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 _____	05/25/2017

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 May 22, 2017 and completed on May 25, 2017, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		6/30/17

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

Electronically Signed | 06/17/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files and staff interview, the facility failed to provide adequate written notices for 3 of 3 residents (Resident #9, #14, and #15) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the Fiscal Intermediary (FI)/Medicare Administrative	F 156	A letter was sent to the resident's representatives for residents #9, and 15 with the updated address for Noridian Healthcare Solutions. Resident # 14 is deceased. All residents were potentially at risk. Charts have been reviewed; residents who were issued a denial in the last 6	

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F 156	Continued From page 6 Contractor (MAC) limits the residents' ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare Part A denial notices occurred on 05/25/17 at 11:15 a.m. The facility's Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form (CMS-10055) failed to contain the FI/MAC's (Noridian Healthcare Solutions) name and address. The following SNFABN forms failed to have the correct contact name and address. * Resident #9 - signed on 12/30/16 * Resident #14 - signed on 04/09/16 * Resident #15 - signed on 02/14/17 During the review of the denial notices, an administrative nurse (#4) confirmed the SNFABN is the current form the facility has been using, and was unaware the contact information was incorrect.	F 156	months were sent a letter with the correct address for Noridian Healthcare Solutions. The denial form was updated on 05/25/2017 with the correct address MDS nurse was educated on 05/30/2017 on keeping up with the updates on forms and to reach out to the Cooperate MDS nurse specialist monthly regarding any updates. DON or designee will ensure and monitor compliance. 1 audit will be conducted per month x4 months. Audits will consist of MDS nurse asking nurse specialist for updates via e-mail. Audits will begin 06/15/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	
F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 205		6/30/17

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F 205	Continued From page 7 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide a written bed-hold notice upon transfer for 2 of 2 sampled residents (Resident #2 and #7) and 1 closed record (Resident #11) transferred for hospitalization. Failure to provide a written bed-hold notice does not allow the resident to make an informed choice regarding their rights. Findings include: Review of the policy, "Benedictine Living Center Bed Hold Policy" occurred on 05/25/17. This undated policy stated, "Hospitalization: When transferred to an acute care hospital Benedictine Living Center will keep a Medicaid resident's bed available for fifteen (15) days. If the hospital stay	F 205	A written copy of the bed hold was mailed to resident #2 & 7 representatives. On 06/14/2017 Resident # 11 is deceased. All residents are potentially at risk for this and charts have been reviewed for the last 6 months for the need to send out the written notice. Written noticed mailed to resident representative on 06/14/2017 The Bed hold policy was reviewed and deemed appropriate. The form Bed Hold Policy Notification was added to the Hospital/ER transfer checklist/pack. Education was provided to staff on 06/13/2017 regarding this written notice. DON or designee will ensure and monitor compliance. All bed holds will be audited	

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F 205	Continued From page 8 exceeds a total of 15 days the resident will be discharged. . . ." The Bed Hold Policy has a place on the bottom of the form for the Resident or Family Member/Responsible Party to sign and date. - Review of Resident #2's record occurred on all days of survey. The facility transferred Resident #2 to the hospital on September 16, 2016. A nursing progress note, dated 09/16/16, confirmed the wife was notified verbally of a bed-hold. During an interview at 3:25 p.m. on 05/23/17, a social worker (#3) stated the facility did not provide a written bed-hold notice. - Review of Resident #7's record occurred on all days of survey. The facility transferred Resident #7 to the hospital on 04/19/17 and 05/02/17. Nursing progress notes stated the following: 04/20/17 10:55 a.m. "Called and spoke to [Resident #7's wife] . . . bed hold. She would like to have his bed held . . ." 05/03/17 8:10 a.m. " . . . She does want the bed hold in place again. " During an interview on 05/23/17 at 4:25 p.m., an administrative staff nurse (#1) stated the facility requires the bed-hold form signed on admission and verbal consent is requested with each hospitalization. - Review of Resident #11's record occurred on May 24-25, 2017. The facility transferred Resident #11 to the hospital on 05/03/17. A nursing progress note, dated 05/03/17, stated, "Spoke with [name of Resident #11's wife], she did state she wishes to hold his room here while he is away." During an interview at 4:25 p.m. on 05/24/17, an administrative staff nurse (#1)	F 205	for 2 months; then weekly audit x1 months; then quarterly x 3. Audits will consist of the use of all transfers out and monitoring progress notes to assure proper forms have been completed. Audits began 06/14/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017 who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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F 205	Continued From page 9 stated the facility did not provide a written bed-hold notice.	F 205		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F 225		6/30/17

