation of medication	F 332	F332 It is the practice of the Facility to ensure that it is free of medication error rates of five percent or greater. 1. The insulin pens are being primed before administration to Residents #24 and #25. Residents #4 and #23 are waiting one minute between puffs when receiving inhaled medication.	6/18/21

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F 332	Continued From page 31 administration on 2 of 2 days (May 7-8, 2012) of survey. Failure to prime insulin pens in accordance with manufacturer's specifications (Resident #24 and #25) and failure to wait one minute between puffs for inhaled medication (Resident #4 and #23) resulted in inaccurate doses administered. Five errors occurred during administration of 40 medications, resulting in a 12 percent error rate. Findings include: Review of the manufacturer's package insert for NovoLog FlexPen occurred on 05/10/12. This insert, dated May 7, 2010, stated, ". . . Giving the airshot before each injection . . . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure you take the right dose of insulin: Turn the dose selector to select 2 units . . . Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . . . Keep the needle pointing upwards, press the push-button all the way in . . . The dose selector returns to 0 [zero]. A drop of insulin should appear at the needle tip. . . . Turn the dose selector to the number of units you need to inject . . ." Review of the manufacturer's package insert for Lantus SoloStar occurred on 05/10/12. This insert, dated March 2007, stated,". . . Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: *ensuring that pen and needle work together *removing air bubbles . . . Select a dose of 2 units by turning the dosage selector . . . Hold the pen with the needle pointing	F 332	2. Any resident receiving insulin pens or inhaler medications have the potential to be affected. 3. Nursing staff was re-educated on correct medication administration by consultant pharmacist or designee. 4. The Quality Nurse or designee will conduct 5 audits of insulin pen and/or inhaled medication administration per week for 3 weeks and 3 audits monthly for the next 2 months and as needed thereafter. Audits will be reviewed at the QA meeting for continued compliance.	

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upwards . . . Tap the insulin reservoir so that any air bubbles rise up towards the needle . . . Press the injection button all the way up. Check if insulin comes out of the needle tip. . . . Check that the dose window shows '0' following the safety test . . . . Select your required dose . . ."

Review of the manufacturer's package insert for Proair (albuterol) inhaler occurred on 05/10/12. This insert, revised 07/10, stated, ". . . 1. . . . Shake the inhaler well before each spray. 2. . . . put your mouthpiece in your mouth and close your lips around it. 3. Push the top of the canister all the way down while you breathe in . . . 4. Hold your breath as long as you can . . . 5. If your doctor has prescribed more sprays, wait 1 minute and shake the inhaler again. Repeat steps 2 through 4. . . ."

- On 05/07/12 at 3:25 p.m., observation showed a licensed nurse (#11) obtained a Novolog FlexPen from the medication cart. Without expelling the 2 units of air recommended by the manufacturer, the nurse set the pen at 6 units, entered Resident #23's room, and administered the insulin.

- On 05/08/11 at 8:40 a.m., observation showed a licensed nurse (#19) obtained a Novolog FlexPen and a Lantus SoloStar from the medication cart. Without expelling the two units of air specified by the manufacturers, the nurse set Novolog FlexPen at 15 units and the Lantus SoloStar at 46 units, entered Resident #24's room, and administered the insulins. While administering the Lantus insulin the nurse could not fully push the injection button, causing the nurse to change the needle. The nurse (#19) failed to expel the two units of air as per manufacturer's guidelines with

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F 332	Continued From page 33 the second needle. - Observation of medication pass occurred on 05/07/12 at 3:19 p.m. with a licensed nurse (#20). The nurse handed Resident #23 an albuterol inhaler. The resident shook the inhaler and self-administered two puffs of the medication without waiting one minute between puffs. The nurse failed to cue the resident to wait. - On 05/07/12 at 3:30 p.m., observation showed the licensed nurse (#11) obtained a Proair inhaler from the medication cart and entered Resident #4's room. The nurse shook the inhaler and handed it to Resident #4. The resident quickly self-administered two puffs of the medication without waiting a minute between puffs. The licensed nurse (#11) failed to cue Resident #4 to wait one minute between puffs of the medication.	F 332		
			F333	6/18/12
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, review of professional literature, and staff interview, the facility failed to ensure residents were free of any significant medication errors for 1 of 1 closed record (Resident #21) with a documented known medication allergy. Failure to ensure residents do not receive medications for which they have a documented allergy may jeopardize the health and safety of the residents.	F 333	It is the practice of the Facility to ensure residents are free of any significant medication errors. 1. Resident #21 was a closed record and no longer resides at the facility. 2. Residents with an allergy have the potential to be affected. 3. Re-education from our Consultant Pharmacist was provided to licensed nurses about medication allergies. The Nursing Service Manager or designee will review admission orders for known medication allergies.	

