STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 05/31/15 and completed on 06/03/15, the sample included 2 residents for complete review, 9 residents for focused review, and one closed record for review. The sample included one additional resident to verify specific concerns during the survey.	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent Health survey results were available for examination on 1 of 3 days of survey. Failure to make the results of the surveys readily accessible to residents is an infringement of their rights. Findings include: Observation on 06/02/15 showed the results of the previous health survey, conducted on 05/29/14, in a binder in the Prairie Rose lounge. The results from the revisit survey, conducted on	F 167		

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

administrator — 7/1/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable *90 days* following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 08/11/14, were not present in the binder. During an interview on the morning of 06/03/15, an administrative staff member (#1) was unable to determine why the revisit survey was not included in the binder.	F 167	F 167 SS = B RIGHT TO SURVEY RESULTS 1) Survey information from 5/29/15 revisit survey was placed in binders available to public.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure reasonable accommodation of individual needs regarding positioning for the only supplemental resident in a sample of 13 (Resident #13) observed in a special recliner. Failure to ensure the resident's feet are supported may cause unnecessary pain, discomfort, and muscle strain. Findings include: Review of the facility policy titled "Wheelchair Positioning" occurred on 06/03/15. This undated policy stated, "Purpose: To ensure all neighbors are safe, properly positioned and in good alignment while in a sitting position. Procedure: . . . Upper or lower body supports . . . may be	F 246	2) Three binders throughout the facility are available to the public and all neighbors. 3) All results from future surveys will be placed in the binders available to public and neighbors. 4) All Binders will be reviewed on a quarterly basis x 1 year by health information or designee to ensure survey information is up-to-date. 5) Date certain 7/08/2015.	7/08/15

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F 246	Continued From page 2 administered at any time per the nurse's discretion. If necessary, therapy can be contacted for a therapy screen/consult/evaluation." Review of Resident #13's current care plan occurred on 06/03/15. The care plan stated, ". . . Mobility: I need assistance with mobility related to my dx's [diagnoses] of Parkinson's, Osteoarthritis, Gout, bouts of knee pain and decreased cognition. . . . Approach: . . . I need A2 [assist of 2 people] and a gait belt to transfer . . . I require assist of 2, gaitbelt and hand held assist with ambulation . . ." Observations on all days of survey showed Resident #13 seated at meal times in a recliner-type chair. The resident's feet failed to reach the floor except for her toes. Occasionally no part of her foot would touch the floor. During an interview on 06/03/15 at 3:44 p.m., an administrative nurse (#3) stated she did not believe an assessment or seating evaluation had been done for Resident #13 with this chair.	F 246	F 246 SS = D REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 1). Resident # 13 no longer utilizes the recliner type chair. 2). All Residents who utilize specialized type chair have the potential to be affected. 3). The current policy/procedure for Wheel Chair positioning is being reviewed and revised. Review of the W/C Positing will be provided for all nursing staff at the in-service scheduled for July 7, 2015. All residents with specialized types of W/C's will be assessed for proper positioning and adjustments made as deemed necessary. 4). Date certain is 7/08/15. 5) The DON/RN Designee will be responsible to monitor. Audits will be conducted for 3 neighbors who are wheel chair bound a week x one month to ensure their feet are properly supported. Audits then will decrease to one neighbor per week x one month and then to one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		

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F 278	Continued From page 3 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 9 of 11 sampled residents coded for a turning/repositioning program (Resident #3, #6, #9, #10, and #11) and for nutrition and hydration intervention to manage skin problems (Resident #1, #2, #3, #4, #6, #7, #10, and #11). Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, October 2014, page M-38 and M-39 stated, "M1200C Turning/Repositioning Program: The	F 278	F 278 ACCURACY OF ASSESSMENT SS=E 1) Resident #1,2,3,4,6,7,10 and 11's most recent MDS identified in the 2567 and any subsequent inaccurate MDS's were corrected to accurately reflect that they were not receiving nutrition/ hydration to manage skin problems. Resident #3,6,9,10 and 11's most recent MDS identified in the 2567 and any subsequent inaccurate MDS's were corrected to accurately reflect that they were not on individualized turning/repositioning programs. 2) All residents who have MDS's due per RAI schedule have the potential to be affected. 3) MDS coordinators utilize the RAI Manual for guidance in coding the MDS. Any nurses completing MDS's shall be in-serviced individually by the MDS coordinator regarding correct coding of items identified in Section M. All current residents' most recent MDS was reviewed for issues in the coding of Section M in regards to nutrition/hydration and turning/repositioning programs and corrections made as deemed necessary. 4) Date certain will be 7/8/15.	

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F 278	Continued From page 4 turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] reposition on side, pillows between knees) and frequency (e.g. every 2 hours), Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention . . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment . . . If it is determined that nutritional supplementation, i.e., adding additional protein, calories, or nutrients is warranted the facility should document the nutrition or hydration factors that are influencing skin problems and /or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed'." Review of the medical records for Resident #1, #2, #3, #4, #6, #7, #9, #10, and #11 occurred on all days of the survey.	F 278	5) The DON/RN designee will be responsible for monitoring to ensure Section M is being coded accurately on MDS assessments. Audits will be completed on 3 MDS's per week x1 month, then 1 MDS per week x1 month, then 1 MDS quarterly x3 quarters. Results of audits, tracking and trending will be reviewed by QA committee. (Audit form attached)	7/8/15
	-Resident #1's quarterly MDS, dated 05/23/15, identified one unhealed pressure ulcer and nutrition or hydration interventions to manage skin problems. The medical record lacked an assessment to indicate a need for nutrition or hydration interventions specific for skin problems. - Review of Resident #3's quarterly MDS, dated 03/16/15, and a significant change MDS, dated			

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F 278	Continued From page 5 04/02/15, identified no pressure ulcers, wounds, or skin problems. Both MDS's identified nutrition or hydration interventions and a turning/repositioning program to manage skin problems during the seven day assessment period. The medical record lacked an assessment to indicate a need for nutrition or hydration interventions and a turning/repositioning program. -Review of Resident #10's quarterly MDS, dated 01/06/15, and annual MDS, dated 04/18/15, identified no pressure ulcers, wounds, or skin problems. Both MDS's identified a turning/repositioning program and nutrition or hydration interventions to manage skin problems. The medical record lacked an assessment to indicate a need for nutrition or hydration interventions and a turning/repositioning program. -Review of Resident #2's annual MDS, dated 02/11/15, identified nutrition or hydration interventions to manage skin problems. Resident #2's medical record lacked an assessment to indicate a need for nutrition or hydration interventions. -Review of Resident #9's admission MDS, dated 03/03/15, identified a turning/repositioning program. The medical record lacked an assessment to indicate a need for an individualized turning/repositioning program to manage skin problems. - Review of Resident #4's annual MDS, dated 07/27/14, and quarterly MDS, dated 04/29/15, identified the resident with no pressure ulcers, but received nutrition or hydration interventions to manage skin problems. The medical record	F 278		

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F 278	Continued From page 6 lacked an assessment to indicate the need for nutrition or hydration interventions. - Resident # 6's quarterly MDS, dated 04/09/15, and significant change MDS, dated 01/13/15, identified a turning/repositioning program. The medical record lacked an assessment to indicate a need for an individualized turning/repositioning program to manage skin issues. - Resident #7's quarterly MDSs, dated 03/12/15 and 12/12/14, identified nutrition or hydration interventions to manage skin problems. The medical record failed to identify any current skin issues and lacked an assessment to indicate a need for nutrition or hydration interventions to manage skin problems. - Resident #11's quarterly MDS, dated 05/06/15, identified a turning/repositioning program and nutrition or hydration interventions to manage skin problems. The medical record failed to identify any current skin issues and lacked an assessment to indicate a need for an individualized turning/repositioning program and for nutrition or hydration interventions to manage skin problems. During an interview on 06/01/15 at 2:15 p.m., an administrative nurse (#2) stated the facility's turning/repositioning program is an every two hour schedule for any resident requiring repositioning, and is not an individualized program. At 4:00 p.m., the nurse verified the criteria for coding nutrition or hydration intervention to manage skin problems was not met for Resident #1, #2, #3, #4, and #7. During an interview on the morning of 06/03/15,	F 278		

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F 278	Continued From page 7 an administrative nurse (#3) stated the facility did not develop an individualized repositioning program for Resident #6 and #9.	F 278	F 280 SS = D RIGHT TO PARTICIPATE PLANNING CARE- REVISE	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policies/procedures, and staff interview, the facility failed to review and revise the plan of care for 3 of 11 sampled residents (Resident #1, #2, and #6). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident.	F 280	1). Resident # 1, # 2, & # 6 care plans were revised to reflect accurate transferring procedures. 2). All residents care plans reflecting the need for assistance with transfers have the potential to be affected. 3). Benedictine Living Center of Garrison will ensure that all resident's Care plans will reflect the mode of transfers based on appropriate transfer assessments. Transfers assessments are completed upon admission and as needed related to changes in resident's health status. When immediate transfer assessment is in need and PT is not available the charge nurse will assess the resident's current cognition and health status. Once assessment is completed the charge nurse will relate to staff in a shift-to-shift report , Just In Time (JIT) communicate and with a Resident Transfer Review Form about changes in a resident's condition needing the change in transfer mode. Staff observations and concerns about the changes in the resident 's health condition that reflect in a change in transfer needs will be written on a Resident Transfer Review form and given to DON to take to weekly IDT meeting. IDT will determine if change should be made and update the care	