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F 225	Continued From page 10 reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff notified the State Survey Agency within 24 hours of a possible misappropriation of property for 1 of 1 allegation reviewed (Resident #16). Failure to notify the State survey agency of a possible misappropriation of property placed all residents at risk for future loss of personal property.	F 225	Resident #16 chart reviewed no need for further action All residents are potentially at risk and all reports have been reviewed. Policy Abuse Prevention Plan for Nursing Homes has been reviewed and updated to reflect a manager on duty weekends and holidays and to notify immediately. Managers were trained on 06/01/2017 on	

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F 225	Continued From page 11 Findings include: Review of the facility policy title "Abuse Prevention Plan for Nursing Homes" occurred on 05/23/17. This policy, dated 08/16/16, stated, " . . . b. When there is reasonable suspicion of a crime against a resident that does not result in serious bodily injury, the covered individual(s) will notify law enforcement and the Secretary of Health & Human Services no later than 24 hours after forming the suspicion. . . ." Facility staff identified Health & Human Services refers to the State Survey Agency. Review of the facility allegations occurred on 05/24/17 at 4:00 p.m. with Social Service staff member (#3). A form titled "Elder Justice Act-Reporting Suspicion of a Crime" identified a crime on 06/11/16. This form identified the following regarding Resident #16 " . . . Said she had 90$ and now only has 20$. States she's missing 70$ out of her wallet. . . " A progress note, dated 06/13/16 stated, "Report submitted to Dept of Health and Human Services electronically." The facility completed an investigation on 06/13/16 and informed the McLean County Sheriff's Department of the missing money. During an interview on 05/24/17 at 4:10 p.m., a Social Service staff member (#3) stated staff reported the missing money on Saturday, 06/11/16 . She further stated on the weekends a report is completed and left in her work box for her to follow-up on Monday, as she does not	F 225	the proper procedure if notified. Education was provided to staff on 06/02/2017 to ensure understanding of the policy Abuse Prevention Plan for Nursing Homes and where to locate the Manager on call schedule. DON or designee will ensure and monitor compliance. Audits will be conducted weekly x 2 months then monthly x 1 months; then quarterly x 3. Audit will consist of all reports of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. Audits began 06/05/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance Team beginning 06/22/2017 who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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F 225	Continued From page 12 work on the weekend and has no back up to report this type of allegation.	F 225		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accommodate the needs for 1 of 3 sampled resident (Resident #5) requiring assistive devices. Failure to apply a soft neck brace and place bunny boots on a Resident placed the resident at risk for improper posture and skin breakdown. Findings include: Review of Resident #5's medical record occurred on all days of survey. Diagnoses included muscle weakness and abnormalities of gait and mobility - unable to balance. The current care plan stated, " . . . Skin: I am at risk for skin breakdown due to immobility, incontinence and hx [history] of falls. . . . Approach: I have a soft foam cervical collar that is to placed when I am up in my w/c [wheelchair] and removed when I am eating or laying down. . . . bunny boots when in bed . . ." A nursing progress note, dated 02/27/17, stated,	F 246	Neighbor # 5 was assessed and no issues noted that need to be reported to MD or family. All neighbors are potentially at risk for this and education has been provided to staff on 06/13/2017 regarding assistive devices and care sheets. All care sheets and care plans have been reviewed for accuracy. The implementation of a sign off sheet was implemented for all neighbors with assistive devices. DON or designee will ensure and monitor compliance. 2 audits will be conducted per week x4 weeks; then 1 audit per week x 4 weeks; then 2 audits a month x1 months; then quarterly x 3. Audits will consist of direct observation of residents with devices. Audits will began 06/19/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/ 22/2017 who will recommend	6/30/17

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F 246	Continued From page 13 "Neighbor's sister, [sister's name], brought soft neck brace from [name of clinic]. [Resident #5's name] agreeable to trial soft neck brace at this time per Dr. [name]. PT [Physical Therapy] placed soft neck collar allowing for 2 finger widths between collar and skin to allow for comfortable and proper fit. She is to have it on when sitting up in w/c and off when laying down at night. . . ." Observation on initial tour on 05/22/17 at approximately 9:45 a.m. showed Resident #5 out of her room and the soft neck brace on her dresser. Observation on 05/22/17 at 3:40 p.m. showed two certified nursing assistants (CNAs) (#6 and #12) assisted Resident #5 out of bed and into the wheelchair. The CNAs failed to apply the soft neck brace. The resident's chin rested on her upper chest area. Observation during the daytime on 05/23/17 showed Resident #5 up in her wheelchair and without the soft neck brace in place. The resident's chin rested on her upper chest. Observation on 05/24/17 at 10:30 a.m. showed Resident #5 in an activity with her soft neck brace in place. With the collar in place, the resident's head position was maintained in an upright position. During an interview on 05/25/17 at 10:55 a.m., a supervisory nurse (#1) stated the resident's soft neck brace went to laundry on Tuesday 05/23/17, and she was not sure why the resident did not have it in place on Monday 05/22/17.	F 246	changes and on-going monitoring/auditing after analysis. Completion date June 30, 2017	

