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 _____	08/28/2014

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 For the standard Medicare/Medicaid recertification survey started on 08/25/14 and completed on 08/28/14, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	Preparation and submission of this plan does not constitute an admission or agreement by the Lutheran Sunset Home of the truth of the facts alleged and shall not be construed in any administrative or judicial form for the purpose of establishing liability of our facility, it's Board of Directors, administration, employees or representatives. This plan is our allegation of substantial compliance.	10-2-14
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial needs of 1 of 4 sampled residents (Resident #7) who experienced a significant decline in status. Failure to provide activities that met Resident #7's individual needs and interests, including one-to-one activities, limited his ability to reach his highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of Resident #7's medical record occurred on August 26-28, 2014. Diagnoses included senile dementia, mild depression, macular	F 248	The care plan for resident # 7 has been reviewed and revised to reflect activities designed to meet his current assessment. . All residents with significant change comprehensive assessments in the last three months will have their care plan reviewed for appropriate activity programs. QA (Quality Assurance) studies will be completed weekly under the direction of the Activities Director until 100% compliance is achieved. After compliance has been achieved, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained. Activity staff will be instructed through in-service education on 9-26-2014 that daily observation of resident "self-directed" activities must be completed by the activity staff prior to documentation of said activity. The observation period will be 7 days prior to an MDS, after a change in the resident's activity program, during any short term illness, and following any event that has the potential to seriously impact the resident's emotional state. QA (Quality Assurance) studies will be completed weekly under the direction of the Activities Director until 100% compliance is achieved. After compliance has been achieved, (QA) studies not less than quarterly will be completed to assure compliance has been maintained.	10-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	9/24/14

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

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F 248	Continued From page 1	F 248		

degeneration, glaucoma, and bilateral mixed hearing loss. The significant change Minimum Data Set (MDS), dated 07/23/14, identified severely impaired cognition, minimal depression, extensive assistance of one person for transfers, and set up help of one person for locomotion on the unit. This MDS identified reading, music, animals, news, groups, favorite activities, outdoors, and religion as very important to the resident.

Resident #7's current activities care plan identified ". . . Have friends that visit often. Asset: Was a missionary and speaks Spanish/English. Declines most facility activities . . . Resident will continue to set his own activity goals and pursue them and ask for help as needed. [Resident's name] will play the piano and listen to his talking books on a daily basis thru next review . . . Friends will take him out for lunch. Friends brought him a large print Bible per our request. Pastor visits. Have showed him where the reading machine is. His interests are: religion, religious music, writing, reading, church (may go out for this), gardening, and farming. Often will mend things on the sewing machine, also is a fixit man, assist as needed. Plays the piano. Loves his talking book machine, mostly listens to his bibile [sic] tapes."

The Care Assessment Area for Activities Notes, dated 07/25/14, stated, ". . . [Resident's name] has had some declines in activities where he is being very forgetful, he has not been playing the piano like he was and thinks he has been, he does say his hands hurt at times. He no longer comes to the activity room daily to read the newspaper like he use [to] nor does he spend as much time in the library but he is out and about

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F 248	Continued From page 2 daily. He kind of wanders around the place. He told me today that he feels ok. We will continue our visits and monitor for any further declines." Observation of Resident #7, his room, and staff interview revealed the following: 08/26/14 *8:05 a.m. - Resident lying in bed. *8:20 a.m. - Certified Nursing Assistant (CNA) (#11) completed cares and resident returned to lying in bed. *10:00 a.m. - Resident lying in bed. *1:40 p.m. - CNA (#11) stated she repositioned resident from wheelchair to recliner at 1:30 p.m. *1:45 p.m. - Resident asleep in recliner. *3:00 p.m. - Resident asleep in recliner. *3:30 p.m. - CNA (#12) stated resident sleeping. *5:00 p.m. - Resident sitting in hallway in wheelchair. *5:30 p.m. - CNA (#12) stated resident sleeping. 08/27/14 *7:45 a.m. - Observation of Resident #7's room showed no television, no radio or talking book machine. Observation showed a hymn book and bibles. *9:00 a.m. - CNA (#13) stated resident is receiving physical therapy. *9:10 a.m. - Resident lying in bed. *10:10 a.m. - Resident lying in bed. Following cares resident returned to lying in bed. *11:05 a.m. - Resident lying in bed. *11:10 a.m. - CNA (#14) stated resident "goes to station (unit) three and takes a snooze." *Approximately 12:30-1:00 p.m. - An Activity Assistant (#16) stated the resident sleeps in his wheelchair after watches birds in library. A CNA (#12) stated the resident sits in his chair by sun room and visits with friend [resident's name] in	F 248		