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F 333	Continued From page 34 Findings include: Review of the facility policy and procedure titled "Admission of a resident" occurred on 05/10/12. This policy, revised 11/22/11, stated, " . . . POLICY: . . . an admission checklist will be used by nurses for all admissions. Nurses will initial each item on the admission checklist as it is completed. . . . The Nursing Service Manager on each floor will assure all items on the checklist are completed. . . . PROCEDURE: Medical Records Clerk: Have chart ready for new admissions by placing the following information in the admission packet for the chart: . . . Allergy cards . . . Clinical Support Nurse: . . . Notify Pharmacy of choice. . . . Fax admission profile and completed E-MAR [electronic medication administration record] to pharmacy. . . . Enter medications to PCC [electronic charting system] in the Physician Orders section. . . . Complete allergy label in RED ink and place in the sleeve on the inside cover of the chart. . . . Staff Nurse on day of Admission . . . Compare medication cartridges with E-MAR for discrepancies and correct. . . . Nursing Service Manager responsibilities: . . . Review all admission orders within 24 hours. Review the residents medications . . ." Lippincott Williams and Wilkins, "Nursing 2011 Drug Handbook" 31st ed., page 3, stated "Adverse reactions . . . Drug hypersensitivity, or drug allergy, is the result of an antigen-antibody immune reaction that occurs in the body when a drug is given to a susceptible patient. One of the most dangerous of all drug hypersensitivities is penicillin allergy. In its most severe form,	F 333	4. The Quality Nurse or designee will audit 50% of new admissions each month for three months and as needed thereafter, if applicable. Results of the audits will be reviewed at the QA Meeting for continued compliance.	

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F 333	Continued From page 35 penicillin anaphylaxis can rapidly become fatal. . . ." Page 239-240 of this Nursing Drug Handbook identified the following "Penicillins - amoxicillin and clavulanate potassium, Augmentin . . . Administration P.O.[by mouth] Before giving drug, ask patient about allergic reactions to penicillin. . . ." Review of Resident #21's medical record occurred on May 09-10, 2012 and identified an admission diagnosis of pneumonia. The facility Clinical Support Nurse (#5) signed/noted the admission orders including diagnoses, allergies and orders for medications on Resident #21's admission day. These admission orders included an allergy to "Penicillin" and medication orders for ". . . Augmentin (Amoxicillin & Pot [potassium] Clavulanate) 875-125 MG [milligram] Tablet By mouth (Oral) - BID [twice daily] Everyday, Give 1 tablet BID until 3/15/2012. . . ." Review of the E-MAR identified Resident #21 received a dose of Augmentin/Amoxicillin in the evening of the day of admission and on the morning of the following day. Progress Notes identified the following: * 02/22/2012 2:10 p.m. Admission " . . . Belongings [Resident's name] has . . . a med alert bracelet. . . ." * 02/23/2012 1:14 p.m. "Res. [resident] c/o [complained of] itching to her back this AM at 0930, writer assessed area and noted that res. back was red and blotchy. . . . [name of medical provider] assessed this area and noted that res. had an allergy to Penicillin, res. was taking Amoxicillin for pneumonia started at [name of hospital]. . . . orders to DC [discontinue]	F 333		

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F 333	Continued From page 36 Amoxicillin . . . also started on Triamcinolone 0.01% cream to rashy areas BID x 7 days. Zyrtec [an antihistamine] once daily po x 7 days and Benadryl [an antihistamine] 25 mg po q [every] 6 hours PRN [as needed] for rash. . . ." * 02/23/2012 1:37 p.m. "Benadryl 25 mg . . . itching and rash." * 02/23/2012 7:10 p.m. Followup "I still itch like hell." * 02/24/2012 1:14 a.m. "Benadryl . . . Requested for itching" Review of Resident #21's E-MAR identified facility staff administered Benadryl again at 08:02 a.m. on 02/24/12 and 7:04 a.m. on 02/25/12. Resident #21 also received Zyrtec daily from May 23-29, 2012. During interview on 05/09/12, at 5:45 p.m., an administrative nurse (#4) confirmed the facility admission orders, reviewed by the nurse and faxed to the pharmacy, identified Resident #21's Penicillin allergy. During interview on 05/10/12, at 8:05 a.m., a nursing staff member (#5) stated she reviewed the orders/allergies for Resident #21's admission and failed to identify the Penicillin allergy.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 It is the practice of this Facility to store, prepare, distribute and serve food under sanitary conditions. 1. Scoops are removed from all food thickener and fiber powder cans. Fiber powder cans are dated with a 6 month shelf life. Turkey is cooled following guidelines from the Food Code. 2. All residents eating food prepared and stored in facility kitchens have a potential to be affected.	6/18/12