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F 246	Continued From page 14 During an interview on 05/25/17 at 11:00 a.m., a physical therapist (#11) stated Resident #5's soft neck brace needs to be in place when up in her wheelchair as directed by the physician. The IDT [Interdisciplinary Team] decided it should be remove at meal time. Observations on 05/22/17 at 1:00 p.m. and 05/23/17 at 12:30 p.m. showed Resident #5 laying in bed and staff failed to apply the bunny boots to the resident's feet.	F 246		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: NEUROLOGICAL CHECK 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards/facility policy for 2 of 5 sampled residents (Resident #2 and #5) who experienced falls. Failure to complete neurological assessments following a fall has the potential for a head injury to go undetected. Findings include: Review of facility policy titled "Neurochecks"	F 281	NEURO CHECKS: Resident # 2 received a neurological assessment on 06/12/2017. No issues noted. Resident # 5 received a neurological assessment on 06/12/2017 No issues noted. All neighbors who have had an unwitnessed fall are potentially at risk and all neighbors that had an unwitnessed fall during the last 3 months and did not have a neurological assessment received a neurologic assessment. The policy Neurochecks	6/30/17

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F 281	Continued From page 15 occurred on 05/25/17. This undated policy, stated, "Anytime someone falls and hits their head or is suspected to have hit their head, neurochecks should be completed. The initial neurocheck . . . is documented under the fall event. Four subsequent neurochecks are completed and documented under the neuro-checks observation . . . [do neurological checks] at the fall, 4 hours after the fall, 4 hours after last check, 8 hours after last check, and 8 hours after last check. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included long term current use of anticoagulants (blood thinners) and Parkinson's disease. The significant change Minimum Data Set (MDS), dated 09/24/16, identified a history of falls in the last one to six months. The resident's current care plan stated, ". . . I am at risk for falls due to dx [diagnosis] of Parkinson's disease, unsteady gait, use of high-risk meds and hx [history] of falls. I will maintain my maximum level of functioning and be free from injury. . . ." Review of Resident #2's progress notes identified the following: * 01/03/17 at 6:30 a.m., ". . . was found on the floor bedside [sic] his bed. He was lying face down. Noted left eye is swollen and bruised. . . . Bridge of his nose is reddened. No deformity. . . . PERRLA [pupils equal round and reactive to light accommodation] . . ." * 01/03/17 at 12:12 p.m., ". . . order to send to ER [emergency room] for x-ray to right hand . . ." * 01/03/17 at 12:30 p.m., ". . . Wife did request once we got over there to have them check his head out also (not just x-ray [of] his hand/wrist) . .	F 281	has been reviewed and deemed appropriate. Staff were educated on 05/30/2017 regarding neuro checks, when to assess and how to properly document to ensure understanding of the neurological assessment. A checklist was created to assist licensed nursing staff to properly complete all aspects of a fall. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 2 weeks; then 2 audits a week x 2 weeks; then 2 audits a month x 2 months; then quarterly x 3 months. Audits will consist of the use of all fall event forms and monitoring progress notes from the event to assure proper documentation and assessments. Audits began 06/06/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017 G TUBE Resident # 7 was reviewed on 06/01/2017 with MD and no further interventions needed at this time. One other neighbor who has a gastrostomy tube is potentially at risk for this and was reviewed on 06/01/2017 with MD. No interventions needed. Education was provided for all licensed nursing personnel on 06/01/2017 to ensure the understanding of the policy regarding peg tube feedings/medications. Education consisted of the written policy,	

