STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

(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 recertification and complaint survey started on 05/13/19 and concluded 05/16/19.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but	F 574		6/13/19

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

Electronically Signed | 06/09/2019

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F 574	Continued From page 1 not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview with the resident council, observation, review of the admission packet, and staff interview, the facility failed to provide	F 574	Corrective Action; Upon notice, a list of necessary contact information was given to the	

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F 574	Continued From page 2 residents, in writing, with a complete and/or accurate list of names, addresses (mailing and email), and/or telephone numbers of all the pertinent State regulatory, advocacy, and informational agencies. Failure to provide this written information to residents has the potential to limit residents' and their families' access to these agencies and has the potential to impact all residents. Findings include: During the resident council interview conducted on 05/14/19 at 2:38 p.m., the residents stated they were not clear about how to contact the pertinent State regulatory, advocacy, and/or informational agencies. Observation on May 14-16, 2019, showed a wall mounted enclosed glass case and a binder located near the entrance hallway, that contained written information for the residents and public to view. The wall mounted enclosed glass case contained a list with names and telephone numbers, the binder contained a list with some names, mailing addresses, and telephone numbers, such as the State Ombudsman program, the State Survey Agency, etc. However, the lists contained some inaccurate information (i.e. names, addresses, etc.) and failed to include all the pertinent required agencies. In addition, the lists lacked a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community.	F 574	administrator, who posted the contact information in the entryway. Identification of Others; The Social Services Director (SSD) will provide notification to current resident on location of required posting. SSD will provide a printed copy at the request of the resident. The SSD/director will also present location and intent of required posting at the Resident Council Meeting. Systemic Changes; The Administrator/designee will provide education to applicable staff on accuracy of required posting and importance of including all components of required posting. The Administrator/designee will provide education to the SSD to validate that required information related to posting and intent is to be included in the admission packet. Monitoring/QAPI; The Administrator/ designee will conduct random monitoring weekly 2x a week for 3 months to validate admission packets have required notification and that accurate posting containing all required information is available for resident review. The Administrator/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 574	Continued From page 3 On the morning of 05/16/19, review of the facility's admission packet of written information/material provided to the residents contained the same inaccurate information as in the above-stated binder. During an interview on the afternoon of 05/16/19, two administrative staff members (#1 and #4) verified the facility failed to provide residents, in writing, with a complete and/or accurate list of names, addresses, e-mails, and/or telephone numbers of all the pertinent State regulatory, advocacy, and informational agencies.	F 574		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		6/13/19

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F 580	Continued From page 4 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, family interview, and staff interview, the facility failed to notify residents' representatives or physicians promptly of a change in condition for 2 of 20 sampled residents (Resident #31 and #49). Failure to update resident representatives promptly on injuries of unknown origin and new treatment orders (Resident #31 and #49) and failure to update the physician promptly on a deterioration in skin condition (Resident #31)	F 580	Corrective Actions: The DON/designee validated that Resident #31 and representative was notified of any changes in condition, and new physician orders. Care plan has updated as applicable The DON/designee validated that Resident #49 and representative was notified of any changes in condition, and new physician orders. Care Plan has	

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F 580	Continued From page 5 may delay treatment and is a violation of residents' rights. Findings include: Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on 05/16/19. This undated policy stated, ". . . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). . . . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . . . discovery of injuries of an unknown source . . . need to alter the resident's medical treatment significantly . . . Unless otherwise noted by the resident, a nurse will notify the resident's representative when: . . . The resident is involved in any accident or incident that results in an injury including injuries of an unknown source . . . there is a significant change in the resident's physical, mental, or psychosocial status . . ." - Review of Resident #31 medical record occurred on all days of survey. Progress notes stated the following: * 04/18/19 at 11:00 p.m. to 11:26 p.m.: ". . . resident left dorsal foot area has open area, due to edema, skin cleaned and dressing applied . . . measurement on left dorsal foot 2 x 1.5 cm [centimeter] . . . resident left foot has pitted edema +2, wear ACE wrap in AM and off at HS [hour of sleep] . . . has some redness around the wound . . . will continue to monitor." * 04/24/19 at 5:43 p.m.: ". . . called physician to	F 580	updated as applicable. Identification of Others; The DON/designee will review physician orders for the last 7 days to validate that residents and responsible parties as applicable have been notified of any changes in condition, new physician orders and that care plans have been updated. If concerns are identified they will be corrected. The DON/designee will review 24-hour report and Alert Charting for the last 7 days to validate that the physician has been notified timely of any changes in condition. If concerns are identified they will be corrected. Systemic Changes; The DON/designee will provide education to the license nurses regarding the requirements of timely notification of residents, resident representatives and physicians with changes in condition and new physician orders as applicable. Monitoring/QAPI; The DON/designee will conduct audits 3x/week for 3 months to validate that residents, responsible parties and physicians are notified timely of changes in condition. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 580	Continued From page 6 notify of ulceration and request new treatment. . . . Cleanse ulceration to L [left] dorsal foot with NS [normal saline] once daily. Apply medihoney to slough and cover with a dry gauze dressing daily. . . ." * 04/26/19 at 11:21 a.m.: "Residents sister [name of person] called and notified of resident skin alteration. . . ." The medical record lacked evidence of wound monitoring from 04/19/19 to 04/24/19. During an interview the morning of 05/16/19, an administrative nurse (#7) confirmed the physician and resident representative were not notified promptly of a change in Resident #31's medical condition. - During an interview on the afternoon of 05/13/19, a family member stated the facility does not update her of changes to Resident #49's plan of care/health status. The family member stated, "She could have skin issues, I'd never know. They don't tell me anything." The family member also stated Resident #49 started speech therapy and staff failed to update her. Review of Resident #49's medical record occurred on all days of survey. Diagnoses included multiple sclerosis. Progress notes stated the following: *02/10/19 at 10:46 p.m.: ". . . 4th nail on right toe has come of [sic]. No pain and no bleeding noted. Note left for NP [nurse practitioner] to visit. To covered [sic] with bandage . . ." *02/11/19 at 11:19 a.m.: ". . . New orders per [NP] to apply bacitracin ointment to left fourth toe and cover with bandaid - change BID [twice per day]	F 580		

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F 580	Continued From page 7 and PRN [as needed]. Notify provider/NP if no improvements/worsens on 2/15/19. . . ." *02/11/19 at 4:53 p.m. (NP note): ". . . pt [patient] seen today for left toe nail that was removed likely due to trauma. Pt reports discomfort at nail injury site. Toe nails are over grown and nursing will trim. . . ." *03/27/19 at 1:21 p.m.: ". . . New orders per [NP] for SLP [speech-language pathology] evaluate and treat for dysphagia and difficulties with self feeding. . . ." Resident #49's medical record lacked evidence of representative notification of the above injury and new order for speech therapy.	F 580		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format	F 640		6/13/19

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F 640	Continued From page 8 that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), the facility failed to ensure timely electronic data submission of required Minimum Data Sets (MDS) assessments for 9 of 20 sampled residents (Resident #1, #12, #13, #16, #20, #35, #38, #40, and #54) and 2 of 3 closed resident records reviewed (Resident #64 and #65).	F 640	Corrective Active; All listed residents MDS have been reviewed for timeliness of completion and submission. Identification of Others; All residents could be affected by the listed deficiency	

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F 640	Continued From page 9 Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: Review of Resident #1, #12, #13, #16, #20, #35, #38, #40, and #54's medical records occurred on all days of survey. Review of Resident #64 and #65's medical records occurred on 05/16/19. The MDSs showed the following: ENTRY TRACKING: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-36 stated, the entry tracking record, ". . . Must be completed within 7 days after the admission/reentry. Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days)." Review of Resident #20's medical record identified an admission date of 01/11/19. The entry tracking record was submitted to the Centers for Medicare and Medicaid Services (CMS) on 02/04/19, 10 days late. ADMISSION: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-21 regarding completion dates stated, ". . . The MDS completion date (Item Z0500B) must be no later than day 14 [the admission date counts as day one]. This date may be earlier than or the same as the CAA(s) [Care Area Assessment Summary] completion date, but not later . . . The CAA(s) completion	F 640	Systemic Changes; Education was provided to the MDS coordinator about the importance of completing and transmitting MDS on time. Monitoring/QAPI; An audit on resident MDS submission timeliness will be conducted 1x a week for 3 months. The MDS will be audited by the DON or her designee and findings will be presented to QAPI for further consideration.	

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F 640	Continued From page 10	F 640		

date (Item V0200B2) must be no later than day 14 [the admission date counts as day one]."

-Review of Resident #12's medical record identified an admission date of 11/20/18. The admission MDS, dated 11/27/18, showed the facility dated items V0200B2 and Z0500B 12/18/18, 15 days late.
-Review of Resident #13's medical record identified an admission date of 11/21/18. The admission MDS, dated 11/28/18, showed the facility dated items V0200B2 and Z0500B 12/07/18, three days late.
-Review of Resident #16's medical record identified an admission date of 08/31/19. The admission MDS, dated 09/07/18, showed the facility dated item V0200B2 09/14/18, one day late.
-Review of Resident #35's medical record identified an admission date of 10/31/18. The admission and 5-day PPS MDS, dated 11/07/18, showed the facility dated V0200B2 and Z0500B 11/16/18, three days late.
-Review of Resident #64's closed record identified an admission date of 12/04/18. The admission and 5-day PPS MDS, dated 12/11/18, showed the facility dated V0200B2 and Z0500B 02/19/18, two days late.
-Review of Resident #65's closed record identified an admission date of 01/25/19. The admission and 5-day PPS MDS, dated 01/31/19, showed the facility dated V0200B2 and Z0500B 02/10/19, three days late.

ANNUAL:
The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-22 stated, ". . . The MDS

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F 640	Continued From page 11	F 640		

completion date (Item Z0500B) must be no later than 14 days after the ARD [Assessment Reference Date] (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later . . ."

Review of Resident #40's annual MDS with an ARD of 01/04/19, showed the facility dated V0200B2 and Z0500B 02/09/19, 22 days late.

QUARTERLY:
The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-33 stated, ". . . The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days)."

Review of Resident #54's quarterly MDS with an ARD of 01/25/19, showed the facility dated Z0500B 02/19/19, 11 days late.

OBRA DISCHARGE:
The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-37 stated, "Discharge Assessment-Return Not Anticipated . . . Must be completed (Item Z0500B within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days)."