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F 280	Continued From page 8 Findings include: Review of the facility policy titled, "Care Plans-Comprehensive" occurred on 06/03/15. This policy, dated September 2010, stated, ". . . 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; . . . g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; . . . i. Reflect currently recognized standards of practice for problem areas and conditions. . . .8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. . . ." - Review of Resident #2's record occurred on all days of survey. The current care plan stated, "Problem . . . ELIMINATION: I need assistance with toileting and am incontinent of b/b [bowel and bladder] . . . Approach . . . Utilize the EZ stand and A2 [assist of 2] with toileting. I use the BR [bathroom] . . ." Observation on 06/01/15 at 4:45 p.m., showed certified nurse aides (CNAs) (#4 and #5) prepared to transfer Resident #2 from the recliner into her wheelchair. One CNA (#4) asked the resident if she needed to use the bathroom and the resident stated, "No." The CNAs used a mechanical-sit-to-stand lift to bring Resident #2 to a standing position. As the resident stood in the lift, the CNA checked and then changed her incontinence brief, wet with urine. The CNAs failed to take the resident into the bathroom as care planned.	F 280	plan per facility standard. A new policy/procedure for Change in Transfer Ability was developed. In servicing regarding the change in Transfer Ability Policy will be provided for all nursing staff at the in-service Scheduled for July 7, 2015. 4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor resident care plans for the accurate transfer status and also monitor a transfer of the same resident to ensure proper transfer assistance and device was provide. Audits will be conducted on 3 neighbor's care plans/transfers a week x one month. Audits will then decrease to one neighbor per week x one month, and then one neighbor per quarter x 3 quarters. Care plans will continue to also be reviewed quarterly with care conferences. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/8/15

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F 280	Continued From page 9 During an interview at 12:45 p.m. on 06/03/15, an administrative nurse (#3) stated staff should toilet Resident #2, not check and change her brief. - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: . . . Mobility: I do need assistance with mobility r/t [related to] generalized weakness, Dementia, unsteady gait and occasional back pain. . . . Approach: A1-2 [assist of one to two people] with ambulation, fww [front wheeled walker] and gait belt. . . . At times I am able to pivot transfer with A1-2 and a gait belt. If I am weak, unsteady or having pain, utilize either the EZ stand [stand-up lift] or lift [full body mechanical lift] and A2 [assist of two people]. . . ." . A "Therapy Communication to Restorative Services" form, dated 02/23/15, listed goals and recommendations for Resident #6's restorative program scheduled six times weekly. A progress note, dated 04/22/15 at 10:53 a.m., stated, "Falls reviewed by IDT [interdisciplinary team]. On 4/12, neighbor was found on the floor in front of her w/c [wheelchair] . . . Dycem applied to top of w/c cushion. . . . Neighbor is on RC [restorative care] ambulation and exercise programs."	F 280		
	On 05/31/15 at 3:20 p.m., observation showed two CNAs (#12 and #13) pivot transferred Resident #6 from the recliner to her wheelchair. The wheelchair lacked Dycem on top of the cushion. The CNAs failed to request the nurse to assess the resident for weakness, unsteadiness, or pain to determine which method of transfer was needed.			

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F 280	Continued From page 10 On 06/02/15 at 8:18 a.m., observation showed two CNAs (#14 and #15) assisted Resident #6 to stand from her bed and ambulate with a walker to the bathroom. After the resident finished in the bathroom, the two CNAs assisted her to stand, pivot, and sit in her wheelchair. The wheelchair lacked Dycem on top of the cushion. One CNA (#15) stated they put Dycem on the resident's chair in the past to prevent her from scooting down or sliding off, and was unsure why the Dycem was not on the chair now, or if they were still supposed to use it. The CNAs were unable to find the Dycem in the resident's room. The CNAs failed to request a nurse assess the resident to determine which method of transfer they should use. The care plan failed to include Resident #6's restorative care program and the use of Dycem in her wheelchair as an intervention to prevent falls. The facility failed to clarify which mode of transfer to use (pivot, EZ stand, or full-body lift) or when CNAs were to notify the nurse for assessment of the resident's transfer ability. See F323. -Review of Resident #1's medical record occurred on all days of survey. Diagnoses include generalized pain, osteoarthrosis, lumbar disc degeneration, and severely impaired cognizance. The significant change Minimum Data Set (MDS), dated 02/27/15, identified extensive assist of two or more persons with transfers. Resident #1's care plan, revised on 05/26/15, identified, ". . . Problem . . . Nursing-Mobility: I do need assistance with mobility and get weak and	F 280		

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F 280	Continued From page 11 SOB [short of breath] quickly . . . Approach . . . A1-2 [assist of one to two persons] to pivot transfer with a gait belt. Utilize the EZ stand and A2 PRN [as needed] if weak or extremely unsteady . . ." Observation on 05/31/15 at 4:05 p.m. showed two CNAs (#9 and #10) used an EZ stand lift to transfer Resident #1 from his bed to the toilet. Both CNAs then transferred the resident from the toilet to his wheelchair utilizing a gait belt and pivot transfer. Observation on 06/01/15 at 9:20 a.m. showed a CNA (#11) transferred Resident #1 from his wheelchair to the toilet utilizing a gait belt and pivot transfer. During an interview on 06/03/15 at 11:30 a.m., an administrative nurse (#3) stated when CNAs follow a care plan that indicates different methods of transfers for a resident, the CNAs should consult a licensed nurse to determine an appropriate transfer method if the care plan identifies multiple transfer methods. Resident #1's care plan failed to include the expectation for CNA's to consult a nurse to determine an appropriate transfer method.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	This plan of correction is this facility's allegation of compliance with applicable regulatory requirements. F 281 SS = D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1). All PRN Medication orders along with all PRN Medication administered to Resident # 4, # 6, & # 7 is reviewed in the MAR by DON/RN Designee to ensure timely medication follow up and medication effectiveness is appropriately documented and signed off by charge nurse. PRN medication sheets are also reviewed to ensure follow up is completed and signed by charge.	

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	355064	A. BUILDING _____ B. WING _____	06/03/2015

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F 281	Continued From page 12 Based on staff interview, record review, and policy review, the facility failed to provide care in accordance with professional standards for 3 of 11 sampled residents (Resident #4, #6, and #7) regarding the documentation and follow-up of as needed (PRN) medications. Findings include: Review of the facility policy titled, "Medication Administration" occurred on 06/03/15. This undated policy, stated". . . Anytime a PRN (as needed) medication is administered, the charge nurse must follow up in 1 hr [hour] and document the effectiveness on the MAR [medication administration record] . . ." - Review of Resident #4's medical record occurred on all days of the survey. Review of the resident's quarterly MDS, dated 04/29/15, revealed the resident had severely impaired cognition, and received PRN pain medication. Review of Resident #4's medication administration record (MAR) for February, 2015 revealed the following: *The resident received Tramadol (pain medication) on 02/12/15 at 7:00 p.m. for signs and symptoms of discomfort but staff failed to follow up to determine whether the medication had been effective. *The resident received Zofran (anti-nausea medication) 4 milligrams (mg) on 02/02/15 at 9:15 a.m. for nausea but staff failed to follow up to determine its effectiveness. *Staff provided Tramadol on 02/28/15 at 3:00 p.m. for "discomfort - restless", but again failed to follow up to determine its effectiveness.	F 281	2). All residents who reside within facility who have PRN medications and PRN pain medication orders have the potential to be affected. 3). All PRN Medication that is administered by a CMA, is only administered once approval is obtained by the charge nurse. All PRN Medications will be followed up within a timely manner of administration by the charge nurse. The charge nurse is to assess resident for effectiveness of PRN medication and document the effectiveness of PRN medication on the PRN documentation sheet in the MAR or noted in progress notes. Medication Administration and PRN medication documentation reviewed with all nursing staff. In-service will be provided for all nursing staff at the in-service scheduled July7 7, 2015. 4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor. PRN MAR audits for efficacy documentation will be conducted on 3 neighbor's PRN MAR's a week x one month. Audits will then decrease to one neighbor per week x one month, and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/8/15

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F 281	Continued From page 13 Review of Resident #4's MAR for March, 2015 revealed staff provided the resident Tramadol on 03/01/15 at 7:00 p.m. for signs and symptoms of discomfort, but failed to ensure the medication had been effective. During an interview on 06/03/15 at 11:45 a.m., administrative nurse (#3) stated she expected the nurses to follow-up with the residents after the resident received a PRN to determine whether the PRN had been effective. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The April and May 2015 MARs revealed the following: * Resident #6 received loperamide (antidiarrheal) two tablets on 04/05/15 at 6:00 p.m. per the physician standing orders. Review of the record revealed staff failed to document a concern with loose stools or the resident's response to the medication. * Resident #6 received PRN lorazepam (antianxiety) 0.5 mg on 05/22/15 at 9:30 p.m. and 05/28/15 at 7:30 p.m. for "agitation." Review of the "PRN Medication Notes" showed staff failed to enter the resident's response to the medication on both occasions. The surveyor requested a copy of the above Medication Note and received it on 06/01/15 at 11:00 a.m., at which time the result of the lorazepam was written as "effective" for both dates. During an interview on 06/02/15 at 6:20 p.m., an administrative nurse (#2) stated she and another licensed nurse (#24) assess for the effectiveness of PRN medications given to residents by certified	F 281		