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F 248	Continued From page 3 room 14. *1:05 p.m. - Resident sleeping in chair on station three. *2:14 p.m. - Resident sitting in recliner in his room. CNA asked resident if he was taking a nap, "a little snoozer." Resident replied "Yes, sir." When interviewed regarding what he does for fun, with his face expressing concentration/effort, Resident #7 stated, "Giving sense to the Lord . . . Teach truth . . . Try do that every day." *2:30 p.m. - Resident sitting in room with lights out. *2:45 p.m. - CNA (#17) stated resident sleeping in chair. *4:00 p.m. - Resident sleeping in chair in room. 08/28/14 *9:00 a.m. - Resident lying in bed with curtains open (birdhouse visible). Resident saw this surveyor and immediately sat up and asked "You want to talk?" Informed resident just checking on him. During an interview on 08/28/14 at 9:00 a.m., a CNA (#13), when asked about Resident #7's participating in activities on 08/27/14, stated, "No not really. Roams and visits with [resident's name] on station one in room 14." When asked if he had visited [resident's name] on 08/27/14, the CNA (#13) stated, "Yes, every day." Review of Resident #7's activity rosters and staff interview with activity aides (#16 and #18) on the afternoon of 08/27/14 identified the following: 08/26/14 3:22 p.m. - Sensory -Animal Therapy (birdhouse outside window) 3:22 p.m. - Indoor/Outdoor - Indoor Wheelchair (wheel self in wheelchair)	F 248		

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F 248	Continued From page 4 3:22 p.m. - Self Directed - Books on Tape (talking books) 3:22 p.m. - Self Directed - Daily Devotions (reading bible) 3:22 p.m. - Self Directed - New Reading (reading newspaper) 3:22 p.m. - Self Directed - Reading (reading book) 08/27/14 5:27 p.m. - Sensory - Animal Therapy 5:27 p.m. - Self Directed - Books on Tape 5:27 p.m. - Self Directed - Daily Devotions 5:27 p.m. - Self Directed - Reading The activity rosters conflict with observations on those days. Review of the 1 to 1's (1:1) (direct interaction of staff with resident) roster showed Resident #7 received a 1:1 activity of a "Visit" (visit elsewhere in facility) on 08/07/14 and 08/10/14 in the month of August. During an interview on 08/27/14 at 3:30 p.m., an activity assistant (#16) stated examples of 1:1's included room visit, visit elsewhere, indoor walk, outdoor patio, back rub, lotion therapy, and read to resident. During an interview with activities assistants on 08/27/14 at 3:30 p.m. (#16 and #18), staff provided a reference sheet for station #1 to use when entering information for activity rosters. The activity assistant (#16) stated staff do not physically see the resident completing the activity before entering these activities. The activities listed for Resident #7 included daily devotion, books on tape, read newspaper, indoor wheelchair, birds, AR visit, library (some), piano (some), and handiwork (sewing) (some).	F 248		

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F 248	Continued From page 5 During an interview on 08/27/14 at 3:30 p.m., an activity assistant (#16) confirmed Resident #7 has declined in the last 3-6 months, has had increased confusion, and requires more 1:1 activities. During an interview on 08/27/14 at 3:30 p.m., an activity assistant (#18) indicated Resident #7 is a "tough one" and requires "more guidance and 1:1 visits but has no way to keep track of 1:1's." This staff member (#18) stated she questions residents about once a month to determine if each resident is completing the same activities on the reference sheet. During an interview on 08/27/14 at 4:50 p.m., an administrative activity staff member (#19) stated activity staff is expected to complete 1:1's two to three times a week. She stated Resident #7 does not always want these 1:1's. She stated that these 1:1's would be provided according to "15 minute rule" and less if resident not able to have a conversation.	F 248		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	Resident #1's MDS dated 8/20/14 and Resident #5's MDS dated 6/30/14 has been modified to reflect that an interview was attempted. Resident #5's MDS dated 6/30/2014 and resident #7's MDS dated 7/23/2014 have been modified to reflect that no documented delusion occurred during the MDS assessment period. Resident #2's MDS dated 7/21/14, Resident #3's MDS dated 7/23/14, Resident #8's MDS dated 7/25/14, Resident #9's MDS dated 6/24/14, and Resident #12 MDS dated 7/29/14 has been modified to reflect a partial turning/repositioning program.	10-2-14

