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 _____	05/23/2018

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 The standard Medicare/Medicaid survey started on 05/21/18 and concluded on 05/23/18.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) 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.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #96) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017,	F 637	F637 Comprehensive Assessment After Sig Change It is the practice of this facility to complete Significant Change Assessments according to the RAI Manual. 1. Resident #96 had a SC assessment completed on 6/3/18 after OT completed their treatments and resident did not resume prior status. 2. All residents with a Significant Change in Status have the potential to be affected. 3. RAI Manual reviewed for definition of Significant Change in Status Assessment by the MDS Coordinator and the DON. Re-education provided to the MDS Coordinator to make a progress note	6/29/18

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

Electronically Signed | 06/20/2018

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F 637	Continued From page 1 page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement. . . ." Review of Resident #96's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 03/10/18, identified the resident to be independent with bed mobility, transfers, walking in room, toileting, locomotion on and off the unit, and supervision with walking in the corridor. The current care plan stated, ". . . I have an ADL Self Care Performance Deficit r/t [related to] weakness . . . I have a fx [fracture] of my right humerus. I will improve my level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene to my prior level of independence through the review date. (Revision on: 04/02/2018). AMBULATION: I am currently non-ambulatory. LOCOMOTION: I use my scooter for distance travel. TOILET USE: I require assist of two with toileting. Use two with a gait belt to pivot me into my w/c [wheel chair], drive me into the bathroom, then pivot transfer me onto the toilet. . . . BED MOBILITY: I require assist of two with bed mobility. . . . TRANSFER: I need two assist with a gait belt to pivot transfer	F 637	when she is monitoring a resident for a significant change based on the RAI definition of a Significant Change. 4. The Quality Nurse or designee will audit 5 residents with an acute change in condition weekly for 4 weeks then monthly for 3 months then quarterly for 1 year for documentation of monitoring of Significant Change. Audits will be reviewed at the facility QAPI meeting for continued compliance.	

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F 637	Continued From page 2 into and out of my w/c [wheel chair]. . . ." During an interview on 05/21/18 at 8:31 a.m.., Resident #96 stated she went from being independent to requiring assist of two staff since her fall on 03/31/18. Observation on 05/22/18 at 4:24 p.m., showed two CNAs (#8 and #9) transferred Resident #96 from the recliner to her wheel chair with use of a gait belt. Resident #96's medical record identified the following progress notes: * 03/31/18 at 1:10 p.m.: "Fall . . . unobserved. . . . Resident stated that she went to put her robe away in the drawer and must have stumbled backwards and fell to the floor. she stated she landed hard on the floor . . . Resident unable to move R) [right] upper extremity . . . upper arm into humerus area was extremely painful and resident unable to move. . . . telephone order "ok to send resident in via ambulance for assessment . . . related to fall & R) shoulder pain. . . ." * 04/1/18 at 1:30 p.m.: "Returned from [name of hospital] (was there for observation over night r/t [related to] pain control)." * 04/2/18 at 10:51 a.m.: "Resident was sent to the ER [emergency room] on 3/31 due to right shoulder fracture. . . ." * 04/4/18 at 9:43 p.m.: " . . . Resident extensive assist of one for ADL's; extensive assist of two for pivot transfers and toileting. Mood was pleasant. Appetite was good. . . ." Review of Resident #96's documentation for activities of daily living for the dates of April	F 637		

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F 637	Continued From page 3 24-May 23, 2018 identified the resident required extensive assist with transfers, toileting, and extensive assist to total assist with locomotion on the unit. During an interview on 05/23/18 at 10:18 a.m., the MDS coordinator (#7) confirmed she was unable to locate any information that would identify why a significant change MDS was not completed on Resident #96 after her fall on 03/31/18, which resulted in a major decline in the resident's status.	F 637		
F 658 SS=C	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice related to priming insulin pens during 3 of 3 observations of insulin administration, (05/22/18 and 05/23/18). Failure to remove the needle shield prior to priming an insulin pen may result in a resident receiving an inaccurate amount of insulin. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 05/23/18. This policy, dated 02/01/18, stated, ". . . With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the	F 658	It is the practice of this facility to complete insulin pen priming according to professional standards of practice. 1. Re-education was given to nurses and Medication Aides to remove the needle shield when priming the insulin pen. 2. All residents who receive insulin via an insulin pen have the potential to be affected. 3. Re-education provided to all nurses and medication aides to remove the needle cover when priming the insulin pen. 4. The Quality Nurse or designee will audit 5 insulin injections per week for 4	6/29/18