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F 281	Continued From page 14 medication aides, and "knew these doses [lorazepam given on 05/22/15 and 05/28/15] were effective, but just had not documented the results right away." The nurse (#2) stated she filled in the response to these medications before she copied the PRN Medication Note on 06/01/15. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. Resident #7's May 2015 MAR revealed the resident received Milk of Magnesia 30 cubic centimeters (cc) on 05/18/15, time unlisted, per the physician standing orders. Review of the record failed to show staff followed up on the effectiveness of the medication. Failure to follow-up on the effectiveness of a PRN medication may lead to unrelieved symptoms and unnecessary pain or discomfort.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: WEIGHT MONITORING 1. Based on record review, review of facility policy/procedure, and staff interview, the facility	F 309	F 309 SS = D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (WEIGHT MONITORING) 1) Resident # 2 had weight recorded and was reviewed for significant weight change. 2). All Residents with weight vital monitoring have the potential to be affected. 3). Review of the weight Monitoring and Documentation Policy/Procedure will be provided for all nursing staff at the in-service scheduled for July 7, 2015. 4). Date certain is 7/08/15. 5) The DON/RN Designee will be responsible to monitor. Random audits on 3 random neighbors for weight and/or weight changes will be conducted weekly x one month to ensure regular weights are being taken. Audits will then decrease to one neighbor per week x one month and then to one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15

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F 309	Continued From page 15 failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #2) who experienced weight changes. Failure to assess and monitor weight loss, as directed by the physician, did not allow the resident to maintain her highest practicable physical condition. Failure to follow the physician's recommendation limited staffs ability to accurately assess weight changes related to diuretics and/or reduced intakes. Findings include: Review of facility policy "Weight Monitoring and Documentation"occurred on 06/03/15. This undated policy, stated, "Policy: Neighbors will be weighed weekly on their 'aswb' (Assessment, skin, weight, bed changed) day indicated on the shower schedule. The Dietitian will identify neighbors with significant weight changes and communicate to the nursing department. . . .3. Standard for weighing a neighbor (effective 4/15/13): . . . 4. If there is a (+) or (-) five pound weight difference from the previous weight, an automatic reweigh will occur. The CNA [certified nurse aide] will record the weight on the shower sheet and in Matrix [electronic medical record] . . . The Dietitian and/or designee will document the identified problem and specific intervention in a Nutrition Assessment and update the care plan as necessary."	F 309		
	Review of Resident #2's medical record occurred on all days of survey. Diagnoses include lower extremities with ulcer-venous stasis ulcers and history of edema. Review of a significant change Minimum Data Set (MDS) dated 02/11/15, indicated a non physician prescribed weight gain, and a quarterly MDS, dated 05/14/15, indicated a physician prescribed weight loss.			

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F 309	Continued From page 16 Review of Resident #2's physician's orders identified the following: * 02/18/14 bumetanide (a diuretic) 2 mg (milligrams) once a day Monday, Wednesday, Friday * 11/15/14 through 11/21/14 bumetanide increased to daily for one week * 11/25/14 bumetanide 2 mg once a day Monday, Wednesday, Friday Review of progress notes for November and December 2014 showed seven entries referring to pitting edema in Resident #2's lower extremities. Review of dietary progress notes showed the following: * 11/18/14, ". . . weight is 158 lbs [pounds] and has gone up significantly since her previous weight r/t [related to] fluid in her legs, and not to actual changes in her body mass. She has been eating well and drinking adequately . . . do expect to see some weight loss as the swelling in her legs goes down. . . ." * 02/24/15, ". . . Weight 163.3 pounds. Weight has fluctuated a great deal this past year, ranging between 128-163 pounds . . . Breakfast 50-75%, dinner and supper usually < [less than] 25% . . . Staff indicated that Neighbor does better at breakfast and seems more confused at lunch and dinner and requires more cueing. Staff stated for quite awhile Neighbor would consume 2-3 cups of hot chocolate at meals - which could have contributed to the weight gain. . . . Staff also indicated that Neighbor would consume buns with peanut butter at each sitting . . . Will recommend changing diet to small portions due to decreased intakes . . . "	F 309	F 309 SS = D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (BOWEL MANAGEMENT) 1). Resident # 4 did not have any adverse effect from lack of nursing intervention to promote regular bowel movements. 2). All residents who have the potential to be affected. 3). Review of the policy Bowel Monitoring and Interventions will be provided for all nursing staff at the in-services for scheduled for July 7, 2015. 4). Date certain 7/08/15. 5). The DON/RN Designee will be responsible to monitor. Random audits on 3 neighbors will be conducted weekly x one month to ensure appropriate bowel management procedures. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15

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F 309	Continued From page 17 A physician's progress note dated 02/26/15, stated, ". . . Recommendation from the dietician says she should have a small portion with a multivitamin daily, and we'll need to watch her weight. Assessment 1) Poor appetite . . . We'll change her diet to small portions and watch her weight to see if she's losing or if she can gain some." A review of Resident #2's weights showed the following: 01/25/15 - 163.3 pounds - only weight recorded for the month 03/18/15 - 146.8 pounds - the record lacked a weight for 51 days 03/23/15 - 134.6 pounds 04/13/15 - 136.6 pounds 04/20/15 - 136 pounds Review of the above weights for Resident #2 showed a 16% significant weight loss in 3 months. During an interview at 4:40 p.m. on 06/01/15, an administrative nurse (#2) verified the facility lacked weights for Resident #2 during the 51 day period. Failure to monitor Resident #2's weight, as directed by the physician, placed the resident at risk for unidentified weight gain or loss. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/29/14. BOWEL MANAGEMENT 2. Based on staff interview, record review, and policy review, the facility failed to provide necessary care and services to promote regular bowel movements (BMs) for 1 of 7 sampled	F 309		

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F 309	Continued From page 18	F 309		

residents (Resident #4). Failure to monitor BMs and provide timely interventions may result in unrelieved constipation.

Findings include:

- Review of the facility's "Bowel Monitoring and Interventions Policy" occurred on 06/03/15. This undated policy stated, ". . . The purpose of this policy is to provide for quick detections of bowel concerns. . . . 1. Each resident is assessed every shift for bowel function. 2. Staff documents bowel results every shift. 3. Should a resident go two (2) days without having a bowel movement, resident is offered Milk of Magnesia. If no results by day three (3), neighbor is given a suppository. Nursing provides interventions per standing orders. . . ."

Review of Resident #4's medical record occurred on all days of the survey. The resident's diagnoses included constipation. The resident's quarterly Minimum Data Set (MDS), dated 04/29/15, identified severely impaired cognition and extensive assistance of one person for toileting and personal hygiene.

Review of a progress note, dated 01/06/15 at 5:51 p.m., identified a history of irregular BMs for Resident #4 as follows, ". . . Neighbor [Resident #4] is also on day 3 today for no BM [bowel movement], the stool is right there and neighbor states it hurts to push. Nurse did give a supp [suppository], and manually evacuated a small portion of the stool. Neighbor did have very small results after. Obtained an order for Miralax [a medication for constipation] daily. And CMA [certified medication aide] will give a dose of MOM [Milk of Magnesia] as well. Will continue to monitor. . . ."

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F 309	Continued From page 19 Review of Resident #4's Vitals Report identified the following related to bowel movements: *02/06/15 9:37 p.m.: large *02/07/15: no documentation *02/08/15: no documentation (no MOM offered as per the facility policy) *02/09/15 10:30 a.m.: "none" *02/10/15 5:14 a.m.: large *05/25/15 11:14 a.m.: medium, 10:06 p.m.: large *05/26/15: no documentation *05/27/15 1:57 p.m.: "none" (no MOM offered as per the facility policy) *05/28/15: no documentation *05/29/15 1:45 p.m.: "none" *05/30/15 7:53 p.m.: large Review of Resident #4's progress notes and Medication Administration Record (MAR) for February 2015 and May 2015 lacked evidence staff followed the facility's bowel management policy. During an interview on 06/03/15 at 11:20 a.m., the CMA (#7) stated a night shift nurse reviewed the bowel records and made lists for who needed interventions according to the bowel monitoring protocol. Day shift staff provided the medications, and documented the effectiveness of the medication on the MAR. During an interview on 06/03/15 at 11:45 a.m., an administrative nurse (#3) stated she expected staff to follow the bowel monitoring and interventions policy.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	F 312 SS = D ADL CARE PROVIDED FOR DEPENDENT RESIDENT 1). Resident # 4 did not have any adverse effect from not being shaved. We have implemented a CNA task form specifically for Resident # 4 for the CNA staff to sign off that shaving was offered, refused, and/or completed.	