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F 278	Continued From page 6 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 9 of 14 sampled residents (Resident #1, #2, #3, #5, #7, #8, #9, #11, and #12) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an accurate assessment of a resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, stated the following: * Section C0100 (Cognitive Patterns), page C-1,	F 278	Resident #2's MDS dated 7/21/14, Resident #8's MDS dated 7/25/14, Resident #9's MDS dated 6/24/14, Resident #11's MDS dated 6/30/14 and Resident #12's MDS dated 7/29/14 has been modified to reflect a nutrition/hydration program unrelated to skin problems. Residents scoring yes for C0100, E0100B, M1200C and M1200D on their most recent MDS will be reviewed for accuracy of coding. Modifications will be completed as needed. The MDS Coordinator reviewed scoring C0100 and E0100B with social service personnel and reviewed required documentation for scoring M1200C and M1200D with nurse managers and Director of Nutritional Services on 8/28/14. The DON (Director of Nursing) reviewed care plan interventions for turning/repositioning with nurse managers on 8/28/14. Documentation of turning/repositioning will be completed by direct care staff. In-service/Education will be provided prior to implementation. Effectiveness of turning/repositioning will be reviewed with each MDS. The Director of Nutritional Services will develop an assessment form clarifying the hydration/nutrition needs for each resident. QA (Quality Assurance) studies will be completed weekly for accuracy of scoring the MDS under the direction of the MDS Coordinator until 100% compliance is achieved. After compliance has been achieved, periodic, not less than semi-annually, QA studies will be completed to assure compliance has been maintained.	

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F 278	Continued From page 7 stated, "Should Brief Interview for Mental Status Be Conducted? . . . Code 0 [zero], no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700 Staff Assessment of Mental Status. Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing . . . Proceed to C0200, Repetition of Three Words . . ." * Section D0100 (Mood), pages D-1 and D-2, stated, "Should Resident Mood Interview Be Conducted? . . . Code 0, no: if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter . . . but one is not available. Skip to item D0500, Staff Assessment of Resident Mood . . . Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood . . . Continue to item D0200, Resident Mood Interview . . ." - Review of Resident #1's medical record occurred on August 26-28, 2014. The significant change MDS, dated 08/20/14, identified unclear speech, sometimes able to make self understood, and usually understands others. The MDS showed C0100 and D0100 coded as 0, "No" (Resident is rarely/never understood). As per the coding instructions, a staff member failed to attempt to complete a resident interview for Sections C and D. During an interview on the morning of 08/26/14, an administrative nursing staff member (#8) verified facility staff failed to attempt to complete a resident interview for Sections C and D, as per	F 278		

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F 278	Continued From page 8 the coding instructions. The Long-Term Care Facility RAI User's Manual, October 2013, stated the following: * Section E0100 (Potential Indicators of Psychosis), pages E-1 and E-2, stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . . The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included unspecified psychosis and dementia. The resident's significant change MDS, dated 06/30/14, identified long and short term memory problems and delusions during the seven day assessment period. A nurses note, dated 06/27/14, stated, ". . . resident [Resident #5] was trying to verbalize and speech was garbled and not understood. Asks fellow residents are you my grandma?' . . . MT [Medication Technician] reports no aggressive behavior . . ." Another nurses note, dated 06/29/14, stated, ". . . Wondering where his [Resident #5] mother is. Attempted to redirect but made no further comment." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses	F 278		

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F 278	Continued From page 9 included senile dementia. The resident's significant change MDS, dated 07/23/14, identified severely impaired cognition and delusions during the seven day assessment period. A nurse's note, dated 07/19/14, stated, " . . . Confused. Talking about leaving. States he is not a 'patient' here but a person. Reassurances given, not easily redirected but seems content with reassurances. Feels he's her [sic] for a 'purpose' and should be doing 'talks' and things. Is confused about his stay. . . ." During an interview on 08/28/14 at 9:40 a.m., an administrative staff member (#7) agreed the above documentation does meet the requirements to code Resident #5 and #7 for delusions on the MDS. The Long-Term Care Facility RAI User's Manual, October 2013, stated the following: * Section M1200C (Turning/Repositioning Program), page M-38, stated, "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [exampli gratia] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." * Section M1200D (Nutrition or Hydration Intervention to Manage Skin Problems), pages M-38 and M-39, stated, "The determination as to whether or not one should receive nutritional or	F 278		

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hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation . . . and obtain dietary consultation as needed,' . . ."

- Review of Resident #11's medical record occurred on August 27-28, 2014. The annual MDS, dated 06/30/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. There were no pressure ulcers, wounds, or skin problems identified on the MDS. The most current dietary note, dated 07/18/14, failed to identify any skin concerns.