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	355047	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to properly cool potentially hazardous food and store food in a safe and sanitary manner in 1 of 1 kitchen and 3 of 6 kitchenettes (Second, Third, and Fourth Floor). Failure to follow safe food sanitation practices has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared and stored in these areas. Findings include: Review of the "Product Cooling Temperature Log" occurred on the afternoon of 05/09/12. The log stated "Cool from 140 degrees to 70 degrees in two hours. Cool from 70 to 40 degrees in four hours." Review of the facility's policy, "Sanitation/Food Storage and Holding," dated March 2012, stated, ". . . Never store scoops in containers. . . ." - A dietary tour occurred on 05/09/12 at 1:00 p.m. with an administrative dietary staff member (#17). Observation showed a pan tightly covered with foil on a cart in the walk-in freezer. The pan contained eight half turkey roasts, each approximately five pounds, cooling. During an interview, a dietary staff member (#18) identified dietary staff placed the roasts in the walk-in freezer twenty minutes prior.	F 371	3. Policy on Sanitation Food Storage and Holding was updated regarding removal of scoops from food thickener and fiber powder, dating of fiber powder cans and a more detailed process for meat cooling. The Turkey Cooling Log was revised. It is now kept in the weekly menu book on the day the turkey is to be roasted. All Dietary staff were re-educated on the proper labeling/dating, storage and sanitation of food by the Dietary Coordinator or designee. All staff were educated that scoops cannot be left in fiber powder and food thickener containers via employee newsletter and all-staff email. 4. The Dietary Coordinator or designee will conduct audits weekly to ensure scoops are removed from food thickener and fiber powder along with dating of the fiber powder for 2 months and as needed thereafter.	

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F 371	Continued From page 38 At 2:00 p.m. (an estimated one and a half hour after placement of the roasts in the walk-in freezer), upon request, the administrative dietary staff member (#17) measured the temperatures of the roasts. The temperatures obtained ranged from 99 degrees Fahrenheit (F) to 88 degrees F. The administrative dietary staff member (#17) confirmed the roasts would not cool to 70 degrees F within two hours without an adjustment in the cooling method. The administrative dietary staff member (#17) made adjustments to the cooling process so the roasts cooled to the proper temperature within two hours. When interviewed on the afternoon of 05/09/12, an administrative dietary staff member (#17) confirmed dietary staff should conduct monitoring during the cooling of foods to ensure time and temperature parameters are met for food safety. - Observations on 05/07/12 between 5:33 p.m. and 5:38 p.m. in the second and third floor kitchenettes showed two containers of "Thick n Easy" thickening powder with scoops stored inside. Observation on 05/08/12 at 4:21 p.m. in the fourth floor kitchenette showed a container of "Thick n Easy" and "Fiber Basics" fiber powder with scoops stored inside. The container of "Fiber Basics" stated, "Use within 6 months of opening," however, observation showed staff failed to label the container with an open date. Observation on 05/09/12 between 1:00 p.m. and 2:00 p.m. of two kitchenettes on the second and third floors, showed facility staff continued to	F 371	The Dietary Coordinator or designee will review the Turkey Cooling Temperature Log each time turkey is on the menu for the next 3 months. Results of the audits will be reviewed at the QA Meeting.	

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F 371	Continued From page 39 store scoops within two containers of "Thick n Easy." The administrative dietary staff member (#17) confirmed staff should not store scoops within the dry food product.	F 371	F499 It is the practice of this facility to employ staff that are licensed, certified or registered in accordance with applicable State laws. 1. Medication Aide I are no longer utilized for medication administration. 2. All employees will be screened to assure they are properly credential for their positions. 3. The facility will utilize Medication Aide II or III for medication administration, if needed. 4. The Director of Nursing or designee will screen all applicants to ensure proper credentials for the position they are applying for.	6/18/12
F 499 SS=E	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record review, review of state licensing regulations, and staff interview, the facility failed to ensure 2 of 2 medication assistants I (medication assistants #1 and #2) utilized by the facility were authorized to work in a skilled nursing facility in accordance with applicable State laws. Failure to ensure medication assistants are certified in accordance with applicable State laws to pass medications at a skilled nursing facility may jeopardize the health and safety of the residents. Findings include: Review of North Dakota Administrative Code State Licensing Chapter 33-43-01-20 (1) a Nurse Aide Training, Competency Evaluation, and Registry, page 33 identified the following: " . . . Effective July 1, 2011 . . . .1. a. A medication assistant 1 may work in settings where the	F 499		

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F 499	Continued From page 40 licensed nurse is not regularly scheduled, however, may not work in a nursing facility or acute care setting, including clinics. . . ." On 05/07/2012, an administrative nursing staff member (#3) provided a list of facility personnel and stated the facility does utilize medication assistants. Review of personnel files on the afternoon of 05/08/12 identified two medication assistant Is. Review of the staffing schedules from December 2011 through May 2012 identified the medication assistant (#1) passed medication on 12/20/11 from 4:00 p.m. to 9:00 p.m. The other medication assistant (#2) passed medication on 04/11/12 from 6:30 a.m. to 3:00 p.m. During interview on 05/10/12 at 10:15 a.m., an administrative nursing staff member (#3) stated she was not aware medication assistant Is were not authorized to administer medications at a skilled nursing facility.	F 499		