Review of Resident #1's medical record identified a discharge date of 11/21/19. The facility failed to complete a discharge assessment and submit it to CMS.

MEDICARE PPS DISCHARGE:

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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F 640	Continued From page 12 The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), page 2-46 stated, ". . . Part A PPS Discharge Assessment (A0310H=1) . . . Must be submitted within 14 days after completion of the MDS completion date (Z0500B + 14 calendar days)." Review of Resident #38's Medicare Part A PPS discharge assessment, dated 01/16/19, showed the facility dated Z0500B 01/19/19 and submitted the assessment to CMS 02/04/19, two days late.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Sets (MDSs) for 2 of 20 sampled residents (Resident #12 and #54). Failure to accurately complete Section A (Identification Information) and Section P (Restraints and Alarms) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION	F 641	Corrective Active; The cited residents MDS were reviewed for accuracy and corrected. Identification of Others; DON or designee completed review of all current residents to assure any with serious mental illness and restraints are identified accurately on the MDS. Systemic Changes; Education was provided to the MDS coordinator on appropriate documentation on residents with serious mental illness and bedrails. Monitoring/QAPI; An audit on a resident MDS section	6/13/19

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F 641	Continued From page 13 The Long-Term Care Facility RAI Manual, revised October 2018, page A-19 to A-20, stated, ". . . Section A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding Instructions: Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: PASRR Level I screening did not result in a referral for Level II screening, or Level II screening determined that the resident does not have a serious mental illness . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . . Coding instructions: Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included paranoid schizophrenia and anxiety. The record showed a completed PASRR Level I and Level II screen for an indicated serious mental illness prior to Resident #12's admission to the facility on 11/20/18. Review of the admission MDS, dated 11/27/18, showed section A1500 coded "No" which resulted in a skipped coding pattern and staff failed to code section A1510 A. Serious mental illness. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI Manual, revised October 2018, page P-1 to P-8, stated, ". . . Prior	F 641	P0100 and A1510 will be conducted 2x a week for 3 months. The MDS will be audited by the DON or her designee and findings will be presented to QAPI for further consideration.	

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F 641	Continued From page 14 to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint. . . . Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. . . . Coding instructions: Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period. After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use: Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition. Code 1, used less than daily: if the item met the definition and was used less than daily. Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period. . . ." - Review of Resident #54's medical record occurred on all days of survey. Diagnoses included osteoarthritis, muscle weakness, difficulty in walking, morbid obesity, and incontinence. The most recent quarterly MDS, dated 04/25/19, identified Resident #54 as cognitively intact. The current care plan stated, " . . . Use of side rails to bed , (top rails only), for assistance with changing position due to bilateral shoulder pain related to severe arthritis. . . ."	F 641		

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F 641	Continued From page 15 Review of the quarterly MDS, dated 04/25/19, showed section P0100 A. Bed rail coded a "2" to indicate a restraint used daily during the look-back period. During an interview, on 05/15/19 at 11:20 a.m., an administrative nurse (#18) stated Resident #54's bed rails are used as an assistive device for bed mobility and agreed she coded the MDS incorrectly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		6/13/19

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F 656	Continued From page 16 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to develop and implement a comprehensive care plan for 1 of 3 sampled residents (Resident #16) receiving dialysis. Failure to comprehensively assess dialysis care and implement interventions related to access sites/monitoring of residents may result in complications, including bleeding, loss of access sites, or hypotension. Findings include: Review of the facility policy titled "End-Stage Renal Disease, Care of a Resident with" occurred on 05/16/19. This undated policy stated, "Education and training of staff, may include the following as applicable: . . . The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . . . Signs and symptoms of worsening condition and/or complications of ESRD [end-stage renal	F 656	Corrective Actions; The DON/designee reviewed Resident # 16 care plan to validate monitoring of the hemodialysis fistula was added and this task was added to the TAR on 5/20/2019. Identification of Others; The DON/designee reviewed resident□s currently receiving dialysis to validate that their care plans included hemodialysis fistula care and monitoring. Systemic Changes; The DON/designee provided education to licensed nurses on requirement of providing care and monitoring of hemodialysis fistulas as well a including interventions on care plan. Monitoring/QAPI; The DON/designee will conduct reviews	

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F 656	Continued From page 17 disease] . . . The care of grafts and fistulas . . . The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care . . ." Resident #16's current care plan stated, ". . . Focus . . . I have a potential for complication related to hemodialysis for diagnosis of: Renal Failure Chronic . . . Date Initiated: 02/21/2019 . . . Goal . . . I will not develop complications related to hemodialysis through next 30 days. . . . Interventions . . . I will attend [dialysis center name] three days per week . . ." Resident #16's dialysis care plan failed to identify access sites and interventions related to the assessment and care of sites and monitoring of Resident #16 for complications related to dialysis.	F 656	of new admissions and physician orders 1 time a week for 3 months to validate that residents receiving hemodialysis have care and monitoring ordered and are noted on care plan. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		6/13/19

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F 657	Continued From page 18 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 06/28/18. Based on observation, record review, and staff interview, the facility failed to review/revise the comprehensive care plans to reflect the current status for 2 of 20 sampled residents (Resident #17 and #54). Failure to revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #54's medical record occurred on all days of survey. Diagnoses included chronic kidney disease, muscle weakness, and incontinence. The skilled therapy notes showed physical therapy services discontinued on 12/31/18 and occupational therapy services discontinued on 01/11/19. The most recent quarterly Minimum Data Set (MDS) dated 04/25/19, identified Resident #54 to be cognitively intact. The progress notes showed the following: * 02/07/19 at 3:02 p.m., ". . . Continues to refuse	F 657	Corrective Actions; The DON/designee reviewed Resident #54 care plan and updated as applicable. Resident #17 no longer resides at facility. Identification of Others; The DON/designee will review residents who are receiving hemodialysis and have enteral feeding tubes to validate that care plans are accurate, and any needed revisions have occurred. Systemic Changes; The DON/designee will provide education to the Inter-disciplinary team on the requirements of timely revisions to the care plans on admission, quarterly, change in condition and as needed. Monitoring/QAPI; The DON/designee will conduct reviews 1 time a week for 3 months to validate that quarterly reviews, changes in condition and as needed updates to the care plan have been completed/revised timely. Any	

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F 657	Continued From page 19 to get up despite being offered multiple times, . . ." * 04/18/19 at 10:30 p.m., ". . . Order signed by MD [physician] for D/C [discontinue] of Ensure enlive this date. . . ." * 04/24/19 at 11:10 p.m., ". . . Bed mobility: . . . prefers to stay in bed . . . Toileting: Is incontinent of b & b [bowel and bladder]. Check et [and] change as needed . . ." Resident #54's current care plan stated, ". . . Interventions: Remind resident to wear gripper socks when up . . . Get up every morning at 11:00 AM for therapy . . . OT [Occupational Therapy] ADL [Activities of Daily Living] training/adaptive equipment to improve self-care, home management training, meal preparation, safety procedures and/or instructions in use of assistive devices and/or technology . . . Get up and be ready for therapy by 10:30 AM and go to therapy by 11:00 AM . . . Adjust toileting times to meet patient needs . . . Provide assistance with toileting . . . Supplements: 8 oz [ounces] Ensure Enlive PM and HS [hour of sleep] . . . Assist with dentures as needed . . . Refer to dentist/hygienist for evaluation/recommendations re: denture realignment, new fitting . . . Fistula to right upper arm: assess for bruit/thrills . . ." Observation on all days of survey showed Resident #54 did not wear dentures, the resident reported she preferred not to wear her dentures. During an interview on 05/15/19 at 5:20 p.m., an administrative nurse (#1) reported Resident #54 had a fistula insertion procedure in June 2018 to be prepared for dialysis. Later Resident #54's	F 657	concerns will be corrected. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 657	Continued From page 20 physician determined she did not need dialysis, however the fistula remained intact and no longer required monitoring. The administrative nurse (#1) confirmed staff failed to update Resident #54's care plan in all areas noted above. - Review of Resident #17's medical record occurred on all days of survey. Resident #17's progress notes showed the following: * 03/22/19 at 12:33 p.m., ". . . Order received: May remove G-Tube (Gastric tube) . . . . " Resident #17's current care plan stated, ". . . Focus: presence of g-tube . . . Interventions: Provide water flushes as ordered . . . " Observation on all days of survey showed Resident #17 did not have a G-Tube. During an interview on 05/15/19 at 4:30 p.m., an administrative nurse (#1) confirmed staff failed to update Resident #17's care plan.	F 657		
F 658 SS=E	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 observations, record review, review of facility policy, review of professional reference, family and staff interview, the facility failed to follow professional standards of nursing practice for 5 of 20 sampled residents (Resident #30, #35, #43, #49, and #61). Failure to carry out a	F 658	Corrective Action; The DON/designee assessed Resident # 35 and wt□s are stable. Orders were added for nurse to enter weight and validate that CNA obtained wt. Resident # 30 and 49 both had appts scheduled by	6/13/19

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F 658	Continued From page 21 physician's order (Resident #35), failure to follow facility policy when priming insulin pens (Resident #43 and #61), and failure to ensure residents received follow up care as ordered (Resident #30 and #49) may result in adverse health effects. Findings include: PHYSICIAN'S ORDERS Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice, "10th Edition, 2016, Pearson, Boston, Massachusetts, page 68, stated, " . . . Carrying Out a Physician' Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease, chronic systolic (congestive) heart failure, and acute respiratory failure with hypoxia. A cardiology progress note, dated 04/08/19, identified an order for daily weights and report to provider if weight increased by 2 or more pounds in a day. The record showed the facility failed to record weights for Resident #35 on 9 of the past 37 days. During an interview on the morning of 05/16/19, an administrative nurse (#1) confirmed she expects nurses to follow physician orders and that the weights were missed. - Review of Resident #30's medical record	F 658	the RCC for follow up per MD orders. Resident #43 and 61 blood sugars were reviewed by the DON and found to be stable. Identification of Others; The DON/designee completed a review of the all residents with daily weights ordered and found to be in compliance. These orders were also updated with above tasks. The DON/designee completed a review of all residents admitted or returned from appt in past 7 days h reviewed and validated that appts were scheduled as per orders. The DON/designee completed a review blood sugars on insulin dependent diabetics and found to be stable. Systemic Changes; The DON/designee will provide education to the licensed nursing staff on requirement of physician orders being carried through. RCC will print progress notes the day following appointments, and verify appts have been made. All nursing staff will be reeducated in use of the insulin pen. Monitoring/QAPI; The DON/designee will conduct monitoring 3 times a week for 3 months through chart review and observations to validate that residents daily wts are being obtained, appointments are being followed through, and insulin is being administered appropriately via pen.	