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F 312	Continued From page 20 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, staff interview, record review and policy review, the facility failed to ensure 1 of 6 sampled residents (Resident #4) who required assistance with shaving received necessary services to maintain good grooming. Findings include: - Review of the facility's policy "Shaving the Resident" occurred on 06/02/15. The policy, last revised October 2010, identified, "The purpose of this procedure is to promote cleanliness and to provide skin care. . . ." Review of Resident #4's medical record occurred on all days of the survey. The resident's quarterly minimum data set (MDS), dated 04/29/15, identified the resident with severely impaired cognition and needed extensive assistance from one staff member with personal hygiene. Review of Resident #4's current comprehensive care plan stated, ". . . I do need assistance with my cares r/t [related to] Alzheimer s/Dementia [sic] . . . . I do need assistance with my AM/PM [morning/evening] cares, dressing, personal hygiene and oral care. Shave me as needed. . . ." Observation on 05/31/15 at 2:55 p.m. showed	F 312	2). All residents who are dependent on staff for shaving have the potential to be affected. 3). Benedictine Living Center of Garrison will ensure that all residents residing within the facility will be provided shaving to maintain resident dignity. All residents will be offered shaving 2 x weeks on shower and bath days and prn. Benedictine Living Center of Garrison has purchased 3 facility electric razors to be available for nursing staff for use to ensure shaving is completed. We have sent letters to resident's families requesting the purchase of a personal electric razor to meet the shaving needs of the resident to maintain good grooming practices. All nursing staff updated during shift reports of purchases of new razors and letters sent to families on June 5, 2015. Review of the Shaving the Resident Policy to be provided to all nursing staff at an in-service scheduled for July 7, 2015	

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F 312	Continued From page 21 Resident #4 rested in bed with her eyes open, and had multiple unshaven gray and white hairs on her chin. Observation on 06/01/15 at 9:20 a.m. showed the resident sat at the table in the Prairie Rose dining room and still had multiple hairs on her chin. On 06/03/15 at 9:53 a.m., observation showed the resident continued to have multiple unshaven chin hairs. At 10:20 a.m., the certified medication assistant (CMA) (#7) stated she provided the resident cueing and assistance with grooming. The CMA (#7) stated Resident #4 did not typically need to have facial hair removed, but confirmed the resident had hairs visible on her face. During an interview on 06/03/15 at 11:45 a.m., an administrative nurse (#3) stated she expected staff to shave residents anytime the residents needed to have it done.	F 312	4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor. Random audits on 3 neighbors requiring staff assistance for shaving will be conducted weekly x one month to ensure neighbors are shaved. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/8/15
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 314	F 314 SS = D TREATMENT/SERVICE TO PREVENT/HEAL PRESSURE SORE 1) Resident # 1 pressure area was assessed by provider on 7/2/2015 to ensure proper foot care is in place. 2). All Residents at risk for developing pressure areas/ulcers have the potential to be affected.	

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F 314	Continued From page 22 facility policy, and staff interview, the facility failed to provide the necessary treatment and services to promote the healing of a facility acquired pressure ulcer for 1 of 1 sampled resident (Resident #1) with a heel ulcer. Failure to provide timely and appropriate interventions and ensure staff consistently implemented those interventions resulted in further deterioration of Resident #1's existing pressure ulcer on the heel. Finding include: Review of the facility policy titled "Pressure Ulcer Risk Assessment, dated October 2008, stated, ". . . Pressure ulcers are often made worse by continual pressure . . . multiple factors, including pressure intensity, pressure duration . . . significantly affect the potential for the development and healing of pressure ulcers . . ." Review of the facility policy titled "Pressure Ulcer Treatment," dated February 2014, stated, ". . . Intervention Care Strategies . . . Implement pressure- relieving device(s) in accordance with resident's assessed needs . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a right heel ulcer. The significant change Minimum Data Set (MDS), dated 02/27/15, and the quarterly MDS, dated 05/23/15, identified impaired cognitive skills, at risk for pressure ulcers, one unhealed pressure ulcer, and ulcer treatments including pressure reducing device for chair/bed. Review of the current physician's orders showed an order to off load heel ulcer with a prevalon offloading heel boot at all times. The resident's current care plan stated, ". . . Skin:	F 314	3). All new residents have a skin assessment and Braden Scale completed upon admission to facility by DON/Nurse Designee. These assessments are completed to document any skin related issues and pressure sores that are present upon admission to facility. Braden Scale is completed for 4 weeks from admission date by charges nurses to identify any changes in resident's skin and health status to determine if appropriate skin interventions are in place and reviewed quarterly. Residents who are determined to be at risk of developing pressure ulcer and/or have a pressure ulcer present have immediate intervention put into place upon admission and as health conditions warrant: ex: pressure relieving bed/wc pads, air mattresses, bunny boots, ect. If wound is not open and no s/s of infection present a preventive dressing can be put into place on wound area per facility standing orders and wound is followed up on doctor rounds. When signs/symptoms of infection are present and/or ulcer does not seem to be healing appropriately on call physician is notified and appropriate order are	

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	355064	A. BUILDING _____ B. WING _____	06/03/2015

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F 314	Continued From page 23 I am risk for skin breakdown due to dx[diagnoses] diabetes, occasional incontinence, generalized weakness, . . . I have a pressure ulcer on my right heel which is resolving . . . Approach . . . Treatment to pressure ulcer as ordered . . ." Review of Resident #1's pressure ulcer wound record showed the following: * 02/27/15: right heel wound debrided. * 03/28/15: right heel ulcer 0.1 cm (centimeter) circumference x 0.1 cm depth. * 04/18/15: right heel ulcer 0.4 cm circumference x 0.1 cm depth. * 05/02/15: right heel ulcer 0.3 cm circumference x 0.1 cm depth. * 05/09/15: right heel ulcer 0.3 cm circumference x 0.1 cm depth. * 05/16/15: right heel ulcer 1 cm circumference x 0.1 cm depth. * 05/23/15: right heel ulcer 0.9 cm circumference x 0.1 cm depth. * 05/30/15: right heel ulcer 2 cm wide x 1 cm height x 0.1 cm depth. The pressure ulcer wound records show the wound increased in size significantly in May 2015. Observation on 05/31/15 at 4:05 p.m. showed Resident #1 with prevalon boots on while laying in bed. Two certified nurse assistants (CNAs) (#9 and #10) transferred the resident to his wheelchair, removed the prevalon boots, and placed pedor (a stretch orthopedic shoe) shoes on the resident's feet. Observation on 06/01/15 at 8:30 a.m. showed Resident #1 seated in his wheelchair at the dining room table with pedor shoes in place. Observation on 06/01/15 at 9:20 a.m. showed	F 314	received and implemented by the charge nurse. Weekly Push Tool assessments and staging of pressure ulcer is completed by charge nurse to gauge wound healing and to detect any signs of infection. All new physician orders and skin interventions are implemented and communicated by the charge nurse to staff in a shift-to-shift report and in a JIT (Just in time Communication). The current policy/procedure for Pressure Ulcer Treatment is being reviewed and revised. All nursing staff will be in serviced July 7, 2015. 4). Date certain is 7/08/15. 5) The DON/RN Designee will be responsible to monitor. Audits on 3 neighbors receiving pressure ulcer and/or skin related issues and skin treatments will be conducted weekly x one month to ensure treatment cares follow physician orders. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2015
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 24 Resident #1 seated in his wheelchair in the Prairie Rose hallway with pedor shoes in place. Observation on 08/02/15 at 4:05 p.m. showed Resident #1 with bilateral prevalon boots in place while laying bed. Removal of the right heel ulcer dressing revealed an open pressure ulcer approximately the size of a penny. The pressure ulcer wound showed pale pink tissue with surrounding tissue edges white and calloused. The CNA (#4) transferred the resident to his wheelchair. The CNA (#4) removed the prevalon boots and placed pedor shoes on the resident. During an interview on 08/03/15 at 11:30 a.m. an administrative staff member (#3) stated the pedor shoes were in place for safety precaution because the resident will self transfer unsupervised. She stated the pedor shoes were not a pressure ulcer relieving intervention. Failure to provide the prevalon offloading heel boots at all times delayed the right heel ulcer from healing.	F 314		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		

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F 318	Continued From page 25 Based on record review, review of facility policy, and staff interview, the facility failed to ensure 3 of 3 sampled residents (Resident #4, #6, and #10) scheduled for restorative nursing programs received the therapy program developed by the facility's therapy staff. Failure to provide restorative nursing services did not provide the residents the opportunity to maintain their range of motion (ROM), balance, strength, and mobility. Findings include: Review of the facility policy titled "Rehabilitative Nursing Care" occurred on 06/03/15. This policy, dated July 2013, stated, ". . . rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence . . . Rehabilitative nursing care is performed daily for those residents who require such service . . . as prescribed by the resident's Attending Physician . . ." - Review of Resident #10's medical record occurred on June 2-3, 2015. Diagnoses included paraplegia, restless leg syndrome, bone disorder, history of femur fracture, and dementia. The annual Minimum Data Set (MDS), dated 04/18/15, identified moderately impaired cognition and extensive assistance required for all activities of daily living (ADLs). The MDS also identified the resident received active range of motion restorative nursing four times during the assessment period. The current care plan, stated, ". . . Problem . . . Restorative Therapy: I have paraplegia with decreased ROM to lower extremities bilaterally . . . Approach . . . Restorative therapy to provide ROM exercises 5 days per week . . ."	F 318	F 318 SS = E INCREASE/PREVENT DECREASE IN RANGE OF MOTION 1) Residents # 4, # 6, # 10 were reassessed for restorative nursing and care plans adjusted accordingly. 2). All Residents receiving Restorative Nursing have the potential to be affected. 3). A Nurse Designee has been chosen to oversee the Restorative Program and Restorative CNA's. All orders pertaining to Residents who are/or will be participating in Restorative Program are handled the Nurse Designee. Physical Therapy will notify Nurse Designee of any resident who will be coming off of therapy that will benefit from restorative services. Physical Therapy to Restorative Program Form is filled out by PT with recommendations for restorative services. Nurse Designee will evaluate all orders pertaining to restorative services. Printed orders are placed in Restorative Nursing binder for restorative nursing aide to review and initiate. Residents, who have many documented instances of refusing restorative nursing treatments, will be reviewed by Nurse Designee and IDT to evaluate and to recommend changes to individual's restorative Program.	