- Review of Resident #12's medical record occurred on August 27-28, 2014. The quarterly MDS, dated 07/29/14, identified nutrition/hydration interventions and a turning/repositioning program present during the seven day assessment period. There were no pressure ulcers, wounds, or skin problems identified on the MDS.

Review of the most current dietary note, dated 07/31/14, failed to identify hydration/nutrition needs or interventions for Resident #12.

Resident #12's current care plan stated, "Problem/Need: Potential for skin breakdown . . . Approaches: Reposition every 2-3 hours in bed and in the chair. Heel lift boots on in bed. Posterior wedge behing [sic] back when sidelying [sic] . . . Problem/Need: H/O [history of] stage II

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F 278	Continued From page 11 pressure ulcer to upper spine . . . Approaches: . . . Reposition every 2 hours . . ." The medical record failed to identify facility staff monitored Resident #12's turning/repositioning program and reassessed the program to determine the effectiveness of the intervention. - Review of Resident #8's medical record occurred on August 26-28, 2014. The quarterly MDS, dated 07/25/14, identified nutrition/hydration interventions and a turning/repositioning program present during the seven day assessment period. There were no pressure ulcers, wounds, or skin problems identified on the MDS. The most current dietary note, dated 08/01/14, failed to identify skin concerns. Resident #8's current care plan stated, ". . . At risk for pressure ulcers. Refuses to reposition off back for long periods . . . Repeat education: need for routine repositioning as needed . . . Self care deficit . . . turning-reposition every 2 hours . . ." The medical record failed to identify facility staff monitored Resident #8's turning/repositioning program and reassessed the program to determine the effectiveness of the intervention. - Review of Resident #1's medical record occurred on August 26-28, 2014. The significant change MDS, dated 08/20/14, identified a turning/repositioning program present during the seven day assessment period. There were no pressure ulcers, wounds, or skin problems identified on the MDS. Resident #1's current care plan stated,	F 278		

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	355084	A. BUILDING _____ B. WING _____	08/28/2014

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F 278	Continued From page 12 "Problem/Need: Potential for pressure ulcers . . . Approaches: Pressure relieving mattress to bed . . . Reposition every 2 hrs [hours] as [Resident #1] will allow. . . ." The facility failed to identify specific interventions (e.g. reposition on side, pillows, between knees, etc.) related to Resident #1's turning/repositioning program, failed to monitor the program, and failed to evaluate the effectiveness of the program. - Review of Resident #2's medical record occurred on August 26-28, 2014. The annual MDS, dated 07/21/14, identified nutrition/hydration interventions and a turning/repositioning program. There were no skin problems other than a skin tear identified on the MDS. Resident #2's medical record failed to identify a nutritional assessment for coding nutrition/hydration interventions to manage skin problems. Resident #2's current care plan and pressure ulcer risk assessment both stated, ". . . Reposition every two hours when in bed . . " The medical record failed to identify facility staff monitored Resident #2's turning/repositioning program and reassessed the program to determine the effectiveness of the intervention. - Review of Resident #3's medical record occurred on August 26-28, 2014. The quarterly MDS, dated 07/23/14, identified a turning/repositioning program and no pressure ulcers, wounds, or skin problems. The current care plan stated, "Problem/Need: Potential for	F 278		

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F 278	Continued From page 13 impaired skin integrity . . . Approaches: . . . timely every two hours repositioning . . ." Resident #3's medical record failed to identify specify interventions (e.g. reposition onside, pillows between knees, etc.), and reassessed the program to determine it's effectiveness. - Review of Resident #9's medical record occurred on August 27-28, 2014. A significant change MDS, dated 06/24/14, identified a turning/repositioning program, nutrition/hydration interventions during the seven day assessment period and two Stage III pressure ulcers. Review of the dietary note associated with the significant change MDS, dated 06/25/14, failed to identify hydration/nutrition needs or interventions specific to the healing or treatment of the pressure sores experienced by Resident #9. Resident #9's care plan, at the time of the pressure sores, stated, "Problem/Need: Multiple areas of skin breakdown . . . Approaches: . . . Encourage to lie down for 1-1.5 hours every AM [morning] and PM [afternoon]. . . . Keep area open to air. Prevolon boots to be on all the time except for bathing. . . ." The medical record failed to identify facility staff implemented and monitored Resident #9's turning/repositioning program and reassessed the program to determine the effectiveness of the intervention. During an interview on the afternoon of 08/27/14, an administrative nurse (MDS) (#8) agreed Resident #1, #2, #3, #8, #9, #11, and #12's medical records failed to support the MDSs	F 278		