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F 281	Continued From page 16 ." * 01/03/17 at 2:29 p.m., ". . . returned to facility . . . from ER . . . x-ray done to his facial bones . . . no fracture . . . will continue to monitor . . ." * 01/03/17 at 3:26 p.m., ". . . Neighbor was having periods of apnea and gurgling respirations in between. . . . Neighbor does have swelling to his left eye from fall last night and is on Coumadin [blood thinner]. . . . Was over to the ER earlier today and they did x-ray [of] his facial bones but did not do a CT [computerized tomography scan] of his head . . . [neurological checks done by nursing] . . . Neighbor did arouse when talked to but was in and out of the conversation. . . . Will continue to monitor neighbors status . . . . [physician] did offer that if wife wants a CT of his head [it could be done] . . . [Resident #2] could have a slow bleed. . . . [wife] doesn't want extreme measures done and she is ok with continuing to monitor him here [nursing home]. . . ." * 01/03/17 at 5:53 p.m., ". . . neuro checks are WNL [with in normal limits] . . . " * 01/04/17 at 8:43 a.m., ". . . Neuro Checks are still WNL . . ." Review of the neurological checks flow sheet identified the second neuro check set was completed on 01/03/17 at 3:30 p.m. Facility staff failed to assess and document Resident #2's neurological status at the time of the fall [6:30 a.m.], 4 hours after the fall [10:30 a.m.], and 16 hours after the fall [10:30 p.m.] with a known bruise to his left eye and nose. The last neuro check was documented in the progress note, but not in the neurological check flow sheet.	F 281	questions and answers. New licensed nursing staff will receive education regarding policy and procedure during new employee orientation. DON or designee will ensure and monitor compliance. 3 audits will be conducted per week x 2 weeks; then 1 audit a week x 2 weeks; then 2 audits a month x 2 months; then quarterly x 3. Audits will consist of direct observation of licensed nursing administering medication. Audits began 06/07/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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F 281	Continued From page 17	F 281		

On the morning of 05/25/17, an administrative nurse (#1) confirmed staff are expected to perform neuro checks as per facility policy and staff failed to complete all the required neurological checks for Resident #2.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, muscle weakness and abnormalities of gait and mobility- unable to balance. The current care plan stated, ". . . I am at risk for falls due to unsteadiness with transferring, generalized weakness, impulsivity, . . . and hx of falls with fracture."

The nursing progress notes stated the following:
* 08/20/16 - 8:15 a.m."CNA (certified nursing assistant) stated to this nurse that neighbor was on floor in her room, neighbor stated she was trying to put on a stocking, but already had stocking on. . . . alert and oriented x2, lifted of (sic) floor with a mechanical lift, assessed neighbor observed 3 cm (centimeter) bump on L [left] forehead, L knee 1 1/2 cm abrasion, R [right] knee 2 cm abrasion . . . Notified [name of nurse practitioner] on call, she stated to observe and do neuro checks, if any changes call her. . . ."
* 08/21/16 - 12:10 a.m. "Neighbor was woken for neuro checks. Wakes easily. Responds appropriately. . . . Moves all extremities per her normal (sic). . . . Has a bump to her left forehead. . . ."
* 08/21/16 - 3:46 p.m. " . . . Neuro checks remain WNL . . ."

During an interview on 05/23/17 at 11:15 a.m., an administrative nurse (#1) stated Resident #5's neuro checks were documented in the progress

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notes as staff did not open a computerized event report.

The medical record lacked evidence of neuro checks at four, eight, and 24 hours after the fall.

ADMINISTRATION OF MEDICATIONS VIA GASTROSTOMY TUBE

2. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide care and services according to professional standards of practice for 1 of 2 observations (05/22/17) of medications administered via a gastrostomy tube (g-tube). Failure to administer medications according to professional standards has the potential to cause the feeding tube to plug or the resident to receive an incorrect dosage of medication.

Findings include:

Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education Inc., New Jersey, page 778 - 780, stated, ". . . Avoid leaving prepared medications unattended. . . . Do not administer whole or undissolved medications because they will clog the tube. . . . If you are giving several medications, administer each one separately and flush with at least 15 to 30 ml [milliliters] of tap water between each medication. . . ."

Observation on 05/22/17 at 3:58 p.m. showed a licensed nurse (#13) crushed three medications together and obtained two liquid medications for administration via g-tube. The nurse knocked on

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F 281	Continued From page 19	F 281		

Resident #7's open door and stated, "He said, Do not come in." The nurse returned to the medication room, poured water into the crushed medications, stirred the medications, and set the unlabeled medications on the counter. At 5:08 p.m. the nurse (#13) obtained the medications, entered Resident #7's room, checked the g-tube for residual, flushed the tube with water, and administered the liquid medications. The nurse poured half of the crushed medications into the syringe and the medication did not flow into the g-tube. The nurse tried to shake the syringe and emptied the medication mixture back into the water cup and stated it is "too thick." The nurse examined the syringe, noted the tip of the syringe was clogged, added water to the syringe, and in an attempt to unclog the tip of the syringe sprayed the water and medication mixture in the room. The nurse attempted to administer the remainder of the medications by pushing the medications into the g-tube and stated, "I think I plugged it up." The nurse manually squeezed the tubing of the g-tube to push the medication mixture in. The nurse flushed the tube with water and completed the administration of the crushed medications.

A physician's order, dated 05/22/17, stated, "May crush and combine medications to administer via peg tube."

During an interview on 05/25/17 at 10:55 a.m., a nursing supervisor (#1) stated she expected staff to administer medications via g-tube soon after combining the medications with water, not allowing the medications to sit for an hour, and not pour medications out of the syringe and re-administer the medication.