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F 318	Continued From page 26 Review of the current physician's orders showed an order, dated 01/30/13, for a restorative care exercise program five times a week. Resident #10's "Therapy Communication to Restorative Services" form, dated 04/29/13, identified the following, ". . . Current functional status: Dependent . . . Problem/Needs: decreased mobility & strength . . . Goals: maintain current ROM . . . Recommendation/Approaches: . . . upper extremity . . . active shoulder flex w/ [with] dowel x10 [ten times] . . . Push/Pull with dowel x10 . . . triceps/biceps with red theraband x10 . . ." Resident #10's Restorative Flowsheet showed the following: * February 2015: staff failed to offer the ROM exercise program 3 of the 20 scheduled times. * March 2015: staff failed to offer the ROM exercise program 6 of the 22 scheduled times. * April 2015: staff failed to offer the ROM exercise program 6 of the 22 scheduled times. * May 2015: revealed staff attempted the exercise program 6 of the 21 scheduled times. Review of the restorative documentation showed staff failed to consistently provide a restorative care exercise program for Resident #10 five times a week as ordered. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, osteoporosis, and history of falls. The quarterly MDS, dated 04/09/15, indicated transfers with extensive assistance of two or more people, walks in the corridor with extensive assistance of one person, and restorative nursing for both active range of motion	F 318	Nurse Designee will communicate all new orders and order changes to Restorative Aides. Residents participating in Restorative Program are evaluated quarterly and as resident's condition warrants. As staffing levels increase; BLCG's goal is to train additional certified nurse assistants in the task and in the techniques of the Restorative Program. Adding additional trained staff will offer alternative time frames to ensure restorative services always available for residents. The current policy for restorative nursing was reviewed and revised. All nursing staff will be in serviced regarding the Restorative Nursing Policy at the in-service scheduled for July 7, 2015. 4). Date certain is 7/08/15. 5) The DON/RN Designee will be responsible to monitor. Audits on 3 neighbors receiving restorative nursing will be conducted weekly x one month to ensure restorative nursing orders care plans are followed accordingly. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/8/15

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F 318	Continued From page 27 and walking occurred on six days of the seven day look back period. Resident #6's "Therapy Communication to Restorative Services" form, dated 02/23/15, stated, ". . . Goals: 1) Maintain present ambulation status; 2) Maintain lower leg strength. Recommendations: . . . Walking; Standing ex [exercises] . . . start with 7 reps [repetitions] . . . Frequency: 6x/wk [times per week] . . ." The therapy began on 03/05/15 after reviewed by the nurse. Resident #6's Restorative Flowsheets revealed the following: *March, 2015 - staff failed to offer the ambulation and exercise program 13 of the 23 scheduled times. *April, 2015 - staff failed to offer the ambulation and exercise program nine of the 26 scheduled times. *May, 2015 - staff failed to offer the ambulation and exercise program 17 of the 26 scheduled times. The facility failed to consistently provide Resident #6 the restorative nursing program six times a week as ordered. - Review of Resident #4's medical record occurred on all days of the survey. The quarterly MDS, dated 04/29/15, identified severe cognitive impairment; extensive assistance of one person for walking in the corridor, locomotion on and off the unit, and transfers; and walking in the resident's room did not occur. The MDS also identified the resident received active range of motion and walking restorative nursing services three times during the assessment period.	F 318		

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F 318	Continued From page 28 Review of the resident's care plan revealed, ". . .I have decreased strength and endurance and difficulty with gait. I refuse and am not always compliant with RC [restorative care] program . . . Wellness ROM and Ambulation programs. . . . I do refuse to participate at times if I am tired or weak. . . ." Review of the current physician's orders showed an order for a restorative care exercise program five times a week (initiated on 04/22/13), and a restorative care ambulation program three times a week (initiated on 01/30/14). Resident #4's Restorative Flowsheets revealed the following: *March, 2015 - staff failed to offer the exercise program 11 of the 20 scheduled times, and failed to offer the ambulation program two of the 12 scheduled times. *April, 2015 - staff failed to offer the exercise program ten of the 25 scheduled times. *May, 2015 - staff failed to offer the exercise program seven of the 20 scheduled times, and failed to offer the ambulation two of the 12 scheduled times. Review of the facility's restorative care schedule for the week of 06/01/15 to 06/07/15 revealed a schedule for the resident to receive ambulation and range of motion exercises on 06/01/15, 06/03/15 and 06/05/15, but failed to identify range of motion exercises five days a week as ordered. On 06/03/15 at 9:25 a.m., a restorative care aide (RC aide) (#7) reported it was difficult at times to complete all of the assigned restorative care services, and stated occasionally, she was pulled	F 318		

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F 318	Continued From page 29 from providing restorative care to pass medications. The RC aide also reported she used the restorative care schedule to determine how often to provide restorative services. During an interview on 06/03/14 at 11:45 a.m., an administrative nursing staff member (#3) stated she did not see any assessments regarding Resident #4's restorative care needs in the resident's record since 2011, but stated she thought the resident's needs and restorative care schedule had changed since then. The staff member (#3) stated she expected staff to follow the resident's restorative plan, but stated it was unclear as to how often staff needed to offer the resident restorative care services.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: ~~THIS IS A REPEAT CITATION FROM THE~~ SURVEY COMPLETED ON 08/06/14. SAFE HANDLING OF HOT LIQUIDS 1. Based on observation, record review, facility guidance on hot liquids, and staff interview, the facility failed to provide supervision to attain the	F 323	F 323 FREE OF ACCIDENT HAZARDS SAFE HANDLING OF HOT LIQUIDS: 1) Staff will be educated on hot liquid protocol for Neighbor #3 on 7-7-15 at a mandatory staff training meeting. 2) At risk Neighbors for hot liquids will be posted on the coffee machines in each kitchen. 3) New admissions will continue to be assessed at the time of admission. Current Neighbors will continue to be reviewed at least quarterly as part of their regular MDS Schedule, as well as on any significant change, or any time staff feels an individual may no longer be safe.	

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F 323	Continued From page 30 highest degree of safety possible while consuming hot liquids for 1 of 6 sampled residents (Resident #3) with safety precautions regarding hot liquids. Failure to provide hot coffee as identified in the resident's hot beverage assessment and care plan placed the resident at risk of injury. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, osteoarthrosis, osteoporosis, and muscle weakness. A significant change Minimum Data Set (MDS), dated 04/02/15, identified supervision and setup help with eating. The resident's care plan, dated 4/17/15, stated, ". . . Problem . . . Nutritional Status . . . I have been evaluated to make sure I am safe to have hot liquids, I need 1/2 coffee and 1/2 cool water . . . Goal . . . I would like to remain safe with hot liquids . . . Approach . . . Burn Screen: 1/2 full of coffee and 1/2 full of water . . . I have tremors and shakes sometimes . . ." Review of the facility's Neighbor Burn Screen, dated 03/04/15, stated, ". . . Risk Factors: . . . tremors/shaking . . . at times with weakness noted . . . Need for Adaptive Equipment/Modifications: . . . Allow coffee to cool a bit OR add cool water to hot beverages . . ." Review of the Resident #3's diet card (used by dietary staff to indicate food preferences and dietary orders) occurred on 06/01/15. The diet card lacked specific instruction regarding hot beverages for this resident. Observation showed the following:	F 323	4) Culinary Director will be the owner of this process. Audits will be completed appropriate interventions (as outlined by the care plan and "at risk" lists) are being followed by staff. These audits will be completed 2xweek x 6 weeks for each neighbor identified as "at risk". And then monthly for 3 months to ensure continued compliance. QA Team will review audits quarterly. 5) Date Certain 7/8/15	7-8-15

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F 323	Continued From page 31 * 06/01/15 at 9:15 a.m.: Resident #3 sitting at a table in the dining room. Coffee placed in front of the resident showed steam coming off the coffee. Observation showed no staff member supervising the resident with her hot beverage. * 06/01/15 at 11:34 a.m.: Resident #3 sitting at a table in the dining room. Coffee placed in front of the resident showed steam coming off the coffee. Observation showed no staff member supervising the resident with her hot beverage. * 06/02/15 at 5:00 p.m.: Resident #3 stayed in her room for the evening meal. The dietary staff member (#17) prepared the resident's tray. The dietary staff member poured coffee directly from the coffee machine into a coffee cup and placed on the resident's tray. A certified nurse assistant (#4) took the tray with the hot coffee to the resident's room, placed it on the bedside table, and left the resident alone with the hot beverage. A request was made for the administrative nurse (#2) to come into the resident's room. The administrative nurse was made aware of concerns of an unsupervised resident with hot coffee who was assessed as unsafe with hot beverages. The administrative nurse immediately removed the hot coffee from the resident's room. Staff failed to supervise the resident with hot beverages and failed to follow the care plan to mix the hot coffee with half cool water. During an interview on 06/01/15 at 5:15 p.m., an administrative nurse (#2) stated the resident should not have had the hot coffee served without half cold water and stated the dietary staff member (#17) was new. During an interview on 06/03/15 at 11:30 a.m., an administrative staff member (#1) when asked to provide a policy on hot beverages, stated the	F 323		