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F 658	Continued From page 22 occurred on all days of survey. Diagnoses included multiple sclerosis, neurogenic bladder, and Foley catheter placement. The record identified a hospital stay from March 3-7, 2019 for a diagnosis of urinary tract infection. Discharge instructions identified a follow up appointment at the urology clinic on 03/18/19. The medical record lacked evidence the resident went to this appointment. During an interview on the afternoon of 05/16/19, an administrative nurse (#1) confirmed Resident #30 did not go to the urology appointment. - During an interview on the afternoon of 05/13/19, a family member stated she was upset because Resident #49 missed a neurology appointment in March which was previously scheduled. The resident was then unable to see the neurologist until June. Review of Resident #49's medical record occurred on all days of survey and identified a diagnosis of multiple sclerosis. A nurse's note, dated 9/7/2018, stated, ". . . Pt. [patient] returned from appointment with [medical doctor]. Continue with exercise and ROM [range of motion] at least twice a day. . . . Pt. to follow-up with [neurologist] on 3/18/19 at 1030. . . ." The record also contained an appointment reminder letter from the medical provider which listed a neurology appointment on 03/18/19. Resident #49's record lacked evidence the resident went to this appointment. During an interview on the morning of 05/16/19, a supervisory nurse (#7) confirmed Resident #49 missed the neurology appointment and is	F 658	The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 658	Continued From page 23 scheduled to go in June. Failure to ensure residents receive scheduled follow up care may result in inadequate medical management and adverse health outcomes. INSULIN PENS Review of the facility policy titled, "Insulin Administration Instructions" occurred on 05/16/19. This undated policy stated, ". . . - Take off and keep the outer needle cap, then remove the inner needle cap and discard it - Select a dose of 2 units by turning the dosage selector - Hold the pen with the needle pointing upwards and tap the insulin reservoir so that any air bubbles rise up towards the needle - Press the injection button all the way in and check if insulin comes out, repeat the process until you see a drop of insulin, a max of six times . . ." - Review of Resident #43's medical record occurred on all day of survey and identified a physician's order for Humalog (a rapid acting insulin). Observation of medication pass occurred on 05/13/19 at 5:08 p.m. A nurse (#5) selected two units on Resident #43's Humalog Pen and pressed the injection button without holding the pen upwards. The nurse (#5) failed to hold the pen upwards to properly prepare the pen for insulin administration to Resident #43. - Review of Resident #61's medical record occurred on 05/14/19 and identified physician	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 24 order's for Tresiba (a long acting insulin) and NovoLog (a rapid acting insulin). Observation of medication pass occurred on 05/14/19 at 1:17 p.m. A nurse (#6) failed to remove the needle cap selected two units on Resident #61's Tresiba pen and pressed the injection button without holding the pen upwards. The nurse (#6) prepared Resident #61's NovoLog Pen without removing the needle cap, selected two units and pressed the injection button without holding the pen upwards. The nurse (#6) failed to remove the needle cap and to hold the pen upwards to prepare the pen for injection to Resident #61.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide activities of daily living (ADL) assistance to 1 of 11 sampled residents (Resident #45) who required staff assistance for toileting. Failure to provide appropriate assistance to residents who cannot independently carry out ADLs may result in avoidable incontinence, poor grooming/hygiene, decreased self esteem, and an avoidable decline in ADL ability. Findings include:	F 677	Corrective Action; The DON/designee assessed Resident # 45. An OT evaluation was obtained and recommendations followed and care plan was updated. Identification of Others; The DON/designee completed a review of the all residents transfer status and care plans were updated.. Systemic Changes; The DON/designee will provide education all staff to alert therapy UM or charge	6/13/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 677	Continued From page 25 Review of the facility policy titled "Activities of Daily Living (ADLs), Supporting" occurred on 05/16/19. This undated policy stated, ". . . Residents will [be] provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. . . . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting) . . ." Review of Resident #45's medical record occurred on all days of survey. Diagnoses included dementia. The resident's current care plan stated, ". . . Focus . . . ADL Self care deficit related to physical limitations . . . Interventions . . . hands on staff assist with bed mobility, transfers, w/c [wheelchair] locomotion on and off unit, dressing, toileting, personal hygiene, eating and bathing. Staff anticipate needs as ADL's do fluctuate . . . Transfer: extensive assistance of one with gait belt and pivot . . . Focus . . . At risk for falls due to impaired balance/poor coordination . . . Interventions . . . assist to bathroom after meals as needed . . . check on resident and offer toileting regularly . . . Don't leave patient unattended in bathroom . . ." Observation on 05/14/19 at 9:20 a.m. showed a	F 677	nurse when ever there is a condition change. Monitoring/QAPI; The DON/designee will conduct monitoring 3 times a week 3 months through chart review and observations to validate that residents ADL status has not declined or changed and that appropriate referrals have occurred if needed. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 677	Continued From page 26 certified nursing assistant (CNA) (#8) transported Resident #45 in her wheelchair to her room. The CNA called for help from another CNA (#16). The CNA (#16) entered the room and asked the CNA (#8) if they were toileting the resident. The CNA (#8) stated, "No, we are going to change her in bed. She's just so hard to transfer." The CNAs attempted to transfer Resident #45 to bed, but the resident became resistive. A nurse (#6) entered the room and instructed the CNAs to re-approach the resident. At 10:44 a.m., two CNAs (#8 and #13) transferred Resident #45 into bed (without offering toileting) and attempted to check and change her incontinence brief. The resident again refused. At 11:31 a.m., observation showed a nurse (#6) exited Resident #45's room. The nurse indicated she checked and changed Resident #45's brief. During an interview on 05/14/19 at 2:16 p.m. a CNA (#8) stated she checked and changed Resident #45's brief in bed and she was now asleep. Observation on 05/15/19 at 11:15 a.m. showed two CNAs (#8 and #9) transferred Resident #45 into bed (without offering toileting) and checked and changed her incontinence brief. When asked if Resident #45 uses the toilet, the CNA (#8) stated, "Not much. She's so unsteady." During an interview on the morning of 05/16/19, a supervisory nurse (#1) agreed staff should follow resident's care plans regarding ADL assistance.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/13/19

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F 684	Continued From page 27 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of professional reference, the facility failed to provide care and services to ensure safe positioning for meals for 1 of 4 sampled residents (Resident #30) observed eating in bed. Failure to ensure proper mealtime positioning placed Resident #30 at risk for aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . coughing . . . during a meal . . . Some patients cough and choke when they aspirate . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. Review of Resident #30's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and dysphagia with honey thick liquids. Nurses' notes identified the following:	F 684	Corrective Actions; The DON/designee assessed Resident #30 to validate that there was no negative outcome. Resident, resident representative and physician were notified of any concerns, physician ordered noted and care plan update as applicable. Identification of Others; The DON/designee will conduct a review of resident who have been identified at risks for aspiration to validate that proper position techniques are implemented and care planned. Systemic Changes; The DON/designee will provide education to applicable staff on appropriate positioning techniques required for residents identified as an aspiration risk. Monitoring/QAPI The DON/designee will conduct random rounds 3 times a week for 3 months during meals to validate that resident at risk for aspiration are positioned correctly to assist in preventing complications	

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F 684	Continued From page 28 *03/10/19 at 7:26 p.m.: ". . . ProMod Liquid [a protein supplement] . . . Patient unable to swallow medication without coughing . . ." *03/10/19 at 7:30 p.m.: ". . . Juven Packet [a nutritional supplement] . . . Patient choking on liquids will update NP [nurse practitioner] . . ." *03/10/19 at 10:42 p.m.: ". . . Writer went into residents [sic] room where he was sitting up eating in bed. Writer gave him his 3 o'clock medication and patient began to cough. Patient face dark red in color. Patient was able to stop coughing after couple min. [minutes] . . . On call was called and writer was instructed to leave progress note . . . for NP. . . ." Observation on 05/14/19 at 12:48 p.m. showed Resident #30 eating lunch in bed. The head of the bed was at a 45 degree angle. Observation showed the resident coughed while eating. At 1:00 p.m., observation showed Resident #30 coughed and choked on his food, expelling pieces from his mouth while his eyes watered. The surveyor entered the room and asked if he needed to sit up. The resident replied, "Yes." The surveyor found a certified nursing assistant who then raised the head of the bed to an almost 90 degree angle. Observation showed a sign next to the bed which stated, "Safe Swallow Strategies . . . Food . . . Sit Upright . . . Drinks . . . Sit Upright . . ." The resident's care plan failed to identify interventions to ensure safe swallowing/positioning during meals. Failure to position Resident #30 (who has dysphagia) in an upright position during meals resulted in the resident choking on his food, and may have resulted in aspiration.	F 684	related to dysphagia. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/13/19

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F 686 SS=G	Continued From page 29 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/28/18. Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to provide appropriate treatment and services to prevent the development and/or deterioration of pressure ulcers for 3 of 5 sampled residents (Resident #17, #30 and #31) with pressure ulcers. Failure to consistently implement interventions, ensure adequate monitoring/assessment, and complete wound care as ordered resulted in the deterioration of Resident #30's pressure ulcer, and delayed treatment/deterioration of pressure ulcers for Resident #17 and #31. Findings include: Review of the facility policy titled "Pressure	F 686	Corrective Actions: The DON/designee reviewed and validated that Resident #30 physician orders were accurate and transcribed correctly, interventions to prevent skin breakdown and promote healing (including repositioning and dietary interventions) were implemented and noted on care plan. Resident, responsible party and physician were notified of any concerns, new physician orders noted, and care plan updated as applicable. The DON/designee reviewed and validated that Resident #31, responsible party and physician were notified of wound status, and documentation of monitoring and assessments of wound (s) was accurate and timely. Care Plan	