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 309		6/30/17

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F 309	Continued From page 21 by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 1 of 10 sampled residents (Resident #7) who received as needed (PRN) bowel medications. Failure to implement less invasive interventions to manage constipation may have resulted in Resident #10 receiving unnecessary suppositories. Findings include: Review of the facility policy titled "Bowel Monitoring and Interventions Policy" occurred on 05/25/17. This undated policy stated, " . . . 3. Should a resident go two (2) days without 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. . . ." Physicians Standing Orders included Milk of Magnesia (MOM), Ducolax Suppository and Fleets enema PRN. Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and constipation. Medications included MOM and Ducolax suppository PRN. Review of Resident #7's medication administration record from March 01 - April 30 2017, identified the resident received a Ducoloax suppository seven times. Staff failed to first administer MOM as per policy. During an interview on 05/25/17 at 10:55 a.m., an	F 309	Resident #7 was reviewed and has had no further episodes of constipation. All neighbors are potentially at risk for this and charts have been reviewed for the need to address constipation. Audit was completed on 06/09/2017 on PRN suppository use and appropriateness. No issues were identified Standing orders were reviewed Education was provided to staff on 06/09/2017 regarding the Bowel monitoring and interventions policy. to ensure understanding of the policy.. Education consisted of the bowel monitoring and intervention policy. New licensed nursing staff will receive education regarding policy and procedure listed above during new employee orientation. DON or designee will ensure and monitor compliance. 1 audit will be conducted per week x 4 weeks; then 2 audits a month x 2 months; then quarterly x 3. Audits will consist of monitoring the use of PRN medications for constipation from the Medication Administration Record. Audits began 06/15/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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F 309	Continued From page 22 administrative staff nurse (#1) stated she expected staff to administer MOM before using a Ducolax suppository.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a safe environment for 1 of 4 sampled residents (Resident #1) who eloped from the facility. Failure to monitor and provide for a safe environment placed the resident at risk	F 323	Resident #1 wander guard was checked for expiration date (10/31/2017) and tested on 06/05/2017. All residents with wander guards were checked for expiration date and function	6/30/17

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F 323	Continued From page 23 for injury. Findings include: Review of the facility policy titled "Elopement/Missing Person Procedure" occurred on 05/25/17. This policy, revised April 2017, stated, "The safety and well-being of all neighbors is ensured . . . Appropriate action will be taken to assure the location of all neighbors. . . . A wander guard system and door alert system is in place. Placed wander guard devices are checked . . . Test results are documented and shared with the Interdisciplinary Team (IDT) . . . . A review of Neighbors and appropriateness of wander guard placement are reviewed by IDT weekly. . . . Following an elopement, the nurse shall . . . [evaluate] the incident and need for a wander guard will be reassessed at time of next weekly IDT meeting. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The resident's annual Minimum Data Set (MDS), dated 09/24/16, identified severe cognitive impairment. The resident's current care plan stated, ". . . displayed the following behavioral symptoms: wandering . . ." The physician orders dated 07/09/2016, stated, "Check wander guard placement daily". The Monthly Guard Checklist, dated 10/14/16 identified Resident #1's wander guard had a manufacture expiration date of November 2015. Review of Resident #1's progress notes identified the following: * 10/20/16, stated, "IDT met to review appropriateness of sunflower neighborhood	F 323	on 06/05/2017. Procedure for checking the placement and function of wander guards and been reviewed and updated to reflect a daily check of function and placement. The monthly wander guard checklist for expiration has been reviewed and is current. Education was provided for all licensed nursing personnel on 06/05/2017 to ensure understanding of the policy and procedure The monthly wander guard checklist. DON or designee will ensure and monitor compliance. 5 audits will be conducted per week x 4 weeks; then 2 audits a week x 2 weeks; then 1 audit a week x 2 weeks; then 2 audits a month x 1 months; then quarterly x 3. Audits will consist of monitoring the medication administration record and observing the expiration date on wander guard. Audits began 06/12/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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 _____	05/25/2017

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F 323	Continued From page 24 [secured unit] . . . does not wander or seek out exits. IDT believe it would be more appropriate for [Resident #1] to be in the Prairie Rose [unsecured] neighborhood. . . ." * 10/31/16, stated, "[Resident #1] was found walking outside about a block and a half away. Staff brought her back to the facility. She was not aware that she had eloped. She was not injuryed [sic]. . . . Alarm had not gone off. New wander guard alarm put on her. Doors checked with new alarm and it locked the doors. . . ." * 11/01/16, stated, "Elopement reviewed by IDT. . . ." * 11/14/16, stated, "Left building walked 40 feet and staff intervened when alarm sounded. . . ." * 11/22/16, stated, "IDT meeting for appropriateness of neighborhood. . . ." * 11/23/16, stated, ". . . room change . . . had instances where she has exited the building. Alarm sounded and [resident] was redirected back inside by staff . . . it would be best if she goes back to the secured Sunflower neighborhood. . . ." * 12/08/16, stated, ". . . moved back to Sunflower neighborhood where she will benefit from the secured environment. . . ." During an interview on 05/25/17 at 10:27 a.m., an administrative nurse (#1) confirmed the facility had an expired wander guard on Resident #1 during the 10/31/16 elopement. The facility failed to develop an effective intervention to prevent elopement and provide for a safe environment for Resident #1 who exited the building unattended.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		6/30/17