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F 323	Continued From page 32 facility had no policy. An administrative staff member (#1) provided the "Interventions to prevent burns from Hot Liquids" document. Review of the facility's document titled "Interventions to prevent burns from Hot Liquids" occurred on 06/03/15. This document, dated 06/17/14, stated, " 1. Lid on cup . . . 4. Slightly chill cup prior to pouring coffee into it . . .5. Ice cube or cold water added to coffee . . . 7. Allow coffee to cool prior to serving 8. Fill coffee cup half full 9. Staff assistance with beverages . . ." The facility failed to provide supervision to ensure the safety of Resident #3 and failed to ensure implementation of the care plan regarding hot beverages. This failure placed Resident #3 at risk of a burn from the hot liquid. INAPPROPRIATE TRANSFERS 2. Based on observation, record review, and review of professional reference, the facility failed to use assistive devices appropriately for 2 of 10 sampled residents (Resident #1 and #6) observed transferred. Failure to utilize appropriate transfer methods placed these residents at increased risk for injury. Findings include: ~~Berman and Snyder, "Kozier & Erb's~~ Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc. New Jersey, page 1162, states, ". . . Transferring with a Belt and Two Nurses: . . . position yourself on both sides of the client, facing the same direction as the client. Flex your hips, knees, and ankles. Grasp the client's transfer belt with the hand closest to the client, and with the other hand	F 323		

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F 323	Continued From page 33 support the client's elbows. . . ." - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: . . . Mobility: I do need assistance with mobility r/t [related to] generalized weakness, Dementia, unsteady gait and occasional back pain. . . . Approach: A1-2 [assist of one to two people] with ambulation, fww [front wheeled walker] and gait belt. . . . At times I am able to pivot transfer with A1-2 and a gait belt. If I am weak, unsteady or having pain, utilize either the EZ stand [stand-up lift] or lift [full body mechanical lift] and A2 [assist of two people]. . . ." On 05/31/15 at 3:20 p.m., observation showed two CNAs (#12 and #13) assisted Resident #6 to transfer with a gait belt from the recliner to her wheelchair. The CNAs held the gait belt with one hand while pulling up on the resident's axillae with their other hand. The resident failed to straighten her legs and the CNAs physically assisted her to pivot into the wheelchair. Pulling up on the resident's axillae has the potential to cause pain, and the inability to straighten her legs increased Resident #6's risk of falling. The CNAs failed to request a licensed nurse assess the resident for weakness, unsteadiness, or pain to determine which method of transfer they should use. - Review of Resident #1's medical record occurred 05/31/15 - 06/02/15. Diagnoses included congestive heart failure, pain, osteoarthrosis, history of hip enthesopathy (disorder of ligament and tendon attachment to the bone), and lumbar disc degeneration. The significant change Minimum Data Set (MDS),	F 323	F 323 SS =D FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1). Resident # 1 & # 6 transfer assessments were completed by a licensed nurse on June 25, 2015. 2). All residents who require staff assistance for transfers have the potential to be affected. 3). The current policy/procedure for Transfers/Gait Belt Use is being reviewed and revised. All nursing staff will be in serviced July 7, 2015. 4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor. Audits on 3 neighbors receiving transfer assistance will be conducted weekly x one month to ensure appropriate transfer assessments and transfer procedures are being followed .Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15

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	355064	A. BUILDING _____ B. WING _____	06/03/2015

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F 323	Continued From page 34 dated 02/27/15, identified the resident as a two person extensive assist with transfers. The resident's current care plan stated, ". . . Fall: I am at risk for falls due to unsteady gait, SOB [shortness of breath], generalized weakness . . . Mobility: I do need assistance with mobility and get weak and SOB quickly . . . Approach . . . A1-2 [assist of 1 to 2 persons] to pivot transfer with a gait belt . . ." Observation on 05/31/15 at 4:05 p.m. showed two CNAs (#9 and #10) transferred Resident #1 from the toilet to his wheelchair utilizing a gait belt and pivot transfer. The CNA (#10) applied a gait belt and assisted Resident #1 to a standing position by pulling the front of the gait belt with one hand while another CNA (#9) assisted the resident to a standing position by pushing the resident's buttocks upward with her hands. The CNA (#10) then grabbed under the resident's axillae once the resident was in a standing position to assist the resident into his wheelchair. Failure to use the gait belt correctly during transfers has the potential to cause pain or injury to the resident.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #6) with weight loss maintained acceptable parameters of nutritional status, such as body weight. Failure to assess and monitor the resident's nutritional status, and implement appropriate interventions may have contributed to Resident #6's significant weight loss. Findings include: Review of the facility policy titled "Weight Monitoring and Documentation" occurred on 06/03/15. This policy, dated 2000, stated, "Policy: Each resident's weight is monitored and fluctuations of [greater than or equal] to 5% [percent] in one month, or [greater than or equal] to 7.5% in 3 months, or [greater than or equal] to 10% over the past six months will be assessed and appropriate individualized dietary interventions and documentation will be implemented. Procedure: . . . 7. Residents exhibiting significant weight changes are to be assessed and finding/interventions documented in a timely manner. . . b. Dietitian/designee will meet with the licensed nursing staff to determine possible causes and intervention . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The quarterly Minimum Data Set, dated 04/09/15, indicated severe cognitive	F 325	F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 1) Neighbor #6 was assessed by the dietitian and interventions are in place. Neighbor #6 will continue to be monitored by the dietitian and dietary manager. 2) Neighbors will be assessed for their nutritional wellbeing quarterly, annually and when a significant change in their status has occurred. Weights for all neighbors will be reviewed monthly by CDM. Any individuals identified as having a weight loss will be assessed by CDM/Dietitian a plan will be developed to address weight loss if necessary (as per Dietitian recommendations). Weight loss will be reviewed by the IDT weekly and any recommendations made at that time. 3) The dietitian will audit weights monthly to make sure that no one with weight loss is missed. Audits to be completed monthly (on-going). 4) Quality indicator reports will be reviewed monthly by CDM and any report showing over 75% will be reviewed by QA team to identify any trends, to see if we have any systematic issues. 5) Date certain 7-8-15	7-8-15

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F 325	Continued From page 36 impairment, extensive assistance of one person with eating, and weight loss of 5% or more in the last month or 10% or more in the last six months, not prescribed by the physician. A physician order, dated 01/15/15, stated, "Diet: reg [regular] as tolerated." Resident #6's weights in pounds included the following: * 07/07/14 - 183.4 * 11/10/14 - 177.3 * 12/08/14 - 181.2 * 01/19/15 - 169.4 = a greater than 5% weight loss in one month * 02/09/15 - 162.8 = a greater than 7.5% weight loss in three months * 03/16/15 - 165.0 = a greater than 7.5% weight loss in three months * 05/11/15 - 159.6 = a greater than 10% weight loss in six months * 06/01/15 - 153.8 The current care plan stated, "Problem: Culinary: I need some help with meals r/t [related to] dementia. . . . Approach: . . . Offer me set up help if I need it, but encourage me to do what I can for myself. . . . You may need to remind me that it is meal time. Supervise me at meals. . . ." A quarterly dietary assessment, dated 11/04/14, stated, ". . . wt [weight] stable - 180# [pounds] . . . eats well. . . ." The Care Area Assessment, dated 01/13/15, noted the resident's decreased appetite was improving, tolerating her diet well, and no concerns. The record lacked any further assessments. On 06/03/15 at 11:50 a.m., a health information staff member (#23) reported she was unable to find any nutritional assessments after the quarterly on 11/04/14.	F 325		

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F 325	Continued From page 37 Review of Resident #6's diet card and the supplement list, the morning of 06/03/15, failed to show the resident received any supplements. Observation throughout the survey showed staff set up Resident #6's meal tray in the dining room and provided cues and encouraged her to eat. Observation showed the resident received whole milk, but no enhanced foods or supplements. Failure of the facility to re-assess Resident #6's continued weight loss, implement dietary interventions, initiate timely and effective interventions, re-evaluate and modify interventions as needed resulted in a severe weight loss.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy review, the facility failed to provide the necessary care and services for 1 of 5 sampled	F 328		

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F 328	Continued From page 38 residents (Resident #1) who required oxygen. Failure to provide oxygen as ordered/as necessary to maintain appropriate oxygen levels has the potential for Resident #1 to experience complications and/or hospitalization related to low oxygen saturation levels. Findings include: Review of the facility policy titled "Oxygen Administration" occurred on 06/03/15. This policy, dated October 2010, stated, ". . . Review the physician's orders or facility protocol for oxygen administration . . . Review resident's care plan to assess for any special needs for resident . . ." Review of Resident #1's medical record occurred on May 31 - June 1, 2015. Diagnoses included congestive heart failure, pneumonia, history of bronchitis, chronic obstructive pulmonary disease with exacerbation, asthma, and a history of tobacco use. Resident #1 was hospitalized in February 2015 for pneumonia and influenza. The current physician's orders included oxygen via nasal cannula at three liters per minute every shift. Resident #1's current care plan stated, ". . . Impaired Gas Exchange: I get SOB [short of breath] with exertion, laying flat and sometimes at rest. I wear 02 [oxygen] continuously . . . Approach . . . I do get SOB with exertion, while lying flat, and at times when at rest. Be sure my oxygen is on at all times . . ." Observation on 05/31/15 at 4:05 p.m. showed two certified nurse assistants (CNAs) (#9 and #10) transferred Resident #1 from the bed to the toilet utilizing an EZ stand lift (a mechanical sit to stand	F 328	F 328 SS = D TREATMENT/CARE FOR SPECIAL NEEDS 1) Resident # 1 oxygen was replaced and had no long term affect from having oxygen off. 2). All Residents who have supplemental oxygen needs have the potential to be affected. 3). Review of Oxygen Administration will be provided for all nursing staff at the in-service scheduled for July 7, 2015. 4). Date certain is 7/08/15. 5) The DON/RN Designee will be responsible to monitor. Audits on 3 neighbors receiving supplemental oxygen will be conducted weekly x one month to oxygen is in place during resident's cares. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15

