STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 07/22/19 and concluded 07/25/19.	F 000		
F 550 SS=C	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		8/30/19

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

Electronically Signed | 08/09/2019

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care and services in an environment and manner that enhanced dignity during 2 of 2 meals observed (07/22/19 and 07/23/19 evening meals). Failure to serve each resident seated at the same table at the same time does not preserve each resident's dignity or enhance their quality of life. Findings include: The facility failed to provide a copy of their policy addressing treating residents in a dignified manner as requested by the survey team. - Observation of the evening meal on 07/22/19 showed the following: * At 5:40 p.m. - Table #1 consisted of three residents sitting at the table, with only one of the three residents receiving their meal. The last resident was served his/her meal at 5:56 p.m., 16 minutes later. * At 5:40 p.m. - Table #2 consisted of four residents sitting at the table, with only one of the four residents receiving their meal. The last resident was served his/her meal at 5:58 p.m., 18 minutes later. - Observation of the evening meal on 07/23/19	F 550	A policy for meal services was created on 8/7/19. The policy aims to create an environment in which residents are served timely meals in a dignified manner. All residents that eat in the dining room have the potential to be impacted by this alleged deficient practice. Mandatory education on the new policy will be provided for nursing and dietary staff on 8/13/19 and 8/15/19. The Dietician, or designee, will do routine audits at varying meal times to ensure that the adopted meal serving policy is being followed. These audits will be performed weekly for a period of eight weeks, and then monthly for a minimum of ten months or until one hundred percent compliance has been achieved. Compliance will be achieved when nursing and dining staff can work together to ensure that residents that join a table that has already been served will receive their meal within 5 to 8 minutes of being seated. The results of these audits will be presented quarterly to the QA committee.	

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F 550	Continued From page 2 showed the following: * At 5:40 p.m. - Table #1 consisted of four residents sitting at the table, with only one of the four residents receiving their meal. The last resident was served his/her meal at 5:58 p.m., 18 minutes later. * At 5:41 p.m. - Table #2 consisted of six residents sitting at the table, with only one of the six residents receiving their meal. The last resident was served his/her meal at 6:04 p.m., 23 minutes later. * At 5:46 p.m. - Table #3 consisted of three residents sitting at the table, with only one of the three residents receiving their meal. The last resident was served his/her meal at 6:03 p.m., 17 minutes later. * At 5:43 p.m. - Table #4 consisted of four residents sitting at the table, with only one of the four residents receiving their meal. The last resident was served his/her meal at 5:57 p.m., 14 minutes later. * At 5:41 p.m. - Table #8 consisted of four residents sitting at the table, with only one of the four residents receiving their meal. The last resident was served his/her meal at 5:53 p.m., 12 minutes later. * At 5:46 p.m. - Table #10 consisted of two residents sitting at the table, with only one of the two residents receiving their meal. The last resident was served his/her meal at 6:05 p.m., 14 minutes later. The first resident finished his/her meal before the other resident received theirs. During an interview on 07/25/19 at 10:06 a.m. , the dietary manager (#6) stated trays are served by first come first serve basis, except if the resident has a yellow ticket. If a resident has a yellow ticket they are served first due to being a	F 550		

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F 550	Continued From page 3 diabetic on insulin. The dietary manager stated the tables are broken down into assistive/independent tables and those requiring more assistance are served at the end.	F 550		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		8/30/19

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F 623	Continued From page 4 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 5 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide residents or their representatives and the State Long Term Care (LTC) Ombudsman a written notice of transfer/discharge as soon as practicable for 8 of 8 residents (Resident #2, #5, #25, #26, #67, #75, #81, and #88) transferred/discharge from the facility. Failure to provide notices of transfer/discharge does not allow residents to make informed decisions or inform the Ombudsman of all transfers/discharges. Findings include:	F 623	Policy was developed on 8/6/19 to include emergent and non-emergent transfers, discharges to home and other facilities, resident and facility initiated. All residents that have had a transfer or discharge from the facility have the potential to be impacted by the alleged deficient practice. Mandatory education will be provide to License Social Workers & all Licensed Nursing staff on August 15, 2019. Education provided includes updated	