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F 686	Continued From page 30 Ulcers/Skin Breakdown - Clinical Protocol" occurred on 05/16/19. This undated policy stated, ". . . In addition, the nurse shall describe and document/report the following, as applicable: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue . . . The physician may guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. . . ." Review of the facility policy titled "Repositioning" occurred on 05/16/19. This undated policy stated, ". . . The purpose of this procedure is to provide guidelines . . . to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. . . . Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. . . . Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. . . ." - Review of Resident #30's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and a right and left ischial ulcer. The current Minimum Data Set (MDS), dated 03/14/19, identified no rejection of cares, extensive assistance from two or more people for bed mobility and two Stage IV pressure ulcers. Resident #30's current care plan stated, ". . . Focus . . . I have potential for altered nutrition	F 686	updated with appropriate interventions as applicable. Resident # 17 no longer resides at the facility. Identification of Others: The DON/designee will conduct a review of residents who have wounds to validate that resident, resident responsible party and physician have been notified of status of wound, physician orders are accurate and transcribed correctly, and care plans are updated with interventions to prevent skin break down and promote healing (including turning and repositioning and dietary interventions) Systemic Changes; The DON/designee will provide education to the licensed nurses on requirements of notifying resident, resident representative and physician on status of wound, validating/clarifying and transcribing wound orders as required. The DON/designee will provide education to the Nursing and Dietary staff on requirements for providing and implementing interventions to prevent skin breakdown and promoting wound healing. Monitoring/QAPI; The DON/designee will conduct monitoring 3 times a week for 6 months through chart review, observation and interviews to validate that resident, resident representative and physician	

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F 686	Continued From page 31 and weight changes r/t [related to] diuretic in use, presence of wounds . . . Interventions . . . Provide Regular diet with enhanced foods, double portions of protein and honey thick liquids as ordered . . . Provide supplements as ordered for wound healing. . . . Focus . . . At risk for complications due to musculoskeletal problems r/t MS [multiple sclerosis] . . . Interventions . . . Assist with bed mobilty . . . Focus . . . Resident has pressure ulcer(s) to right ischium related to: hx [history] of pressure sores, decreased mobility, MS, cardiac, and tendency to stay in one position per preference, resident chooses to set up longer in w/c [wheelchair] against the order to sit up only for 30 minutes for meals.. . . Encourage and assist as needed to turn and reposition; use assistive devices as needed . . . Encourage resident to follow the limit time up in w/c and provide education about risk and benefit of following order or not following order. . . . Pressure reducing surface on bed/wheelchair: Clinitron bed (sand bed) in use since May 8th, 18 [2018] . . . Repositioning during ADLs [activities of daily living] . . . Resident has pressure ulcer(s) to left ischium related to: hx of pressure sores, decreased mobility, and tendency to stay in one position per preference, resident chooses to set up longer in w/c against the order to sit up only for 30 minutes for meals . . . Interventions . . . Adding yogurt to meal trays to try to improve intakes . . ." Nurses' notes and wound assessments stated the following: *01/09/19 at 3:04 p.m.: ". . . Pt. [patient] returned from appointment at [wound clinic]. Left and Right Ischial ulcer: fill with Mesalt [a type of gauze dressing that uses a wicking action to	F 686	have been notified timely of changes in wound status, physician orders are accurate and transcribed and implemented correctly. And interventions related to prevention of skin break down and promoting wound healing are implemented as applicable. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 686	Continued From page 32	F 686		

cleanse draining wounds] and cover with Mepilex [a bordered foam dressing designed to minimize trauma to the wound and surrounding skin at removal] - change daily and PRN [as needed]. Use barrier spray to peri [around] wound skin. . . . Continue with activity orders - up for meals only (60 minutes only) and turn every 2 hours. . . ."
*01/11/19 at 10:12 a.m.: ". . . The unstageable pressure sore to the right ischium measures 2.0 x 2.0 x 0.3 cm [centimeters] [length x width x depth]. The wound bed is 100% granulation tissue. No undermining/tunneling noted. . . . The unstageable pressure sore to the left ischium measures 1.2 x 1.2 x 0.2 cm. The wound bed is 100% granulation tissue. No undermining/tunneling noted. . . . Preventative measures in place include the use of the clinitron bed, keeping skin clean and dry, keep ischium wound sites off pressure, pressure reduction cushion in w/c [wheelchair], turning and repositioning regularly, assistance with meals, daily nutritional supplements, daily skin audit, and weekly skin assessment by nurse. . . ."
*02/19/19: L ischium 1 cm x 0.8 cm x 0.8 cm, wound bed red and 100% granulation tissue, no undermining/tunneling noted, small amount serosanguinous drainage; R ischium 1.7 cm x 1.7 cm x 1.1 cm, wound bed red and 100% granulation tissue, tunneling at 7 o'clock, 2.2 cm, small amount serosanguinous drainage
*03/07/19 (admission assessment post hospitalization): L ischium 0.5 cm x 0.8 cm x 0.3 cm, no tunneling documented; R ischium 1 cm x 2 cm x 1.2 cm, no tunneling documented
*03/13/19: L ischium 1.5 cm x 0.6 cm x 0.4 cm, no undermining/tunneling noted, small amount serosanguinous drainage; R ischium 1.2 cm x 2 cm x 1 cm, tunneling at 7 o'clock, 2.5 cm and 10

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F 686	Continued From page 33 o'clock, 3.2 cm, small amount of sanguinous drainage *04/18/19: L ischium 0.5 cm x 1.5 cm x 0.8 cm, small amount of purulent drainage, periwound macerated; R ischium 1.2 cm x 1.2 cm x 0.8 cm, tunneling at 10 o'clock, 3 cm, moderate amount of serous drainage, periwound macerated *04/30/19: L ischium 1 cm x 1.5 cm x 1 cm, indicated wound was assessed at clinic on this day; R ischium 2 cm, 1.9 cm x 2 cm, indicated wound was assessed at clinic on this day *05/01/19 at 1:39 p.m.: ". . . met for skin and wt [weight] review. Wound is stable, and treatment changed yesterday at wound clinic. . . . Will offer Greek yogurt at meals. . . ." *05/15/19: L ischium 2.5 cm x 1.3 cc (sic) x 0.8 cm; R ischium 4 cm x 2.8 cm x 6.5 cm deep *The record identified staff failed to take measurements from 04/30/19 until 05/15/19 (15 days later). The wound clinic progress note stated the following: *04/30/19: ". . . Patient was last seen by myself on 03/26/19. Last visit, Bilateral ischial ulcers were filled with mesalt ribbon, followed by mepilex border foam dressings. . . . Today, right ischial ulcer was not adequately packed, causing some peri wound skin maceration. Gauze and tape was also utilized by SNF [skilled nursing facility], not mepilex borders as ordered. . . . Assessment: . . . Decubitus ulcer of left ischium, stage 3 . . . Decubitus ulcer of right ischium, stage 3 . . . Plan: . . . Mesalt ribbon (fill wounds lightly but adequately) bilaterally, to cover with large mepilex borders, use NO TAPE, mepilex only. Change dressings daily and PRN. . . .	F 686		

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F 686	Continued From page 34	F 686		

Wounds will not heal if not adequately packed - I wrote to SNF . . . Must use barrier spray to bilateral ischial wound with each dressing change to protect peri wound skin - I wrote to SNF . . . Continue with orders also given to turn patient every 2 hours when in bed, and for him to be up for meals only, for no longer than 60 minutes each time. . . ."

Resident #30's treatment administration record (TAR) identified twice daily dressing changes (not daily as indicated by the wound clinic), and identified packing to the right ischial ulcer (not bilaterally as indicated by the wound clinic).

During an interview on the afternoon of 05/14/19, a nurse (#19) stated Resident #30's skin "has really improved since we stopped using tape," and she thought the wounds were healing.

During an interview on the morning of 05/16/19, a nurse (#20) stated, "Not yet," when asked if staff were packing Resident #30's left ischial ulcer. She further stated, "I have a feeling we're going to need to start [packing the wound]," and "it's starting to get a little deeper." The nurse identified staff measure pressure ulcers weekly.

Observation of the dressing changes on the morning of 05/16/19 showed the nurse failed to pack the left ischial wound. The nurse packed the right ischial wound and stated, "It tunnels back." After completing the dressing change, the nurse stated to the CNA, "We should leave him like that [on his left side] for awhile, get him off that right side." The nurse asked the resident, who agreed.

Observations on 05/13/19 at 11:38 a.m., 12:28

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F 686	Continued From page 35	F 686		

p.m., 2:09 p.m., 2:50 p.m., 3:42 p.m., 4:47 p.m., 5:50 p.m., and 6:31 p.m. showed Resident #30 lying supine in bed with a pillow under his left hip (placing pressure on his right ischial ulcer for nearly seven hours).

Observations on 05/14/19 at 7:51 a.m., 8:42 a.m., 9:08 a.m., 9:55 a.m., 10:39 a.m., 11:17 a.m., and 12:48 p.m. showed Resident #30 supine in bed (five hours). Certified nursing assistant (CNA) charting identified Resident #30 was up in his wheelchair for 45 minutes, charted at 10:41 a.m.; however, observations during this time showed the resident remained in bed.

Observations on 05/15/19 at 8:47 a.m., 9:55 a.m., 10:37 a.m., 11:03 a.m., 11:41 a.m., 12:14 p.m., and 1:19 p.m. showed Resident #30 supine in bed (four and a half hours).

Resident #30's medical record failed to identify repositioning records and/or refusals to be repositioned.

Observations of the following meals showed staff failed to provide double servings of protein and/or yogurt as indicated in his care plan:
*Noon meal on 05/13/19 (no double protein or yogurt)
*Breakfast meal on 05/14/19 (no double protein or yogurt)
*Noon meal on 05/14/19 (no double protein)

The facility failed to consistently implement dietary inventions, reposition Resident #30 every two hours, and complete wound care as ordered by the wound clinic. These failures resulted in increased size/tunneling of Resident #30's ischial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 686	Continued From page 36	F 686		

ulcers and subjected Resident #30 to the need for continued treatments of the open wounds.

- Review of Resident #31's medical record occurred on all days of survey. Diagnoses included multiple sclerosis. Progress notes stated the following:
* 04/18/19 at 11:00 p.m. to 11:26 p.m.: ". . . resident left dorsal foot area has open area, due to edema, skin cleaned and dressing applied . . . measurement on left dorsal foot 2 x 1.5 cm . . . resident left foot has pitted edema +2, wear ACE wrap in AM and off at HS [hour of sleep] . . . has some redness around the wound . . . will continue to monitor."
* 04/24/19 at 5:43 p.m.: ". . . called physician to notify of ulceration and request new treatment. . . . Cleanse ulceration to L [left] dorsal foot with NS [normal saline] once daily. Apply medihoney to slough and cover with a dry gauze dressing daily. . . ."