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F 325	Continued From page 25 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to adequately assess the nutritional status, needs, and risk factors, and implement appropriate interventions to restore/maintain sufficient nutritional status for 1 of 5 sampled residents (Resident #7) who experienced severe weight loss. Failure to meet the residents' nutritional needs through diet, supplements, or other interventions may have contributed to the resident experiencing severe weight loss. Findings include: Review of the facility policy titled, "Weight Monitoring and Documentation" occurred on 05/25/17. This policy, revised 2000, stated, "Each	F 325	1. The CDM and Dietician are monitoring weights. Resident #7 receives all nutrition through peg tube feedings and weight will be monitored monthly for 6 months. 2. All neighbors potentially could be affected, all weights reviewed and no follow up is needed. 3. Culinary Directory will monitor weights monthly. Weight changes of 5% in one month, 7.5% in 3 months, or 10% in 6 months will be referred to the Dietician. 4.Completion Date: 6/30/2017 5.The registered dietician did educate the	

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F 325	Continued From page 26 resident's weight is monitored and fluctuations of >5% [greater than] in one month, or >7.5% in 3 months, or >10% over the past six months will be assessed and appropriate individualized dietary interventions and documentation will be implemented. . . . 5. resident weights are tracked monthly through an established monitoring system to ensure that significant changes are identified and addressed. . . . 7a. nursing staff is to verify the accuracy if [sic] the weight change. Reweighs are recommended for residents with a 5 pound or greater change in weight. . . ." Medication reviewed showed Resident #7 started on Megace on 06/10/16 for diagnoses of nutritional deficiency and behaviors. Review of Resident #7's weight record identified the following: 02/09/17 - 186.1 [lbs.] pounds 02/20/17 - 173 lbs. (7% [weight] wt loss in 2 weeks) 03/06/17 - 169 lbs. 03/06/17 - 170.5 lbs. (re-weigh, 8.39% wt loss in 1 month) 03/20/17 - 165 lbs. 03/27/17 - 167.2 lbs. 04/06/17 - 168.3 lbs. 04/10/17 - 167.2 lbs. 04/17/17 - 165 lbs The dietary progress notes from the culinary services director (#2) showed the following: * 02/07/17 8:42 a.m. - ". . . weight tends to fluctuate quite a bit from the 170's to 190's. . . . meal intakes also fluctuate. At this time I have no immediate concerns . . ." * 03/06/17 9:10 a.m. - ". . . ask for a current	F 325	culinary director on how and when to report resident concerns. This training was completed on 6/22/2017. The Culinary Director will be responsible for monitoring weights with monthly audits to assure that weight is stable. Audits will consist of the Culinary Director monitoring weights monthly for six months, weights will be reported immediately to the Dietician. if Weight changes of 5% in one month, 7.5% in three months, or 10% in six months. Quality Assurance/Monitoring will be implemented by 6/30/2017 The Culinary Director will submit a report to the Quality Assurance Team who will recommend changes and ongoing monitoring/auditing after report.	

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F 325	Continued From page 27	F 325		

weight and will monitor another week to be sure all is ok for [Resident #7]. . . . meal intakes have dropped and he is not eating as well as he did before so if weight correct we may need to intervene to prevent further weight loss."
* 03/13/17 1:04 p.m. - "[Resident #7] has lost 15 pounds in 6 months. . . . meal intakes becoming less. . . . seen before depending on medical conditions and what meds [medication] he may be taking. . . . at this time even with the weight loss, [Resident #7] BMI [Body Mass Index] shows him to be overweight so I will not recommend any changes. . . . If we continue to see weight loss and he approaches a level of concern we will add a supplement if needed. . . . weight on 3/6 is 170.5."
* 03/28/17 8:24 a.m. - "current weight on 3/27 is 167.2, 3 mos [months] ago on December 29th weight was 181.5. This is a loss of 14.3 pounds or 7.88%. [Resident #7] intakes have dropped considerably . . . According to BMI scores he is still overweight however should continue to lose weight we will look at adding a health shake with meals."
* 04/11/17 8:13 a.m. - "current weight on 4/10 was 167.2, according to BMI he is still overweight, should he continue to lose we may need to add health shakes with meals for needed nutrition."