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F 658	Continued From page 4 needle. If not, repeat until one drop appears. . . ." - Observation on 05/22/18 at 8:50 a.m. showed a nurse (#5) prepared an insulin pen for injection. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield while priming the pen and therefore could not visualize a drop of insulin from the needle. - Observation on 05/22/18 at 3:35 p.m. showed a nurse (#6) prepared an insulin pen for injection. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield while priming the pen and therefore could not visualize a drop of insulin from the needle. - Observation on 05/23/18 at 9:21 a.m. showed a nurse (#1) prepared an insulin pen for injection. After placing the needle on the insulin pen, the nurse failed to remove the outer needle shield while priming the pen and therefore could not visualize a drop of insulin from the needle. During an interview on 05/23/18 at 8:32 a.m., an administrative nurse (#3) stated she expected staff to remove the needle shield when priming an insulin pen.	F 658	weeks and monthly for 3 months to verify that the cover is removed from the insulin pen when priming. Audits will be reviewed at the facility QAPI meeting for continued compliance.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the	F 679		6/29/18

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F 679	Continued From page 5 physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and physical, mental, spiritual, cultural and psychosocial well-being for 1 of 1 sampled resident (Resident #111) dependent on staff for activities. Failure to provide activities that meet Resident 111's religious needs and interests, limited the resident's ability to reach his highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled, "Activities/Program Planning" occurred on 5/23/18. This policy, revised February 2017, stated, ". . . It is the policy of Rosewood to provide an ongoing program of activities designed to meet the assessed interest and preferences of residents as well as to support their physical, mental and psychosocial well-being, encouraging both independence and interaction in the community . . . Case manager will assess each resident's interest/preferences and customary routine at admission and at least quarterly . . . Activities may be conducted in different ways: one-to-one programs, person appropriate-activities relevant to the specific needs, interests, culture, background . . . to the extent possible, activities provided will: . . . reflect cultural and religious interest of the resident . . . ."	F 679	It is the practice of this facility to provide meaningful activities designed to meet the religious needs and interests of all residents. 1. Interview completed with resident #111 to assess his interests and preferences for ongoing activities to support his spiritual, mental, and psychosocial well-being. 2. All residents have the potential to be affected. 3. Upon admission of a resident, Care Managers will interview all residents and/or their caregiver to provide individualized activity care plans to include activities of cultural and spiritual interest to the resident. 4. The Quality Nurse or designee will audit 5 residents activity plans weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for inclusion of cultural and spiritual activities.	

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F 679	Continued From page 6 Review of Resident #111's medical record occurred on all days of the survey. The quarterly Minimum Data Set (MDS) dated 4/18/18, identified the resident had visual impairment, usually makes self understood, and usually understands others. The current care plan stated, ". . . I also enjoy sitting in the recliner in my room . . . I enjoy listening to culture appropriate music & (and) my religious book . . . My English is limited & vision is poor. Simplify & rephrase information for me as needed . . . Invite to baking & trivia, sing, & other activities on unit. I may just like to watch. I like to be around people. I'm not interested in activities off unit. . . ." Observations of Resident #111 showed the following: * 05/21/18 at 08:30 a.m.- resident self ambulating with walker in the hallway. He stated his daily goal is to walk up and down the hallways 6-8 times. * 05/21/18 at 02:24 p.m.- Resident sitting alone in his room. No TV or music on. * 05/22/18 at 09:00 a.m.- Resident sitting alone in his room. No TV or music on. * 05/22/18 at 03:00 p.m.- Resident sitting alone in his room. No TV or music on. * 05/22/18 at 04:57 p.m.- Resident sitting alone in his room. No TV or music on. During an interview on 05/23/18 at 02:25 p.m., an administrative nurse (#12) stated the facility does need to provide activities related to Resident #111's culture and religious beliefs and more one-on-one activities, due to his visual impairment.	F 679		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		6/29/18

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F 695 SS=D	Continued From page 7 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and family interview, the facility failed to provide oxygen for 1 of 4 sampled residents (Resident #53) with orders for continuous oxygen. Failure to ensure Resident #53 was provided continuous oxygen per the physician's order may result in increased shortness of breath and other respiratory conditions. Findings include: Review of Resident #53's medical record occurred on all days of survey. Diagnoses included shortness of breath (SOB), and congestive heart failure (CHF). The current care plan stated, "I have oxygen therapy r/t [related to] CHF and SOB. I have a Bipap [bilevel positive airway pressure] r/t sleep apnea. I will have no c/o [complaints of] SOB and my O2 [oxygen] saturation will be greater then [sic] 90%. I have O2 via nasal prongs @ [at] 2L [liters] continuously.. . ." The Current physician's order stated, "O2 at 2L/min [2 liters per minute] continuous every shift for hypoxia."	F 695	It is the practice of this facility to provide oxygen therapy according to professional standards of practice. 1. Re-education was provided to staff caring for resident #53 on maintaining continuous oxygen therapy during transfers and checking the level of her oxygen tank. Resident #53 went to an appointment with the Sanford Sleep Medicine on 5/29/18. Orders were changed for oxygen PRN and during sleep. 2. All residents receiving continuous oxygen therapy have the potential to be affected. 3. Re-education provided to all CNA's and nurses on maintaining continuous oxygen therapy including during transfers and when using an oxygen tank. 4. The Quality Nurse or designee will complete audits on 5 residents on continuous oxygen therapy weekly for 4 weeks then monthly for 3 months then quarterly for 1 year. Audits will be reviewed at the facility QAPI meeting for	