Review of the "Weekly Pressure/Non-Pressure Wound Assessment" form occurred on 05/16/19. This form dated 04/24/19 showed the following:
* Number of stage 3 pressure ulcers: "1"
* Most severe type of tissue: "slough"
* Ulcer/wound measurements: " Site: L dorsal foot, Length 4.9 cm, Width 5.0 cm, Depth 0.0, Stage III"
* Notes: "Facility Acquired Stage 3 pressure ulcer to dorsal L foot. Nurse states resident ulcer presented as a ripple in the skin. Noted after ace bandage was removed. Ulcer is larger than initial presentation. Wound bed with large amount of purulent drainage. Periwound reddened. Resident denies pain to area. Ace bandage

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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F 686	Continued From page 37	F 686		

removed. MD [physician] updated of change in wound and new treatment ordered. . . . Dietician also notified."

The medical record lacked evidence of wound care or monitoring from 04/19/19 to 04/24/19 which resulted in worsening and delayed treatment for healing of a pressure ulcer.

During an interview the morning of 05/16/19, an administrative nurse (#7) confirmed the medical record lacked documentation of wound monitoring/treatment and acknowledged Resident #31's wound deteriorated prior to physician notification.

- Review of Resident #17's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy. Physician orders included weekly skin assessment and treatment for the right heel pressure ulcer, mepilex dressings to both heels, and change the dressings every 72 hours for protection.

Observation of Resident #17's right foot showed reddened areas with dark spots in the middle of four of his toes.

Observation on 05/15/19 and 05/16/19 showed Resident #17's right foot and toes up against the foot board of his bed.

During an interview on 05/15/19 at 1:40 p.m. Resident #17's wife stated she asked staff approximately a month ago about the toes. She voiced concern because he had lost one toe on his left foot due to an ulcer not healing. Staff told

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 38 her the resident had to wait to see the podiatrist. The medical record failed to show facility staff completed skin assessments related to Resident #17's toes or implemented interventions to prevent ulcers to his toes. During an interview on 5/16/19 an administrative nurse (#1) confirmed the medical record lacked documentation and interventions, and/or treatment of Resident #17's toes on his right foot.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide enough supervision and/or assistive devices for 3 of 10 sampled residents (Resident #35, #45, and #62) observed transferred with staff assistance. Failure to use assistive devices per policy and/or manufacture guidance to transfer a resident safely places residents at risk of accidents with/without injury. Findings include: GAIT BELTS	F 689	Corrective Actions; The DON/designee reviewed assistance required to transfer Resident #62. Resident, resident and resident representative, and physician were notified, physician orders were noted and care plan updated as applicable. The DON/designee reviewed assistance required to transfer Resident # 45. Resident, resident and resident representative and physician were notified, physician orders were noted and care plan update as applicable. The DON/designee reviewed assistance	6/13/19

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 689	Continued From page 39 Review of the facility policy/procedure titled "Safe Lifting and Movement of Residents" occurred on 05/16/19. This undated policy, stated, ". . . . 4. Staff responsible for direct care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. . . ." - Review of Resident #62's medical record occurred on May 13-16, 2019. An admission Minimum Data Set (MDS), dated 04/26/19, identified extensive assistance two or more staff for transfers and toilet use. Resident #62's current care plan identified "Transfers: 1 assist, FWW [front wheeled walker]." Observation on 05/14/19 at 11:49 a.m., showed the certified nurse aide (CNA) (#12) lifted Resident #62 under her left arm to transfer from the wheelchair to the toilet. After the CNA (#12) provided person cares, the CNA (#12) again lifted under Resident #62's left arm to transfer from the toilet to the wheelchair. The CNA (#12) failed to utilize a gait belt to assist with Resident #62's transfers. - Review of Resident #45's medical record occured on May 14-16, 2019. The resident's current care plan stated, ". . . Focus . . . ADL [activities of daily living] Self care deficit related to physical limitations . . . Interventions . . . Transfer: extensive assistance of one with gait belt and pivot . . . Date Initiated: 05/02/2018 . . ." Observation on 05/14/19 at 10:44 a.m. showed two CNAs (#8 and #13) placed a gait belt around Resident #45's waist and assisted her to transfer to bed. Observation showed the gait belt was loose and slid up the resident's back. The	F 689	required to transfer Resident # 35. Resident, resident and resident representative and physician were notified, physician orders were noted and care plan update as applicable. Identification of Others; The DON/designee reviewed resident that require assistance with transfers to validate appropriate type and use of transfer devices is implemented as well as accuracy of care plans. Systemic Changes; The DON/designee will provide education to applicable care staff on the proper use of transfer devices including gait belts, mechanical lifts. Further education will include the requirement to report changes in transfer ability to supervisor/nurse manager. Monitoring/QAPI; The DON/designee will conduct monitoring 3 times a week for 3 months through observation and interviews to validate that residents requiring assistance are using appropriate device safely and care plans accurately reflect transfer needs. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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F 689	Continued From page 40	F 689		

resident did not fully bear weight, and her knees were bent to an almost 90 degree angle. The resident sat on the edge of the bed, and a CNA (#8) stated "I don't want her to fall off," as she assisted to the resident to lie down.

Observation on 05/15/19 at 11:15 a.m. showed two CNAs (#8 and #9) assisted Resident #45 to sit up in bed and placed a gait belt around her waist. A CNA (#8) stated, "I like to have two [staff members]. She's so hard [to transfer]." Observation showed as the CNAs (#8 and #9)assisted Resident #45 to stand, the resident did not fully bear weight, and her knees were bent. Each CNA (#8 and #9) placed one arm under each of the resident's arms and used their other hand to lift the resident by the waistband of her pants as they transferred her to the wheelchair.

MECHANICAL LIFT

Review of manufacturer's instructions titled "SARA 3000 Instructions for use," occurred on 05/16/19. These instructions stated, " . . . Warning: The sling chest support strap must always be applied and fastened when using the sling. . . . Lower Leg Straps . . . used to ensure that the lower parts of the resident's legs stay close to the knee support. . . ."

- Review of Resident #35's care plan occurred on all days of survey. The quarterly minimum data set, (MDS) dated 03/28/19, identified extensive assistance of two staff members for transfers. Diagnoses included difficulty in walking and muscle weakness. The residents current care plan stated, ". . . standing lift with two assist to

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 689	Continued From page 41 transfer into bathroom. . . ." Review of an occupational therapy note dated 04/22/19 stated, ". . . Patient and Caregiver Training: Education to pt. [patient] and CNA on continued toilet transfer without standing lift. . . ." Observation on 05/14/19 at 10:32 a.m., showed a certified nursing assistant (CNA) (#10) and a licensed practical nurse (LPN) (#6) utilize a mechanical sit-to-stand lift to transfer Resident #35 from the wheelchair to the bathroom. The CNA (#10) applied the sling under the axilla (underarms) area and then attempted to secure the sling chest support strap. Resident #35 stated, "You don't need to use that, I've been here for 6 months I think I know how its done by now. They don't use that thing". The staff failed to apply the sling chest support strap and the leg straps. Observation on 05/15/19 at 9:38 a.m., showed two CNAs (#11 and #12) utilize a mechanical sit-to-stand lift to transfer Resident #35 from the wheelchair to the bathroom. The CNA (#11) applied the sling under the axilla area and then attempted to secure the sling chest support strap. Resident #35 stated, "oh no you've never used that before why do you want to use it now, I'm not using it." The CNA (#11) told the resident it was for safety and the resident stated, "no you've never used it before, raise me up now". The staff failed to apply sling chest support strap and the leg straps. . During an interview on 05/16/19 at 9:00 a.m., a certified occupational therapy assistant (COTA) (#14) agreed that Resident #35 is unsafe using	F 689		

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THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 689	Continued From page 42 the standing lift without the sling chest support and leg straps. Failure to correctly use the sit-to-stand mechanical lift per manufacture's instructions places the resident at risk for falls and injury.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		6/13/19

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F 690	Continued From page 43 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure appropriate treatment and services to treat a urinary tract infection (UTI) for 1 of 4 sampled residents (Resident #30) with an indwelling urinary catheter. Failure to adequately monitor and promptly treat Resident #30's UTI resulted in an admission to the hospital for a sepsis work up, including continuous bladder irrigation (CBI) and treatment with intravenous (IV) antibiotics. Findings include: Review of Resident #30's medical record occurred on all days of survey. Diagnoses included multiple sclerosis, neurogenic bladder with Foley catheter placement, and decubitus ulcers of the right and left ischium. Nurses' notes identified the following: *02/22/19 at 10:48 p.m.: ". . . New order from [nurse practitioner] on call for [primary medical doctor] ordered a UA/UC [urinalysis/urine culture] for blood in urine and low grade temp [temperature] of 99.9 this shift. Foley changed. Foley was clogged with dried blood and urine was bright red. New foley inserted and NOC [night] nurse was updated and will collect UA/UC. . . ." *02/23/19 at 2:29 a.m.: ". . . Resident noted to have cherry red returns from catheter bag. This	F 690	Corrective Active; The DON/designee assessed Resident #30 to validate that resident was asymptomatic of signs and symptoms of a urinary tract infection. Resident, resident representative and physician notified, and care plan updated as applicable. Identification of Others; The DON/designee completed a review of the Alert Charting and 24-hour report for the last 7 days to validate that residents exhibiting signs and symptoms of infection were being monitored and physician had been notified. The DON/designee completed a review of the laboratory requisition binder for the last 30 days to validate that physician lab orders had been processed and results reported to the physician and any new orders were implemented timely. Systemic Changes; The DON/designee will provide education to the licensed nursing staff on requirement of physician notification related to unresolved signs and symptoms of infections, and requirements of obtaining and reporting lab results to the physician.	