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F 623	Continued From page 6 - Review of Resident #2's medical record occurred on all days of survey and identified a transfer to the emergency room and subsequent hospital admissions on 12/08/18, 12/28/18, and 04/29/19. The record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #5's medical record occurred on all days of survey and identified a transfer to the emergency room and subsequent hospital admissions on 04/29/19. The record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #25's medical record occurred on all days of survey and identified a transfer to the emergency room and subsequent hospital admissions on 04/19/19 and 06/25/19. The record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #26's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admissions on 02/25/19, 04/12/19, and 05/29/19. The record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #67's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admission on 03/16/19. The record lacked evidence the facility completed a transfer form and/or sent a copy to the ombudsman.	F 623	policies, transfer form, instructions for completeness. Packets will be made up and stored at the nurses stations for off hour□s transfers. LSW will follow up on the next business day to ensure the proper paper work was completed. If not completed it will be completed at that time. Copies of the transfer paper work will be stored in social services office monthly. At months end, copies will be faxed or e-mailed, to the state ombudsman. Director of Nursing, or designee, will monitor transfers/discharges to ensure proper notification has been completed. Monitoring will be done weekly for a period of eight weeks, monthly for a period of four months, and then quarterly for a minimum of two quarters, or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	

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F 623	Continued From page 7 - Review of Resident #75's medical record occured on all days of survey and identified a transfer to the emergency room that resulted in a hospital admission on 04/20/19. The medical record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #81's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admissions on 01/31/19 and 06/17/19. The record lacked evidence the facility completed transfer forms and/or sent copies to the ombudsman. - Review of Resident #88's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admission on 04/22/19. The record lacked evidence the facility completed a transfer form and sent a copy to the ombudsman. During an interview on 07/24/19 at 3:19 p.m., an administrative nurse (#5) stated only residents discharged from the facility receive transfer forms. During a second interview at 4:33 p.m., the administrative nurse (#5) confirmed Resident #26, #67, and #81's records lacked transfer notices.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		8/30/19

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F 625	Continued From page 8 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; (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 (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(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 (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon transfer to the hospital for 6 of 8 sampled residents (Resident #2, #5, #25, #26, #67, and #88). Failure to provide the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: - Review of Resident #2's medical record occurred on all days of survey and identified a	F 625	Policy was revised on 7/31/19 regarding bed hold. All resident that have had a transfer or discharge from this facility have the potential to be impacted by this alleged deficiency. Mandatory education will be provide to License Social Workers & all Licensed Nursing staff on August 15, 2019. Education provided includes updated policies, bed hold form, instructions for	

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F 625	Continued From page 9 transfer to the emergency room and subsequent hospital admissions on 12/08/18, 12/28/18, and 04/29/19. The record lacked evidence the facility completed bed hold notices and/or provided Resident #2 with the information. - Review of Resident #5's medical record occurred on all days of survey and identified a transfer to the emergency room and subsequent hospital admissions on 04/29/19. The record lacked evidence the facility completed bed hold notices and/or provided Resident #5 with the information. - Review of Resident #25's medical record occurred on all days of survey and identified a transfer to the emergency room and subsequent hospital admissions on 04/19/19 and 06/25/19. The record lacked evidence the facility completed bed hold notices and/or provided Resident #25 with the information. - Review of Resident #26's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admissions on 02/25/19, 04/12/19, and 05/29/19. The record lacked evidence the facility completed bed hold notices and/or provided Resident #26 with the information. - Review of Resident #67's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admission on 03/16/19. The record lacked evidence the facility completed a notice of bed hold notice and/or provided Resident #67 with the information.	F 625	completeness. Packets will be made up and stored at the nurses stations for off hour□s transfers. LSW will follow up on the next business day to ensure the proper paper work was completed. If not completed it will be completed at that time. Director of Nursing, or designee, will monitor transfers/discharges to ensure proper notification has been completed. Monitoring will be done weekly for a period of eight weeks, monthly for a period of four months, and then quarterly for a minimum of two quarters, or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	

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F 625	Continued From page 10 - Review of Resident #88's medical record occurred on 07/24/19 and identified a transfer to the emergency room and subsequent hospital admission on 04/22/19. The record lacked evidence the facility completed a notice of bed hold notice and provided Resident #88 with the information. During an interview on 07/24/19 at 4:33 p.m., an administrative nurse (#5) confirmed the residents' records lacked evidence of bed hold notices.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and	F 644	Resident #47 had a level 1 screening submitted to Ascend on 7/31/19. Determination results returned on 8/1/19.	8/30/19