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F 328	Continued From page 39 lift). The CNA (#9) removed the resident's nasal cannula before transferring the resident into the bathroom. The resident did not have his oxygen tubing in place during toileting and perineal cares. The CNAs (#9 and #10) transferred the resident from the toilet to his wheelchair utilizing a pivot transfer and gait belt. Observation showed Resident #1 was sweating, breathing rapidly and loudly, with increased chest expansion. The CNA (#9) placed the resident's nasal cannula tubing on the resident at 4:36 p.m. The resident was without oxygen for 31 minutes. During an interview on 06/03/15 at 11:30 a.m., an administrative nurse (#3) stated she would expect staff to ensure Resident #1 received oxygen via nasal cannula during all cares.	F 328		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/29/14. Based on observation, staff interview, record review, and policy review, the facility failed to	F 371	F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1) All culinary staff will be educated on proper use of hairnets, sanitizing and storing dishes, frozen food storage, and maintaining clean kitchen equipment for infection control, at staff meeting on 7/7/15 or individually trained by that date. All equipment in all the kitchen/serving kitchens were inspected, thoroughly cleaned, and disinfected, including the covers of the flower & sugar containers, fans, convection handles & range hood. 2) Hairnets, Sanitizing and storing dishes, frozen food storage, maintaining clean kitchen equipment for infection control will be monitored in each kitchen area.	

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F 371	Continued From page 40 store, prepare, and serve food under sanitary conditions in 3 of 3 kitchens and failed to clean and sanitize 1 of 1 ice machine per manufacturer's directions. The failure to properly sanitize and store dishes, restrain hair, store frozen food, and maintain clean kitchen equipment may result in foodborne illness and unsanitary dining conditions. Findings include: Review of the facility's policies occurred on 06/03/15: The facility's untitled policy for appropriate hygiene and sanitary procedures for nutritional services employees, dated 10/23/13, stated, " . . . 13. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. . . ." The facility's undated Dishwashing Procedures policy stated, ". . . r) All items must be stored inverted, covered or stacked with top dish/tray inverted, unless stored in an enclosed cabinet. . . . t) Clean cups, glasses, and bowls will be handled so that fingers and thumbs do not contact inside surfaces or lip contact surface. . . ." Observation on 05/31/15 at 9:28 a.m. during the initial main kitchen tour showed the following: *A white fan, discolored with dust build-up above the food preparation area *A large warming cart next to the main food holding area stored plates uncovered, with the eating surface facing upward *The range hood ventilation system had blowing cob webs and dust build-up *Two large, white bins used for the storage of sugar and flour, sat under a food preparation	F 371	3) Cleaning checklist was developed to assure equipment & kitchen areas are kept clean. Cleaning checklist will be marked off daily. 4) Culinary director will audit compliance with proper use of hairnets, sanitizing and storing dishes, frozen food storage, maintaining clean kitchen equipment for infection control 2x/wk., per household, x 6 weeks; then monthly, per household x 3 months. QA Team will review audits quarterly. 5) Date Certain 7/8/15 F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1) Ice machine will be cleaned on a monthly basis. 2) All ice machines will be closely monitored to assure cleanliness of machine. 3) Ice machines have been cleaned. A regular check off list will be utilized to assure cleanliness as needed or minimally a monthly basis.	7-8-15

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F 371	Continued From page 41 table, covered with a sticky build-up. The sugar bin had a label that read, "cleaned 1/28". Observation on 06/02/15 during the noon meal preparation and service in the main kitchen area and Dakotah dining room showed the following: *A culinary services staff member (#19) washed her hands, scratched her face with her shirt, opened a can of pudding, and carried it over to a counter across the kitchen. She then grabbed several small bowls from a cabinet, touching the eating surfaces of several of them with soiled hands. Another culinary services staff member (#18) scooped pudding into the bowls for residents to eat, and had a portion of her hair sticking out of her hairnet. *The convection oven had a large amount of residue built up on the front of the handles. *Serving platters stored right side up and uncovered on wooden shelves next to the walk-in refrigerator *A large plastic container of sherbet sat in the Dakotah dining room freezer uncovered, with the serving scoop still resting in the container Observation at 11:00 a.m. on 06/02/15 revealed a culinary services staff member (#17) washed dishes in the dishwashing room next to the kitchen. The staff member (#17) wore a scrub top visibly wet from washing the soiled dishes. At 11:15 a.m., she entered the kitchen, washed her hands, and began to assist with preparing food and beverages for the noon meal with the same soiled scrub top. The staff member (#17) failed to apply an apron or other type of barrier between the soiled top and resident food. On 06/02/15 at 12:15 p.m., a culinary services staff member (#21) stated staff should seal the	F 371	4) ES Director will be the owner of this process. Audits will begin 7-1-15 & will continue 2X monthly for 2 months, and then 1X monthly after that to assure sanitary conditions and prevention of any build-up. Audits will be reviewed at quarterly QA meetings. 5) Date certain 7/8/15 F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1) All staff will be educated on operation of dishwasher, dishwasher temps and what to do if dishwasher is not working properly by 7-7-15 2) All dishwashers will be inspected to ensure they are working properly on a daily basis. The dishwashers in both the serving kitchens were replaced with leased Ecolab dishwashers.	7-8-15

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F 371	Continued From page 42 sherbet in an airtight container, and not leave the scoop in the container. The staff member (#21) confirmed the convection oven handles and sugar/flour bins were soiled, and another department had the responsibility of cleaning the fan. During an interview on 06/02/15 at 5:25 p.m., an administrative culinary staff member (#20) reported she expected staff to store dishes and pans upside down if they were not covered or in a closed cabinet, and expected the plates in the warmer to be covered with a sheet when not in use. She expected staff to avoid touching the eating surfaces of clean bowls and plates, and expected staff to restrain hair while in the kitchen. - The facility's undated Dishwashing Procedures identified, ". . . The facility will implement dishwashing practices that prevent the spread of food borne illness. . . .PROCEDURE 1. Mechanical Dishwashing (Hot Water Sanitizing) . . . d) The temperature of the water shall be maintained at 140 F [degrees Fahrenheit] for the washing cycle (or according to manufacturers instructions) and at 180 F for the rinsing and sanitizing cycle (180 F, 160 F at the rack and dish/utensils surfaces). . . ." The facility's "Dish Machine Temperature Log" for the Sunflower and Prairie Rose dishwasher read, ". . . Make sure temperatures are recorded during the wash and rinse cycle of the dishwasher to ensure accuracy. If temperatures do not meet requirements notify maintenance right away. . . ." Review of the logs on the Sunflower unit identified staff failed to test the dishwasher temperature from January 2015 through June 2015 to ensure	F 371	3) Culinary staff in Dakotah & Prairie Rose, & cna's in Sunflower will check chemical levels as well as temp levels of dishwashers and document on the checklist 3X daily. Instructions for operating & testing each dishwasher will be kept near each dishwasher. Instructions for daily monitoring the chemical supply will be posted in each dishwasher area. Homemaker staff will monitor in Dakotah & Prairie Rose, cna's will monitor in Sunflower Household. 4) Culinary director to complete audit in Sunflower, Prairie Rose, & Dakotah dishwashers 3x/wk. x 1 month. Culinary director to monitor dishwasher temp & chemical level test forms every month, and additional training or machine maintenance will be completed as needed. ECOLAB will test all the dishwashers 1x monthly as well. QA Team will review audits quarterly. 5) Date Certain 7/8/15	7-8-15

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F 371	Continued From page 43 the machine properly sanitized the dishes at the right temperature. The log for November 2014 revealed staff failed to test the dishwasher to ensure it sanitized properly on 22 of the planned 60 times. The log for December 2014 revealed staff failed to test the dishwasher on 54 of the 62 planned times. Review of the April 2015 log for the Prairie Rose unit dishwasher identified the temperature gauge had stopped working properly starting on 04/16/15 and staff tested the water manually. Observation at 12:30 p.m. on 06/02/15 revealed a culinary services staff member (#19) washed dishes in the Prairie Rose unit kitchen using a 2 compartment sink and a dishwasher. The staff member (#19) stated the dishwasher sanitized the dishes by high heat, but she did not know how long the cycle lasted, or how to tell when the cycle had completed. She also reported the machine's rinse temperature gauge had been broken for a few weeks, so she checked the temperature of the water by sticking a thermometer into the pooled water at the bottom of the machine in the middle of the cycle to make sure the temperature reached 180 degrees. Readings taken from a probe thermometer in the pooled water mid-cycle read 150.6 degrees F, and readings through two separate cycles using temperature sensitive stickers revealed the temperature never reached 160 degrees (the temperature needed at dish level for proper sanitization). At 12:00 p.m., an administrative maintenance staff member (#22) stated he reviewed the manufacturers instructions and the "cycle" light would turn off when the cycle was completed. Another temperature sensitive sticker ran through the cycle until the light turned off, and again revealed	F 371		