The Culinary service director (#2) had not consulted the [RD] registered dietitian for 55 days regarding the severe weight loss of Resident #7.

* 04/14/17 1:23 p.m. - ". . . reached out to the dietician [sic] for review and recommendations . . ."
* 04/15/17 8:49 a.m. - "weight on 3/27 was 167.2.

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F 325	Continued From page 28 12/29 weight was 181.5. BMI is at 28.5, neighbor is at risk for further weight loss. Referral was given to dietician [sic]." * 04/24/17 12:32 p.m. - "weight on 4/17/17 was 165 weight 6 mos on 10/17/16 was 185.2. [Resident #7] meal intakes are at 26-50%." The progress notes from 01/19/17 to 05/10/17 lacked involvement by the RD [registered dietitian]. During an interview on 05/23/17 at 10:00 a.m. the dietary supervisor (#2) stated Resident #7 is not underweight from a BMI standpoint. During an interview on 05/25/17 at approximately 10:00 a.m. a culinary services director (#2) stated the RD comes once a month and then as needed. The facility policy titled "Weight Monitoring and Documentation Policy" failed to identify BMI as a suggested guideline for weight concerns. Failure to regularly include the RD in Resident #7 nutritional assessment may have resulted in unnecessary weight loss due to lack of interventions.	F 325		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 327		6/30/17

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F 327	Continued From page 29 (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide fluids to maintain proper hydration for 2 of 3 sampled residents (Resident #5 and #6) who require staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance/encouragement with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy/procedure titled, "Hydration" occurred on 05/25/17. This undated policy stated, ". . . POLICY. . . All staff will offer and encourage fluids as a part of daily interactions with residents, unless fluids are restricted. . . PROCEDURE . . . 3. Risk Factors for the resident becoming dehydrated are: . . . e) Functional impairments that make it difficult to drink, reach fluids, communicate fluid needs, or dependence on staff for the provision of fluid intake f) Cognitive deficits where residents forget to drink or forget how to drink g) Frequent refusal of fluids, or limited fluid intake h) Dysphagia . . . 7. . . b) Approaches to increase hydration level are identified to reduce those risk factors and ensure adequate fluid intake . . . Fluids are available and/or offered/encourage during and between meals. Staff assisting or cuing resident to drink . . . " - Review of Resident #6's medical record occurred on all days of survey. Diagnoses	F 327	Resident # 6 was assessed for dehydration on 06/01/2017. No issues were noted Resident # 5 was assessed for dehydration on 06/01/2017. No issues were noted. All residents are potentially at risk for this and residents that have been identified on the hydration list have been assessed with no issues noted. Residents are placed on the hydration list per Culinary Manager or Dietician. They monitor daily fluid intake and well as the resident's estimated needs based on age, weight, activity level, any recent injuries or UTI's at least quarterly. They also review progress notes to determine if there are any signs of dehydration quarterly. The policy titled hydration has been reviewed and is deemed appropriate. Education to staff was provided on 06/01/2017 regarding the hydration policy and offering fluids after cares to ensure understanding. Staff was educated on physically assisting residents that are not eating or drinking at meal time. DON or designee will ensure and monitor compliance. 2 audits will be conducted per week x 4 weeks; then 1 audit a week x4 weeks; then 2 audits a month x 1 months then quarterly x 3. Audits will consist of monitoring fluid intake on the residents that have been identified as at risk for dehydration. Audits began	

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F 327	Continued From page 30 included dementia and constipation. A quarterly Minimum Data Set (MDS), dated 04/30/17, identified moderately impaired cognition and a problem with long and short term memory, sometimes understands others, and extensive assistance of one person with eating. Resident #6's current care plan stated, "Problem CULINARY - I need a special diet and sometimes I need help at meals because I have memory problems. I don't drink enough . . . Approach: . . . Please help me set up my meals. offer me assistance and encouragement at meals. I may need to be reminded that it is meal time. I am on the hydration list. please watch me for any signs of dehydration. . . ." Observation on 05/22/17 at 3:20 p.m. showed certified nursing assistants (CNAs) (#5 and #6) assisted Resident #6 to the bathroom. After the CNAs provided care they assisted her back into the wheelchair and transported the resident to the TV area. The staff failed to offer the resident any fluids. Observations and interviews during the day on 05/23/17 showed the following: *9:05-9:25 a.m., A CNA (#10) sat at the table next to the resident and verbally cued and physically assisted with eating and drinking. Resident #6 drank 600 milliliters (ml) (20 ounces) of fluids. *11:35 a.m., An interview with a CNA (#10), when asked about care provided to the resident during the morning, she stated, "I gave [Resident #6] a sip of water" this morning. *11:35 a.m.-12:30 p.m., a CNA (#8) sat at the table next to the resident. During the meal the	F 327	06/09/2017. Analysis of the observations and facility's compliance will be presented to our Quality Assurance team beginning 06/22/2017, who will recommend changes and ongoing monitoring/auditing after analysis. Completion date June 30, 2017	