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F 644	Continued From page 11 Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a Resident Review (PASARR) for 1 of 1 sampled resident (Resident #47) with a diagnosis of major mental illness. Failure to complete the PASARR screening may result in the resident not receiving necessary psychiatric services. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #47's medical record occurred on all days of survey. The record identified the facility admitted Resident #47 in April 2017. The record identified Resident #47 demonstrated an angry, demanding, and/or sullen temperament, would charge down the halls, bang on glass, threaten staff, and/or curse/have outbursts. He received a diagnosis of behavioral disturbance/unspecified psychosis in July 2017. The record lacked evidence facility staff completed a PASARR at the time of the	F 644	Diagnosis/chart reviews conducted on all residents for diagnosis added that would trigger re-submission of Level I screenings. One resident was identified. Level I was completed on this resident on 8/5/19 with determination returned on 8/6/19. Policy for Resident Assessment □ Coordination with PASRR Program was reviewed 8/1/19 with no changes. Policy review, Resident Assessment Coordination of PASARR and Assessments Regulations and Interpretive Guidelines education will be provided to Licenses Social Workers, Nursing Management, & Medical Records staff on 8/15/19. Director of Nursing, or designee will perform routine audits after monthly provider visits: Subject will be PASARR Screening updates with the addition of diagnosis that meet criteria. These audits will be done monthly for a period of six months and then quarterly for a minimum of six months or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 12 diagnoses or any time thereafter. During an interview on the morning of 07/25/19, an administrative staff member (#5) confirmed facility staff failed to complete an updated Level I PASARR following Resident #47 behaviors/new diagnosis.	F 644		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of professional reference, the facility failed to ensure staff followed standards of practice for 1 of 2 residents observed during insulin administration (Resident A). Failure to administer rapid-acting insulin within 5-10 minutes of a meal may result in hypoglycemia (low blood sugar). Findings include: Prescribing information for Novolog insulin, found at www.novo-pi.com/novolog.pdf , stated, ". . . NOVOLOG® is rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus . . . Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm. . . ." Observation on 07/23/19 at 5:05 p.m. showed Resident A lying in bed. A staff nurse (#1)	F 658	Chart review conducted on resident #A. No ill effects noted. Blood sugars on 7/23/19 □ 7/24/19 were within acceptable range. HS BS (7/23/19) was 146mg/dl. Scheduled insulin time was adjusted (from 5PM to 5:30PM). All resident using fast acting insulin would have the potential to be impacted by this alleged deficient practice. Mandatory education will be provided on August 15, 2019 to all Licensed Nursing Staff and Medication Assistants regarding diabetes and insulin administration. Skills validation will be completed on insulin injections for licensed nurses and med techs. Insulin dependent residents with short acting insulin orders were identified by dietary by use of yellow paper for menu	8/30/19

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	355084	A. BUILDING _____ B. WING _____	07/25/2019

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F 658	Continued From page 13 administered eight units of Novolog subcutaneously. The resident remained in bed until 5:25 p.m. when a certified nursing assistant (CNA) (#2) assisted Resident A out of bed. The CNA (#2) brought the resident to the dining room where staff served her dinner tray at 5:46 p.m. (41 minutes after insulin administration).	F 658	selection. Dietary and nursing staff (CNA□s and nurses) will be provided training on 8/13/19 & 8/15/19. Director of nursing, or designee, will do routine audits of nursing staff on various shifts. These audits will be completed weekly for a period of eight weeks, then monthly for a period of four months, then quarterly for a minimum of six months or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide activities of daily living (ADL) assistance to 1 of 1 sampled residents (Resident #45) who required staff assistance to apply his glasses. Failure to provide appropriate assistance to residents who cannot independently carry out ADLs may result in decreased visual function. Findings include: Review of Resident #45's medical record occurred on all days of survey. Diagnoses included dementia. The resident's current care plan stated, ". . . Problem/Need . . . Visual	F 677	Care plan for resident #45 was reviewed and updated to reflect that resident removes his glasses and family stated it is best to leave glasses off during times of restlessness. All residents who wear glasses were identified on 7/31/19 via MDS. All care plans were reviewed at this time for the residents identified to wear glasses. Updates completed as necessary. Stickers with an eyeglass picture were added to all care cards on residents identified as needing glasses. Education	8/30/19

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F 677	Continued From page 14 Function: [Resident #45] wears glasses daily. He is able to see adequately to read regular size print in the newspaper or magazines. He enjoys reading farming magazines . . . Approaches Assist him to put on glasses in the morning and take off during times of rest/sleep. . . ." Resident #45's care card, used by certified nursing assistants (CNAs) showed, "Glasses; Yes." A quarterly Minimum Data Set (MDS), dated 06/04/19, identified Resident #45 as needing two or more staff for dressing and personal hygiene and using corrective lenses. - Observation in the dining room on 07/22/19 at 5:17 p.m., showed Resident #45 not wearing glasses. - Observations on all days of survey showed Resident #45 not wearing glasses while seated in his room and in the dining room. During an interview on the afternoon of 7/24/19, when asked if Resident #45 wore glasses, an unidentified CNA stated, "No I do not think so." During an interview on the morning of 07/25/19, a supervisory nurse (#5) agreed Resident #45's should be wearing his glasses.	F 677	regarding this new process and the importance of knowing and updating care plans will be provided to all Certified Nursing Assistants on 8/13/19. Licensed nursing staff will receive similar education on 8/15/19. Director of nursing, or designee, will complete routine audits to ensure that residents with care plans stating that they wear glasses are being followed. These audits will be completed weekly for a period of eight weeks, monthly for a period of four months, and quarterly for a minimum of six months or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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.	F 700		8/31/19