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F 690	Continued From page 44 writer adjusted tubing and noted the urinary returns lighten up to pink. . . . last shift had replaced catheter and noted hematuria. . . ." *02/23/19 at 4:30 a.m.: ". . . Resident noted to have cherry colored urine in foley bag. Specimen was sent to lab. Last nurse had noted clots after removing old catheter. . . ." *02/24/19 at 12:16 a.m.: ". . . Urine in Foley bag continues to be reddish colored. No clots noted. . . ." *02/24/19 at 10:29 p.m.: ". . . Resident continues to have reddish brown urine. . . ." *02/25/19 at 12:12 a.m.: ". . . Urine in Foley bag less red tonight. . . ." *02/25/19 at 3:30 p.m.: ". . . resident continues to have blood in urine and [physician's assistant] called and update order to do CBC [complete blood count] and BMP [basic metabolic panel] note sent ton [sic] the lab. . . ." *03/02/19 at 9:32 p.m.: ". . . Tylenol Tablet 325 mg [milligrams] Give 2 tablet by mouth every 4 hours as needed for pain/fever . . . Per request back et leg pain rated 6/10. . . ." *03/03/19 at 2:15 p.m.: ". . . Noted urine remains red in Foley collection bag. . . . Writer called [physician's assistant] at this time et [and] above information given. Orders received for CBC with diff [differential] et BMP tomorrow a.m. (gross hematuria). Lab request faxed to [name of lab] . . ." *03/03/19 at 2:36 p.m.: ". . . resident foley catheter was change [sic] due to it [sic] urine leakage, urine was bloody, will continue to monitor . . ." *03/03/19 at 7:15 p.m.: ". . . Urine continues to be bloody red in color in Foley collection bag. . . . Writer called [physician's assistant] at this time et updated, requested resident be seen in [hospital	F 690	Monitoring/QAPI; The DON/designee will conduct monitoring 3 times a week for 3 months through chart review and observations to validate that residents exhibiting signs and symptoms of infection are being monitored for resolution, physician is notified of status and physician ordered labs are processed, reported and any required interventions are implemented as applicable. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 690	Continued From page 45 name] ER [emergency room]. Order received to transfer resident . . . Ambulance took resident at 8 p.m. . . ." *03/03/19 at 11:38 p.m.: ". . . Admitted to hospital . . ." *03/07/19 at 6:04 p.m.: ". . . Readmitted today via stretcher from [hospital name] following hospitalization for sepsis. Antibiotics are complete. . . ." The record lacked evidence of monitoring/assessment/communication regarding Resident #30's condition after the provider ordered labs on 02/25/19 until staff contacted him again on 03/03/19 (six days later, and nine days after staff first noted blood in Resident #30's urine). Resident #30's lab results showed staff collected a UA/UC on 02/23/19 at 4:20 a.m., with results faxed to the facility on 02/23/19 at 5:10 a.m. UA results showed: *Urine clarity as "cloudy" (reference range: clear) *Leukocyte Esterase (an enzyme found in white blood cells which can indicate infection) as "large" (reference range: negative) *Elevated white blood cells (WBC) (can indicate infection) at >= 50 (reference range: negative, 0-2, 3-5) *Elevated red blood cells (RBC) (can indicate infection, bleeding, or trauma) at >=50 (reference range: negative, 0-2) *Elevated bacteria at Moderate (31-50) (reference range: negative, rare [0-5], or few [6-30]) The preliminary UC results, faxed to the facility on 02/24/19 at 1:40 p.m., showed the presence	F 690		

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

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F 690	Continued From page 46 of Klebsiella pneumoniae at 30,000 CFU/ml (colony-forming units per milliliter, less than 10,000 CFU/ml is considered normal) The final UC with sensitivity results, faxed to facility on 02/25/19 at 1:40 p.m., showed: *30,000 CFU/ml Klebsiella pneumoniae * <10,000 CFU/ml Mixed Microflora *With susceptibility (i.e., would inhibit the growth of the bacteria) to the following antibiotics: Amoxicillin/clavulanate, Cefazolin, Ceftriaxone, Ciprofloxacin, Gentamicin, Nitrofurantoin, Tobramycin, and Trimethoprim/Sulfamethoxazole The CBC, collected on 02/26/19 at 6:19 a.m. with results faxed to the facility on 02/26/19 at 9:09 a.m., showed the following results: *Elevated WBC at 12.1 (reference range 4-11) *Low RBC (can indicate blood loss) at 4.03 (reference range 4.4-5.8) *Low Hemoglobin (HGB) (can indicate blood loss) at 11 (reference range 13.5-17.5) *Low Hematocrit (HCT) (can indicate blood loss) at 34.2 (reference range 40-50) The above lab reports were signed off on 03/04/19 (the day after Resident #30 was admitted to the hospital). The record lacked evidence staff reviewed the labs prior to this day or communicated results to Resident #30's provider. The hospital progress notes identified the following: *03/04/19 at 1:25 a.m. (admission note): ". . . REASON FOR ADMISSION: hematuria [blood in the urine], lactic acidosis [a buildup of lactase in the bloodstream] . . . sent from NH [nursing	F 690		

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	355024	A. BUILDING _____ B. WING _____	C 05/16/2019

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F 690	Continued From page 47	F 690		

home] due to hematuria which has been present for the past 1 day. . . . workup in ER shows elevated WBC and lactic acid. . . . hgb [hemoglobin] is down from oct [October] 2018. . . . Pt is admitted for further workup of sepsis. . . Last Vitals: . . . BP [blood pressure] 86/49 . . . Recent Results (from the past 24 hour(s)) . . . WBC 18.7 [increased from 12.1 on 02/26/19] . . . RBC 3.83 [decreased from 4.03 on 02/26/19] . . . HGB 10.2 [decreased from 11 on 02/26/19] . . . HCT 32.3 [decreased from 34.2 on 02/26/19] . . . Assessment/Plan . . . Hematuria - urology consult . . . Sepsis . . . sepsis protocol monitor lactic acid, continue Rocephin [ceftriaxone] until cultures available . . ."

*03/04/19 at 8:16 a.m. (urologist note): ". . . Impression: hematuria . . . Most likely hemorrhagic cystitis . . . Plan: . . . When he is discharged we will set up cysto [cystoscope] as out pt . . ."

*03/04/19 at 10:58 a.m. (hospitalist note): ". . . The patient's catheter has been leaking this morning and he has dark red hematuria. Per nursing, patient was oriented to person but currently is orientated x 0. . . . Unable to perform ROS [review of systems]: mental status change . . . Assessment/Plan: Principal Problem: Sepsis . . . Elevated WBC 18.7, Lactic acid 2.4, hypotension 92/58. UA showed elevated WBC >182 indicating likely UTI. . . . Patient continues to be hypotensive with min [minimum] BP 71/45. Typically BP has been 90s/50-60s. . . . Albumin is low 2.1 replacement may help BP. . . . Plan . . . Rocephin, IV albumin x1, IVF [IV fluids] . . . Hematuria . . . Plan . . . Catherer [sic] has been replaced, Urology consulted, continue antibx [antibiotics] to treat UTI, IVF . . ."

*03/06/19 at 10:49 a.m. (hospitalist progress

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F 690	Continued From page 48 note): ". . . admitted for Heavy hematuria + elevated wbc's, urology did see him for foley placement and heavy hematuria, currently he is getting CBI [continuous bladder irrigation], received IV albumin one dose on 03/04/19 to help his hypotension + hypoalbuminemia [low albumin]. . . . Assessment/Plan . . . Principal problem: 1) Acute complicated UTI . . . Stable, improving . . . Sepsis: Clinically undetermined if he was in sepsis or not - resolved . . . Hypotension on admission time was not due to sepsis, it was due to a lack of po [oral] intake + hypoalbuminemia: resolved post IV albumin and IV fluids, b/p continues to be stable . . . Confusion on 03/03/19 due to UTI c/w [consistent with] Toxi[c] metabolic encephalopathy [an acute mental status change often caused by electrolyte imbalance or infection]: resolved - he is back to his baseline . . . Gross heavy hematuria . . . outpatient follow up with cystoscope with Urology . . ." *03/06/19 at 11:46 a.m. (infectious disease consult): ". . . was admitted with heavy hematuria status post CBI not completely improved. On admission the urine culture is now growing Klebsiella pneumonia and enterococcus species. Initially he had a very elevated white blood cell count and altered mental status but now seems to be returning back to his baseline, still on CBI but urine has cleared completely, and leukocytosis [elevated WBC] has resolved. He has received a total of 3 days of high-dose ceftriaxone [Rocephin]. . . ." Discharge instructions, dated 03/07/19, identified a follow up urology appointment scheduled for 03/18/19. Review of Resident #30's medical record identified the resident did not go to this	F 690		

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F 690	Continued From page 49 appointment. When asked for information regarding the above, the facility provided no additional information. The facility failed to provide appropriate monitoring and assessment of Resident #30's condition, failed to promptly monitor lab results and recognize abnormal values, and failed to communicate adequately with the provider which resulted in a deterioration in Resident #30's condition, delayed treatment for a UTI and hematuria, and admission to the hospital. The facility also failed to provide follow up care after this hospitalization. See F658.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning 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 record review, staff interview, and family interview, the facility failed to provide necessary respiratory care and services for 1 of 2 sampled residents receiving scheduled nebulizer medications (Resident #49). Failure to ensure the availability of medications may result in worsening respiratory symptoms and/or respiratory distress.	F 695	Corrective Actions; The DON/designee validated that medication prior authorization was approved for Resident #49 on 6/5/19 and resident has received medication and a Pulmonology appointment has been scheduled for further treatment consideration.	6/13/19