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F 695	Continued From page 8 Observation on 05/21/18 at 11:47 a.m. showed Resident #53 sitting in her wheel chair with no oxygen in place. Resident #53 stated she is to wear the oxygen continuously, but staff occasionally forget to apply it. Observation on 05/21/18 at 3:20 p.m. showed Resident #53 with her oxygen on per nasal cannula. The resident's spouse, present at her bedside, stated the resident was receiving oxygen from the oxygen tank on her whell chair and he noticed the tank was empty, so he switched her oxygen tubing to the concentrator. Observation on 05/21/18 at 11:43 a.m. showed Resident #53 in a full body mechanical lift, being transferred to the toilet, with her oxygen off. During an interview on 05/23/18 at 11:21 a.m., Resident #53 stated staff remove her oxygen every time they transfer her with the Hoyer lift.	F 695	continued compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/29/18

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F 880	Continued From page 9 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 10 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and review of facility policy, staff failed to follow standards of practice for infection control for 1 of 11 residents (Resident #106) observed during peri cares. Failure to follow standards of practice for hand hygiene and glove use has the potential to spread infection throughout the facility. Findings include: Review of the facility polity titled, "Standard Precautions and handwashing" occurred on 05/22/18. This policy, revised March 2018, stated, ". . . All health care workers will routinely use appropriate precautions to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection . . . These Standard Precautions apply to . . . All body fluids, secretions and excretion regardless of whether or not they contain visible blood . . . Gloves are to be worn by all employees when: direct contact with blood or bloodborne pathogens, moist body substances (body fluids,	F 880	It is the practice of this facility to complete hand hygiene and wound care according to professional standards of practice. 1. Re-education provided to staff on hand hygiene policy following removal of gloves and peri-cares. 2. All resident have the potential to be affected by hand hygiene. 3. Re-education provided to all Nursing staff on hand hygiene with resident care. 4. The Quality Nurse or designee will audit 10 observations of hand hygiene weekly for 4 weeks then monthly for 3 months then quarterly for 1 year. Audit results will be reviewed at the facility QAPI meeting for ongoing compliance.	

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F 880	Continued From page 11 secretions and excretions) or contaminated items or surfaces is anticipated. . . ." - Observation on 05/21/18 at 9:31 a.m., showed two certified nursing assistants (CNAs) (#10 and #11) assisted Resident #106 onto the bedside commode. When the resident was done, one CNA (#11) raised the resident, using the ceiling lift, and the other CNA (#10) performed pericares using a wipe and her bare hands. The CNA (#10) then sanitized her hands while the other CNA (#11) transferred and lowered Resident #106 onto the bed, applied a clean brief and adjusted her clothing. The resident was then transferred with the ceiling lift to her wheelchair. The CNA's (#10 and #11) removed the lift sling, and the CNA (#10) brushed the resident's hair. The CNA (#10) failed to wash her hands prior to completing other tasks.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition for 1 of 4 suction machines, with the potential all residents residing Berg Court. Failure to ensure the suction machine remained functional in the event of an emergency situation placed residents at risk for choking and aspiration. Findings include:	F 908	It is the practice of this facility to maintain all equipment in safe operating condition. 1. The Berg Court suction machine was replaced prior to completion of the survey. An additional extra suction machine was ordered and placed in the main floor equipment room as a backup. 2. All suction machines in the facility have the potential to be affected. 3. Re-education provided to nurses and medication aides on checking the suction	6/29/18

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 _____	05/23/2018

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 908	Continued From page 12 Observation of the suction machine, stored on 1st floor Berg Court, occurred on 05/23/18 at 1:44 p.m. with a licensed nurse (#1). Observation showed the nurse attempted to feel the suction with her finger, however, the machine failed to produce suction. This nurse (#1) reported it to the nurse manager (#2). An interview with a managerial nurse (#2) occurred on 05/23/18 at 2:50 p.m. This nurse stated he/she also checked the suction machine and it failed to function correctly. An interview with an administrative nurse (#3) occurred on 05/23/18 3:45 p.m. This nurse stated an extra suction machine is stored in the equipment room on 1st floor. During an interview on 05/23/18 at 3:50 p.m., the nurse (#1) stated she did not know there was an extra suction machine stored on the 1st floor. During an interview on 05/23/18 at 3:53 p.m., another nurse (#4) stated she did not know there was an extra suction machine stored on 1st floor.	F 908	machines weekly for proper function by feeling for suction when the machine is turned on and where the extra suction machine is stored if needed. This is included on the night nurse duties. 4. The Quality Nurse or designee will audit that the suction machines are checked weekly by the night nurses weekly for 4 weeks then monthly for 3 months then quarterly for 1 year. Audits will be reviewed at the QAPI meeting for continued compliance.	