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F 371	Continued From page 44 that temperature did not reach 160 degrees. The staff member (#22) confirmed the machine's temperature gauge had been broken a few weeks, but he had not yet ordered a part for it. Observation in the Sunflower unit kitchen on 06/02/15 at 3:30 p.m. revealed a second dishwasher that sanitized dishes by high heat. A reading taken from a probe thermometer in the pooled water mid-cycle read 152 degrees F, and readings taken from a temperature sensitive sticker revealed the temperature never reached 160 degrees even though the front temperature display read 185.2 degrees during the rinse/sanitize portion of the cycle. On 06/02/15 at 2:35 p.m., an administrative maintenance staff member (#22) reported he did not monitor the temperature or sanitization of the dishwashers on the units, and reported he had no way of accurately taking the water temperatures other than the gauges on the front of the machines. The facility failed ensure dishwashing machines effectively sanitized dishes for resident use. Review of the manufacturer's guidelines for the facility's "Hoshizaki America, Inc." ice machine occurred on 06/02/15. The guidelines, dated November 2013, page 17, stated, ". . . Maintenance schedule . . . air filter . . . every 2 weeks . . . External water filters . . . monthly . . . Icemaker and Storage Bin, Gear Motor Drain Pan, Icemaker Drain . . . every 6 months . . . Inlet Water Valve, Dispense Water Valve, Drain Valve, Water Hoses, Condenser, Icemaker, and Upper Bearing . . . yearly . . ."	F 371		

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	355064	A. BUILDING _____ B. WING _____	06/03/2015

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F 371	Continued From page 45 During the environmental tour on 06/02/15 at 3:05 p.m., the maintenance staff member (#22) identified the ice machine is located in the Dakotah dining room and verified the facility routinely cleans and sanitizes the internal mechanism of the ice machine according to the manufacturer's guidelines. He could not state how often the ice dispensing duct is cleaned or sanitized. During an interview on 06/02/15 at 11:30 a.m., two administrative staff members (#1 and #3) stated they were unaware if there is a cleaning or sanitization schedule. An administrative staff member (#1) stated the facility had no ice machine policy.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F 431 SS = E DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS (EXPIRED MEDICATIONS) 1). Expired medication was removed from Prairie Rose Medication Room and Dakotah Medication Cart. 2). All medication storage areas have the potential to be affected. 3). Benedictine Living Center of Garrison will ensure that all resident's medication will be administered in a safe and appropriate manner. All medication expiration dates are checked prior to medication administration. Medication Store Room and Medication Carts are routinely	

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F 431	Continued From page 46 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to properly store and label medications for 1 of 2 medication rooms (Prairie Rose) and 1 of 3 medication carts (Dakotah). Failure to store all medications securely may result in unauthorized access. Failure to discard expired medications and ensure medication labels contain expiration dates increases the risk of residents receiving outdated medications with reduced efficacy. Findings include: Review of the facility policy titled, "Administering Medications" occurred on 06/03/15. This policy, dated 2001, stated, "Policy Statement: Medications shall be administered in a safe and timely manner . . . Policy Interpretation and Implementation: . . . 9. The expiration/beyond use date on the medication label must be checked prior to administering. . . . 16. During administration of medications, the medication cart	F 431	monitored by nursing staff for expired medications. All expired medications are immediately removed from storage areas and medications are destroyed as per facility policy. All medication removed from medication store room expiration dates are checked prior to being placed on medication cart. Review of Medication Administration will be provided for all nursing staff at the in-service scheduled July 7, 2015 4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor. Audits will be conducted weekly x one month to ensure no expired medications exist.. Audits will then decrease to one neighbor per week x one month and then one neighbor per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting	7/8/15

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F 431	Continued From page 47 will be kept closed and locked when out of sight of the medication nurse or aide. . . ." On 06/02/15 at 5:45 p.m., observation in the Prairie Rose medication room with a staff nurse (#8) identified expired dates on five medications: * One Daily multivitamin bottle expired February 2015 * One Daily multivitamin bottle expired March 2015 * Vanicream ointment expired June 2014 * A box containing four vials of Albuterol 0.083% expired November 2014 * A box containing 24 vials of Albuterol 0.083% expired December 2014 On the morning of 06/03/15, observation of the medication cart on Dakotah showed Prochlorperazine 10 mg (milligram) expired May 2014. On the morning of 06/03/15, observation of the medication cart on Dakotah showed six medications with no expiration date on the label. * Amlodipine 5 mg * Furosemide 20 mg * Myrbetriq ER (extended release) 50 mg * Potassium chloride 10 mEq (milliequivalent) * Lisinopril 20 mg * Muspirocin 2% ointment	F 431	F 431 SS = E DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS (LOCKED MEDICATION CARTS) 1). Medication Cart was immediately locked properly and a written note was place on the MAR and in the Nursing Staff Communication Book, explaining how to properly lock Medication Carts. 2). All Medication Carts have the potential to be affected. 3). Medication Administration was reviewed and includes locking medication carts. In-service will be provided for all nursing staff at the in-service scheduled July 7, 2015 4). Date certain 7/08/2015. 5). The DON/RN Designee will be responsible to monitor. Medication Carts will be audited weekly x one month to ensure no Medication Carts are unlocked. Audits will then decrease to one per week x one month. Then one per quarter x 3 quarters. DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	7/08/15
	On 06/02/15 at 3:05 p.m., a random observation in the Prairie Rose dining room showed a Proair inhaler with no label located in an unlocked drawer in the residents' dining area. During an interview on 06/02/15 at 5:45 p.m., a staff nurse (#8) stated staff is expected to discard expired medications in the medication room.			

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F 431	Continued From page 48 - Review of a progress note for Resident #8, dated 06/04/14, revealed the resident was, ". . . Rummaging through the Dakota med cart. Cart had been locked but got the 1 side open. Staff caught him and then he ran back to his room. He was also caught pushing the med cart down the hallway and shaking the drawer. . . ." Observation on 05/31/15 at 5:20 p.m. revealed a medication cart on the Dakotah hall (not visible from the dining room), with unlocked drawers on the right side of the cart, and medications accessible. The CMA (certified medication aide) (#16) walked out from the dining room and reported she had locked the cart before leaving the area. The CMA (#16) then pulled open a drawer on the right side of the cart without using a key to unlock the cart. The CMA (#16) reported she thought part of the locking mechanism had not latched properly. During an interview on 06/03/15 at 11:30 a.m., an administrative nurse (#3) stated she expected the staff to store all medications in a locked area, to discard all expired medications, and label medications with expiration dates.	F 431		
F 468 SS=C	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were secured to	F 468		

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F 468	Continued From page 49 the walls in 3 of 3 units (Dakotah, Prairie Rose, and Sunflower units). Lack of secured handrails, in areas utilized by residents, can limit residents from experiencing independent mobility and may result in falls. Findings include: Observation on 06/02/15 at 3:05 p.m. showed the following: * Handrail located outside of Dakotah dining room: loose and lifting up. * Handrail located near left front entrance door in Dakotah unit: a middle bolt loose and more then half way out. * Handrail located between the environmental service door and the fire door in Dakotah unit: loose. * Handrail located in the Dakotah unit at the right side of entrance of the Sunflower unit door: loose. * Handrail located in the end hall of the Prairie Rose unit near exit sign: loose. * Handrail located in the end hall of Prairie Rose unit near exit and outside of dining room: loose. * Handrail located in the Sunflower unit on the right side wall of entrance: comes completely out of the wall. A tour of the environment on 06/02/15 at 3:05 p.m. with an administrative environmental staff member (#22) confirmed the above handrails were loose. The administrative environmental staff member (#22) stated he does not check the handrails to ensure they are appropriately secured .	F 468	F 468 CORRIDORS HAVE FIRMLY SECURED HANDRAILS 1) All lose handrails will be tightened by 7-7-15. 2) All handrails will be monitored on a monthly basis to assure they are securely tightened to the wall. 3) Handrails will be secured to the wall. Audits will be done to assure handrails stay tight. 4) ES Director will check all handrails every 2 weeks for 2 months. Than monthly X10 months. QA Team will review audits quarterly. 5) Date certain 7-8-15	7-8-15
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 50 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, facility policy, and staff interview, the facility failed to ensure a physician actively participated as a member of the Quality Assurance (QA) Committee for 3 of 4 quarters (1st, 3rd, and 4th quarters) and failed to develop and implement plans of action to correct deficient practice and sustain compliance with federal requirements as evidenced by repeat citations at	F 520	F-520 SS – E QA COMMMITTEE 1) No residents were directly affected. 2) Attendance at the QA committee meetings does not directly affect other residents. 3) QA committee members will meet on quarterly basis, to include the medical director. 4) QA committee will evaluate information, review reports, consider audit results, and make recommendations on improvements specific to previous state health department survey tags. 5) Date certain 7/08/2015.	7/08/15

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F 520	Continued From page 51 F309, F323, and F371. Failure to ensure a physician participated in quality assurance activities deprived the committee of the physician's perspective for addressing quality issues and assisting with decision making based on identified concerns. Findings include: Review of the facility's policy titled "Quality Council" occurred on 06/03/15. This policy, undated, stated, ". . . A facility must maintain a quality assessment and assurance committee consisting of - the director of nursing services, a physician designated by the facility, and at least three other members of the facility's employees . . ." An interview with an administrative staff member (#23) regarding the facility's Quality Assurance Program occurred on 06/03/15 at 9:30 a.m. The administrative staff member stated a physician did not attend three of the four QA meetings due to scheduling conflicts. The administrative staff member (#23) stated the meeting minutes are faxed to the physician. Failure to effectively implement the QA program resulted in the facility not sustaining compliance with the following repeat deficiencies: F309: bowel management F323: safe handling of hot liquids F371: dietary services	F 520		