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F 695	Continued From page 50 Findings include: During an interview on the afternoon of 05/13/19, a family member stated she was upset as Resident #49 had been without one of her nebulizers "going on three weeks now." Review of Resident #49's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and chronic obstructive pulmonary disease. Current medications included Brovana nebulizer (used to treat shortness of breath) twice per day, started on 11/30/2018. Nurses' notes identified the following: *05/01/19 at 7:34 a.m.: ". . . Brovana Nebulization Solution . . . Medication awaiting Prior Authorization per MD [medical doctor] at this time . . ." *05/01/19 at 7:49 p.m.: ". . . Brovana Nebulization Solution . . . Product not available. Requires prior auth [authorization] . . ." *05/02/19 at 7:04 p.m.: ". . . Brovana Nebulization Solution . . . not available . . ." *05/03/19 at 7:09 a.m.: ". . . Brovana Nebulization Solution . . . no supply available at this time . . ." *05/03/19 at 3:20 p.m.: ". . . This writer contacted pharmacy at the beginning of this shift regarding Brovana which has not been available for sometime now. This writer spoke with [pharmacy technician] who told this writer that they have contacted the prescribing physician for prior authorization and that they are awaiting approval. Will follow up. . . ." *05/03/19 at 7:52 p.m.: ". . . Brovana Nebulization Solution . . . Product not available. MD and pharmacy aware . . ."	F 695	Identification of Others; The DON/designee will review residents who require prior authorization for medications to validate that physician order medications have been ordered and are available. If concerns are identified, provider will be contacted to promptly resolve. Systemic Changes; The DON/designee will provide education to the licensed nurses on requirements for re-ordering medications and steps to take, including notification of provider and nurse manager if medication is not available. Monitoring/QAPI; The DON/designee will conduct reviews 3 times a week for 3 months through record review and interviews to validate that medications are available and if concerns were identified and medications were not readily available that license nurses followed up accordingly. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 695	Continued From page 51 *05/13/19 at 11:47 p.m.: ". . . This writer contacted pharmacy and [clinic name] pulmonology department regarding pending prior authorization for Brovana. Told by pharmacist [name] that they have email [sic] the provider and that they are still awaiting her response. This writer called and left message at [pulmonology department] regarding status of prior authorization. Awaiting return call. . . ." *05/14/19 at 10:37 p.m.: ". . . This nurse received a fax from the [pulmonology clinic] for approval for Brovana. A call was placed to pharmacy with an update and they stated it had not cleared insurance yet. This nurae [sic] also faxed a copy of approval to pharmacy. . . ." *05/15/19 at 6:02 p.m.: ". . . This writer received call from pharmacy that they contacted patient insurance and the doctor office regarding Brovana. According to the pharmacist Prior authorization was signed by the doctor and mailed to insurance. Awaiting delivery. . . ." During an interview on the morning of 05/16/19, a supervisory nurse (#1) identified the facility is still waiting for the medication. Resident #49's medication administration record (MAR) from May 1 - 15 identified staff recorded Brovana as "administered" on 17 of 30 occasions, although record review/staff interview identified Brovana was not available. The record identified Resident #49 last received Brovana on 04/30/19 and lacked evidence of facility communication/follow up regarding the unavailability of the nebulizer from May 4 until May 13.	F 695		

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F 695	Continued From page 52 When asked for further information regarding the above situation, the facility provided no additional information.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/28/18. Based on observation, record review, review of facility policy, and resident interview, the facility failed to provide care and services for the provision of hemodialysis consistent with professional standards of practice for 1 of 3 sampled residents (Resident #16) receiving hemodialysis. Failure to assess and monitor the resident's condition and access site after dialysis and provide ongoing care/monitoring of hemodialysis access sites may result in bleeding, loss of access site, or other complications. Findings include: Review of the facility policy titled "End-Stage Renal Disease, Care of a Resident with" occurred on 05/16/19. This undated policy stated, "Education and training of staff, may include the following as applicable: . . . The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . .	F 698	Corrective Active; Resident #16 was affected during the survey process. His care-plan has been adjusted and orders placed to monitor bruit and thrill. Identification of Others; All residents with dialysis could be affected. All other dialysis resident care plan and orders reviewed and are appropriate. Systemic Changes; Staff will be educated and will fill out pre and post dialysis assessment in PCC for all residents on dialysis. The pre assessment will be printed and sent to dialysis with the resident for communication with dialysis team. Monitoring/QAPI; An audit will be conducted 2x a week for 3 months to ensure that the pre and post dialysis assessments are filled out and	6/13/19

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F 698	Continued From page 53 . Signs and symptoms of worsening condition and/or complications of ESRD [end-stage renal disease] . . . The care of grafts and fistulas . . . The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care . . ." Review of the facility policy titled "Hemodialysis Access Care" occurred on 05/16/19. This undated policy stated, ". . . Care of AVFs and AVGs [Arterio-Venous Fistula and Arterio-Venous Graft] . . . To prevent infection and/or clotting: a. Keep the access site clean at all times. . . . Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing routine care and at regular intervals. . . . Do not use the access arm to take blood pressure. . . . Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. . . . Check the patency of the site at regular intervals. Palpate the site to feel the "thrill," or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access. . . ." During an interview on 05/14/19 at 5:15 p.m., Resident #16 stated facility staff do not monitor/assess his dialysis access sites, but the dialysis staff members do. The resident stated he has had both sites since he came to the facility in February 2019. Observation showed a fistula site to his left arm, and a healing central catheter site to his right chest. Review of Resident #16's medical record occurred on all days of survey. Diagnoses included end stage renal disease, central catheter placement and AVF placement (for	F 698	entered into PCC in a timely manner. Findings will be presented to QAPI for their review and input on further monitoring.	

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F 698	Continued From page 54 dialysis) in December 2018. Record review identified Resident #16 received dialysis three days per week via central catheter until its discontinuation on 04/30/19. Record review identified Resident #16 received dialysis via AV fistula on May 2, 3, 6, and 15. Resident #16's blood pressure records showed staff took his blood pressure on his left arm (the site of the AV fistula) on eight different occasions since his admission. Review of Resident #16's medical record showed no monitoring or assessment of the dialysis sites or the resident's condition after dialysis until 05/15/19, when staff completed a post dialysis assessment.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		6/13/19

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F 725	Continued From page 55 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, resident and family interviews, and group interview, the facility failed to ensure the availability of sufficient nursing staff to promptly respond to residents' needs for 5 of 10 confidential resident interviews (Resident A, B, C, F, and J). Failure to provide sufficient staffing for assistance may result in residents experiencing falls and/or incontinence and may negatively affect the residents physical, mental, and psychosocial well-being. Findings include: Observations and interviews included the following: - During an interview on 05/13/19 at 11:21 a.m., Resident B stated, "I wait a long time for my call light to get answered, I've had to wait 50-60 minutes several times, weekends are the worst by far. They come in and turn the light off and say they will go get someone and no one comes back." - During an interview on 05/13/19 at 12:29 p.m., Resident A stated, "They are slow answering lights, I don't make it on time to the bathroom and then I wet my pants."	F 725	Corrective Action; The Administrator/designee reviewed and validate appropriate response to call lights. Any discovered issues were immediately corrected and education provided to available staff Identification of Others; The Administrator/designee conducted a review on call light response time to identify any prolonged call times. Any concerns were corrected. Systemic Changes; The Administrator/designee provided education to staff with the emphasis on staff mission, and urgency to meet the needs of the residents (call light response) with in a reasonable time frame. Monitoring/QAPI; The Administrator/designee will conduct monitoring of call light response on random shifts 3 times a week for 6 months. Any concerns will be promptly corrected. The Administrator/designee will report any	

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F 725	Continued From page 56 - An interview occurred on 05/13/19 at 4:11 p.m. Resident C and his/her family member. Resident C stated, "I wait long periods of time for my call light to be answered, usually at least 25 minutes. Evenings and weekends are the worst times." Resident C's family member stated he/she had to make the bed [Resident C's bed] at 5:00 p.m. and the day before, staff failed to removed the noon meal tray until 3:00 p.m. - Observation on on 05/14/19 at 12:57 p.m. showed Resident B's call light on. At 1:01 p.m., a nurse (#2) entered Resident #40's room, did not turn call light off, and assisted the resident with cares while this surveyor observed. At 1:23 p.m., the staff nurse finished cares and exited Resident B's room with call light still on. No other staff members came to answer the call light. - During the Resident Council meeting held the afternoon of 05/14/19. Two of the nine residents stated they have experienced long wait times for call lights to be answered. Resident B stated he/she has reported call light wait times to management, and "they do not take into consideration the acuity and when a resident requires two CNAs." Resident F stated, "I waited 45 minutes for my call light to be answered, when the call light was answered I told the CNA that I had a headache and wanted Tylenol, the CNA was to report to the nurse. I waited another 15-20 minutes for the nurse who never came so I wheeled myself to the nurse station to get the medication for my headache." Resident F reported this occurred about two months ago. - Observation on 05/15/19 at 11:37 a.m. showed	F 725	identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 725	Continued From page 57 Resident J's call light was on, and the resident sat in his wheelchair in the hallway. A nursing staff member (#1) entered the resident's room, turned off his call light, and told the resident somebody would be there soon. The staff member then knocked on another resident's room and asked the staff inside if they were going to assist Resident J next. The staff member (#1) then told Resident J the staff were on their way, to which the resident responded, "Yeah sure. I've heard that before." - During an interview on 05/16/19 at 10:15 a.m., Resident J stated call light response times "might be only 10 minutes, but sometimes it can be up to an hour. I have waited an hour before." The resident stated this happens "pretty much" every day, and "that's my only complaint, they don't answer the call light quickly enough." - During an interview on the morning of 05/16/19, an administrative staff member (#1) stated, staff "should acknowledge call light within 5-10 minutes with needs met within 15 minutes." The facility failed to provide a policy regarding answering call lights.	F 725		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an	F 790		6/13/19

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THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

(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 790	Continued From page 58 outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview the facility failed to assist in obtaining dental care to meet the needs of 1 of 1 sampled resident (Resident #49) who requested a dental appointment. Failure to assist the resident in making an appointment and/or	F 790	Corrective Actions; A dental appointment was scheduled for Resident #49 by Nurse Manager. The resident was brought to dental appointment with her representative. They declined the service due to financial	

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F 790	Continued From page 59 arranging transport may result in delayed dental care and/or dental complications. Findings include: During an interview on the afternoon of 05/13/19, a family member stated she has asked staff to make Resident #49 a dental appointment, but they have not done it. The family member stated Resident #49 has been to the dentist "one time in eight years" and "nothing changes or gets done." Review of Resident #49's medical record occurred on all days of survey. A nurses' note, dated 01/29/19, stated, ". . . Care Conference . . . Also requested dental appointment, will f/u [follow up] and update mother and resident when appointments made. . . ." The record lacked evidence staff made a dental appointment for Resident #49. During an interview on the morning of 05/16/19, a supervisory nurse (#7) confirmed Resident #49 had no scheduled dental appointment prior to 05/16/19.	F 790	reasons. Care plan was reviewed and updated to reflect her dental care needs, and the plan for when she will be rescheduled for a new appointment. Identification of Others; Residents who require dental work could be affected by the cited tag. Nurse manager/designee conducted a review on residents with dental needs to validate care plans were updated and necessary appointments were scheduled. Systemic Changes; A Dental Assessment will be performed on admission and quarterly/annual and as needed in conjunction with MDS. This will be discussed at care conferences and appointment set up as needed or requested. Education will be provided by the DON to licensed nursing staff on the new Dental Assessment process. Monitoring /QAPI; An audit will be conducted by the Administrator or his designee 2x a week for3 months on new admissions and upcoming quarterly/annual reviews to validate the dental assessment has been completed and the necessary actions are implemented for the resident's dental needs. Findings will be presented to QAPI for further review and input on additional monitoring.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		6/13/19

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F 803	Continued From page 60 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, review of menu's, review of resident council minutes, group interview, and staff interview, the facility failed to ensure staff consistently followed dietary menus for all residents for 4 of 8 residents with food concerns (Resident #D, #G, #39 and #47). Failure to offer the residents all the menu items listed, does not allow for residents' personal food choices or follow nutritional guidelines for a balanced meal.	F 803	Corrective Actions; CDM interviewed resident #39 and #47 on food ordering process and discussed education provided to kitchen staff on accommodating requests on the listed menu. She went over food available on the every-day menu and cleared up confusions surrounding what is on the every-day menu and what is the featured meal of the day.	