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F 700	Continued From page 15 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to assess a resident's risk of entrapment and attempt alternatives prior to installing a bed rail for 1 of 1 sampled resident (Resident #30). Failure to assess the use of a bed rail prior to installation may have contributed to Resident #30's injuries from the bed rail. Findings include: Review of the facility policy titled "Bed Rail" occurred on 07/25/19. This policy, dated 05/03/19, stated, ". . . The facility will assess all options prior to installing a side or bed rail . . . Assess the resident for risk of entrapment from bed rails prior to installation . . . Review the risk and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation . . ."	F 700	Bed rail assessment was completed on resident #30 on 7/23/19. Risks and benefits reviewed with resident representative on 7/24/19, written consent obtained for continued use of side rails. All residents will have a bed rail assessment completed by 8/31/19. Bed rails that are deemed unnecessary will be removed. Upon terminal cleaning after discharge, the bed rails will be removed if present until a new resident is moved in and the assessment is completed. Education regarding bed rail assessment policy & procedure will be provided to all licensed nurses, CNA's, housekeeping and maintenance staff on 8/13/19 & 8/15/19. Director of Nursing, or designee, will	

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F 700	Continued From page 16 Review of Resident #30's medical record occurred on all days of survey. Observations on all days of survey showed Resident #30's bed rails elevated on one or both sides of the head of the bed. Review of Resident #30 progress notes showed the following: * 07/13/19 at 7:51 a.m - "Resident was found on the floor next to her bed at 5:40am. She had gripper socks on but her legs were still wrapped up in her top sheet from the bed. She was face down into the mattress with her body and legs on the floor as her right arm had gotten stuck in the bed side rail and the mattress. She has a large red area to the right posterior upper arm but denies any pain. . . ." * 07/19/19 at 4:22 p.m. - ". . . [Resident #30] was found early morning beside her bed with her feet tangled in the top sheet from her bed. She has her arm between the siderail and was leaning on the bed. Redness noted to arm at time of incident but no reddness [sic] later. . . COTA [certified occupational therapy assistant] have attempted to complete siderail assessment and she has not been real cooperative. [Resident #30] husband said she uses the siderail and staff also have observed her using it to get in and out of bed. We did have siderail down and were trying to get her to preform [sic] bed mobility but she become upset and will have to try later. A second attempt was done and she would not even get out of her chair to try. . . . Will complete siderail assessment as she allows. . . . Continue all other interventions in place to reduce risk of falls." The record failed to show staff completed an assessment for safety and appropriate use of the	F 700	complete routine audits to ensure that bed rail policy is being followed. These audits will be completed weekly for a period of eight weeks and then monthly for a minimum of ten weeks or until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	

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F 700	Continued From page 17 rails; attempted alternatives to the rails; explained the risks/benefits of the rails, including a risk of entrapment; or obtained consent from the resident/resident representative for the use of the side/bed rails or grab bars prior to the fall incident on 07/13/19.	F 700		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview, the facility failed to ensure 1 of 3 employees reviewed received an annual performance evaluation (Employee #3). Failure to complete performance evaluations on an annual basis does not ensure all staff have the skills and knowledge necessary to meet the needs of the residents. Findings include: Review of certified nursing assistant (CNA) employee files occurred on 07/23/19 and identified Employee #3's hire date as 11/28/12. The most recent performance evaluation was dated 11/08/14. During an interview on the afternoon of 07/23/19, a human resources staff member (#4) confirmed there was not a more recent performance evaluation.	F 730	Skills evaluation was completed on employee #3 on 7/25/19. Skills evaluations will be completed by 8/31/19 on all Certified Nursing Assistants who have been employed by Lutheran Sunset Home greater than 1 year. Payroll will compile a listing of Certified Nursing Assistants anniversary month and send this information to the DON and Nurse Managers on a monthly basis (January list will be sent in December). Evaluations will be completed by the Nurse Managers on a monthly basis. Director of nursing, or designee, will be conducting monthly audits of employee files to ensure timely evaluations are being completed. These audits will	8/31/19

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F 730	Continued From page 18	F 730	continue until one hundred percent compliance has been achieved. The results of these audits will be presented quarterly to the QA committee.	