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F 327	Continued From page 31	F 327		

CNA stated, "you should eat" and "it would make me happy if you would eat." The CNA failed to physically assist or hand a glass to the resident. The resident drank none of her fluid and none of her supplement.
*12:55 p.m., two CNAs (#7 and #8) attempted to assist the resident to the bathroom, but the resident refused to stand up from the wheelchair. One CNA (#7) stated, "They will try later." The other CNA (#8) handed the resident a glass of water from the bedside table and she took one sip. The CNA did not encourage the resident to drink more from the glass.
*4:25 p.m., An interview with a dietary aide (#9) regarding afternoon snacks, reported Resident #6 does not have a scheduled snack.

Review of Resident #6's vitals report for the last month (04/23/17 - 05/22/17) showed facility staff documented meal intakes of fluid of less than 120 ml (4 ounces) 45 times. Observations during the survey showed the fluids consisted of cocoa, juices/lemonade, water, and milk. Review of Resident #6's vitals report, dated 05/23/17, identified 120 ml (4 ounces) of fluid and 26-76% of supplement consumed at the evening meal.

During an interview on the afternoon of 05/24/16, an administrative nurse (#1) reported she would expect staff to offer fluids with each interaction with a resident.

Observations showed when staff offered/or assisted Resident #6 to drink she consumed larger intakes than without assistance.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses

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F 327	Continued From page 32 included supranuclear palsy (deterioration of the brain) and dysphagia (difficulty swallowing). An annual MDS, dated 04/15/17, identified moderately impaired cognition and extensive assistance of one person with eating. Resident #5's current care plan stated, "Problem CULINARY . . . I need help at meals. I have swallowing difficulties . . . I don't drink adequately . . . Approach: . . . I need assistance with meals. Set up my meals for me. . . . Hydration list. Please make sure I have fluids available within my reach. Offer/encourage me to drink during the day. Watch for signs of dehydration and report them to the nurse right away. . . ." Observation on 05/22/17 at 3:40 p.m. showed two CNAs (#6 and #12) assisted Resident #5 out of her bed and into the wheelchair. One CNA (#12) offered water to the resident, however the other CNA (#6) declined and stated she would take Resident #5 to dining room and provide a diet coke. Resident #5 arrived at dining room at 4:00 p.m. and staff offered no fluids at this time. Staff failed to provide Resident #5 fluids until 5:07 p.m. when an unidentified CNA assisted the resident with her evening meal.	F 327		
F 371 SS=B	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		6/30/17

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F 371	Continued From page 33 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 kitchen. Failure to clean fans of dust and debris and failure to maintain the insulation covering fan pipes has the potential to cause contamination of food. Findings include: Observation during the initial kitchen tour, on 05/22/17 at 9:25 a.m., showed a heavy accumulation of black dust/debris on the fan in the walk-in cooler. Observation also showed fiberous insulation hanging from the pipe leading to the fan. The fan and pipe are positioned over shelving units containing food. The main tour of the kitchen occurred on	F 371	1. No adverse effects resulted to any neighbors in the facility as a result of fans with dust and debris on them or as a result of visible insulation covering fan pipes in the walk in cooler. 2. All neighbors who consume food from the kitchen had the potential to be effected. 3.All fans used in the culinary department were cleaned on 5/26/2017 and were placed on a weekly cleaning schedule. Employees received education on the weekly cleaning process 6/15/2017. The insulation in the walk in cooler has been properly covered on 6/15/2017 with	

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F 371	Continued From page 34 05/25/17 at 9:45 a.m. with an administrative dietary staff member (#2). Observation showed the heavy accumulation of dust/debris remained on the fan in the walk-in cooler, as well as the fiberous insulation from the pipe. Observation showed an accumulation of dust and debris on a fan positioned directly over clean dishes by the dishwashing sink and also on another fan in the dishwashing room. During the kitchen tour, an administrative dietary manager (#2) confirmed staff should clean the fans.	F 371	foam wrap. Culinary director will audit the insulation monthly for 6 months to ensure that the solution used is durable and maintains compliance. 4. Completion date: 6/30/2017 5. The Culinary Director will audit the cleanliness of the fans weekly for 6 months and then monthly for 6 months and submit a report of this monitoring to the Quality Assurance team beginning June 2017, who will recommend changes and ongoing monitoring/auditing after report	