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F 803	Continued From page 61 Findings include: - During a confidential interview, on 05/13/19 at 3:31 p.m., Resident D reported the facility has run out of hotdogs five times since she/he moved into the facility. Resident D reports the facility has also run out of hamburgers and bananas. - Observation on 05/13/19 at 6:21 p.m., showed Resident #39 requested tomato juice from a certified nursing assistant (CNA). The CNA left the dining room and returned a short time later. She stated to Resident #39, "We don't have tomato juice, do you want something else?" and identified they were "out." - Review of the Weekly Menu for May 12-18, 2019 and "Always Available Menu" occurred on May 14-16, 2019. The weekly menu showed one main entree, vegetable, fruit and/or dessert at each noon and evening meal. The Always Available Menu showed the following: hamburger or cheeseburger on a bun, hot dog on a bun, deli meat sandwich with cheese on white or wheat, grilled cheese sandwich on white or wheat, egg salad sandwich on white or wheat, chef salad, side salad, cottage cheese, yogurt, tomato soup, chicken noodle soup, vegetable beef soup, mashed potatoes and gravy. - Review of the Resident Council Meeting Minutes occurred on 05/14/19. The meeting minutes dated 04/24/19, stated, ". . . Dietary: Compliments, comments, concerns: New menu changes going well, but don't always have everything on anytime menu per [name of resident] states there were no hamburgers one day . . ."	F 803	Identification of Others; All residents could be affected by the cited tag. CDM immediately checked to ensure proper food stock was available Systemic Changes; The CDM/designee provided education to applicable staff on the process of fulfilling resident dietary request. Further education included what dietary items were available and steps to take if dietary item was not readily available. Monitoring/QAPI; The CDM/designee will conduct audit 2 times a week for 3 months to validate appropriate food items are available and in stock at the facility in accordance with the menu and always available menu. The CDM/designee will report any identified trends to the Quality Assurance Committee will be presented to QAPI for their consideration	

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F 803	Continued From page 62 - During the resident council meeting, held the afternoon of 05/14/19, four of the nine residents stated the facility runs out of food items such as bananas, bacon, hamburgers, and/or other items from the always available menu. - During an interview on the afternoon of 05/14/19, Resident G stated last week he/she requested an egg salad sandwich and was told they didn't have one. - Observation on 05/16/19 at 7:53 a.m., showed Resident #47 ordering breakfast. An unidentified kitchen staff member offered scrambled eggs and bacon. Resident #47 stated, "Bacon and two fried eggs." The staff member stopped the resident stating, "We won't have that kind of egg until the food truck comes." Resident #47 then accepted scrambled eggs and bacon as part of the breakfast order. During an interview on 05/16/19 at 10:10 a.m., a dietary manager (#17) confirmed they had run out of food options from the always available menu on occasion and other food items for short duration.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804		6/13/19

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F 804	Continued From page 63 temperature. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 06/28/18 Based on information received from the complainant, observation, review of facility policy, resident interview, and group interview, the facility failed to ensure residents received food and beverages that were palatable, attractive and at the proper temperatures for 5 confidential residents interviews (Resident A, C, D, H, and I) and 3 of 9 residents who attended the group interview (Resident B, F, and G). Failure to ensure residents receive food and beverages that are palatable, attractive and at proper temperature, places residents at risk of weight loss and nutritional decline. Findings include: Information received from the complainant identified concerns with food palatability. Review of the facility policy titled "Food and Nutrition Services" occurred on 05/16/19. This undated policy stated, "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. . . . Food and nutrition services staff will inspect food trays to ensure . . . the food appears palatable and attractive, and it is served at a safe and appetizing temperature. . . ." Review of the facility policy titled "Preventing	F 804	Corrective Active; CDM check all permanent cold food storage to ensure that temperatures were met to standard. She also reviewed with present staff the method of cooling milk during transportation to resident rooms Identification of Others; Residents who choose milk to drink could be affected by the cited deficiency. Systemic Changes; The CDM provided education with to the dietary staff regarding the requirements of cold food storage and holding temperatures. Further training will be provided related to the process of obtaining food temperatures randomly throughout tray line and point of service to validate appropriate temperatures. Any concerns will promptly be corrected Monitoring/QAPI; The CDM/designee will conduct audit 2 times weekly for 2 weeks and 1 time weekly for 4 weeks regarding food temperature on outgoing trays to validate foods and drinks meet appropriate temperatures. Any concerns will be promptly corrected. The CDM/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.	

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F 804	Continued From page 64	F 804		

Foodborne Illness - Food Handling" occurred on 05/16/19. This undated policy stated, ". . . Federal standards require that refrigerated food be stored below 41 [degrees] F [Fahrenheit] . . ."

- During an interview on 05/13/19 at 11:19 a.m., Resident A stated, "The milk is always warm, it's never cold anymore. Turkey they served yesterday was consistency of jello. You would not even serve the food to your dog."

- During a confidential interview on 05/13/19 at 3:31 p.m., Resident D reported residents can wait 30 minutes for meals to be served, then the food is cold. Resident D reported meals were consistently cold until she/he changed dining rooms.

- During an interview on 05/13/19 at 5:47 p.m. Resident H stated he/she likes fried eggs for breakfast, but the eggs are cold when the breakfast tray arrives, so he/she stopped ordering eggs.

- Observation on 05/13/19 at 5:25 p.m. showed cartons of milk in a plastic container with some ice. Observation showed the top layer of milk cartons were not in contact with the ice. At 6:01 p.m., near the end of meal service, the survey team took the temperature of the milk, which measured 49.8 F.

- During a confidential interview on 05/14/19 at 7:55 a.m., Resident I reported the food as not good all the time and specifically mentioned the Mother's Day meal. Resident I reported no one ate the meat because no one could identify it.

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F 804	Continued From page 65 - During an interview on 05/14/19 at 5:16 p.m., Resident C stated, "Food is terrible. It's not fit for anyone. On Sunday I found a ground up carrot in my turkey and the turkey was purplish in color. The hot food is always cold. I can't drink the milk because it's warm all the time, it's gross". - During the Resident Council interview on the afternoon on 05/14/19, Residents B, F, and G stated the turkey served on 05/12/19 (Mother's Day) looked "jelled" similar to canned meat. They also stated there are other meals served which do not appear to be what is listed on the menu. Resident B stated, "I drank rotten milk, the cartons are in tubs with very little ice." Failure to serve food and/or fluids at palatable temperatures may negatively impact residents' meal consumption.	F 804		
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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		6/13/19

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F 880	Continued From page 66 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. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 67 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, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 9 sampled residents (Resident #31, #36, and #45) observed during personal cares. Failure to follow infection control practices of hand hygiene during personal cares has the potential to spread infection to other residents, personnel, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene occurred on 05/16/19. This undated policy stated, ". . . This facility considers hand hygiene the primary means to prevent the spread of infections. . . . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. . . . Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-microbial) and water for the following situations: . . . Before and after direct contact with residents; . . . Before moving from a contaminated body site to a clean body	F 880	Corrective Actions; Residents #36,31,45 were seen by the infection control nurse to ensure no negative health outcomes happened from the cited tag. Identification of Others; Any resident could be affected by improper hand hygiene or glove usage. Education and competency will be given to all care staff. Systemic Changes; All staff will be re-educated in hand hygiene and glove usage. Monitoring/QAPI; An audit will be performed by the infection control nurse on proper hand washing or glove usage 4x a week for 3 months. Findings will be presented to QAPI for their review and input on further monitoring.	

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F 880	Continued From page 68 site during resident care; . . . After removing gloves; . . ." - Observation on 05/14/19 at 9:35 a.m. showed a certified nurse assistant (CNA) (#15) applied gloves and washed Resident #36's face, upper body and dressed the resident's upper body. The CNA (#15) removed the resident's brief and provided incontinence care for bowel and bladder. The CNA applied barrier cream to the resident's perineal area and continued to wash, dry, and lotion the resident's legs and feet, and dressed the resident's lower body. The CNA (#15) poured mouthwash into a cup, dipped a toothette swab into the mouthwash and completed Resident #36's oral cares. The CNA placed the resident's blanket at the foot of the bed, placed the call light and overbed table next to the resident before removing gloves and performing hand hygiene. - Observation on 05/14/19 at 11:38 a.m. showed two CNAs (#13 and #15) provide incontinent care for Resident #31 after a bowel movement (BM). The CNA (#15) changed gloves and, without performing hand hygiene, placed a clean brief and then removed his/her gloves. Both CNAs positioned the resident into her wheelchair and then the CNA (#15) performed hand hygiene. - Observation on 05/15/19 at 11:15 a.m. showed two CNAs (#8 and #9) checked and changed Resident #45's brief and provided perineal care after an incontinent BM. The CNA (#9) changed gloves and, without performing hand hygiene, placed a clean brief and assisted Resident #45 to a wheelchair.	F 880		

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F 880	Continued From page 69 During an interview on the afternoon of 05/16/19, an administrative staff member (#1) stated she expected staff to follow appropriate hand hygiene procedures for infection control.	F 880		