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F 278	Continued From page 14 coded for a turning/repositioning programs and nutrition/hydration interventions to manage skin problems.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: TRANSFERS AND ASSISTIVE DEVICES 1. Based on observation, record review, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 2 of 3 sampled residents (Resident #5 and #8). Failure to clearly identify how staff are expected to transfer residents increases the risk for falls, pain, and injury to residents. Findings include: - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia. The resident's significant change Minimum Data Set (MDS), dated 06/30/14, identified long and short term memory problems, limited assistance required for transfers and walking in his room, and two falls without injury during the assessment period.	F 323	Resident #5 is no longer in facility. Resident #8's care plan has been revised to indicate specific interventions for transfer. All resident requiring assistance with transfers will have their care plans reviewed and revised as needed to provide specific interventions for transfers. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nursing until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than quarterly will be completed to assure compliance has been maintained. Locks have been installed on all chemical storage cabinets in the soiled utility rooms. Laundry personnel were re-educated on the situations requiring the laundry room be locked, on 9-25-2014. Observation of all chemical storage areas has been completed to assure these areas have locks. QA (Quality Assurance) studies will be completed weekly under the direction of the Laundry Supervisor until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than semi-annually will be completed to assure compliance has been maintained.	10-2-14 See correction faxed 10/6/14 (Megan Rod)

Resident #5 is no longer in facility. Resident #8's care plan has been revised to indicate specific interventions for transfer. All resident requiring assistance with transfers will have their care plans reviewed and revised as needed to provide specific interventions for transfers. Director of Nursing reviewed transfer requirements with professional nursing staff on 8-28-2014. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nursing until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than quarterly will be completed to assure compliance has been maintained.

Locks have been installed on all chemical storage cabinets in the soiled utility rooms. Laundry personnel were re-educated on the situations requiring the laundry room be locked, on 9-25-2014. Observation of all chemical storage areas has been completed to assure these areas have locks. QA (Quality Assurance) studies will be completed weekly under the direction of the Laundry Supervisor until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than semi-annually will be completed to assure compliance has been maintained.

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F 323	Continued From page 15 Resident #5's current care plan stated, "Problem/Need: Self care deficit for mobility related to Senile Dementia . . . Approaches: Ambulates independently with FWW [front wheeled walker]. [name] is independent with transfers." The Certified Nursing Assistant (CNA) care guide, reviewed on 08/27/14, stated, "Transfers: I [independent]. Ambulation: I [with] FWW. Toileting: A [assistance] [one]." Observations, interviews, and progress notes identified the following: * 08/22/14 at 6:00 a.m. (progress note) - A CNA found Resident #5 on the floor laying on right side. No injuries noted but appeared more confused. * 08/25/14 at 8:45 a.m. (progress note) - A dietary aid found the resident on the floor in his room in front of his couch. The resident had been sitting on the couch prior to the fall. No injuries noted. * 08/26/14 at 10:05 a.m. (observation) - Observation showed Resident #5 seated on the toilet and a CNA (#2) provided cares. The CNA applied a gait belt but the resident refused to stand. Another CNA (#3) entered the bathroom. The CNA (#2) told her they may need to utilize the PAL lift (a sit to stand mechanical lift) to assist the resident off the toilet. The CNA (#3) stated, "He won't hold onto the PAL lift, we tried yesterday." The CNA (#3) left the room and returned with the PAL lift. The CNAs stood Resident #5 to an upright position but as the CNA (#2) provided perineal cares, the resident let go of the handle with his left hand and his left arm extended over his head. The CNA (#3) lower the resident back onto the toilet. The CNA (#2) left the room and returned with two nurses (#1 and #19). The CNAs (#2 and #3) released Resident	F 323		

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F 323	Continued From page 16 #5 from the PAL lift, applied a gait belt around his waist, and with the assistance of the nurse (#1), transferred the resident from the toilet to the wheelchair. * 08/26/14 at 1:22 p.m. (A restorative nursing progress note) - "Staff reporting increased difficulty with transfers . . . increase in falls as well. Observed transfer from chair to wheelchair this a.m. Resident would not stand up or bear any weight during the transfer . . . Used the stand lift with assist [of] 2 to transfer. Resident did not bear weight and stand with the lift but needed many cues and physical assist to hold onto the lift during the transfer. Discussed transfer with Nurse Manager." * 08/26/14 at 2:37 p.m. (progress note) - "Writer aware of COTA [Certified Occupational Therapy Assistant] observations with transfers and discussed with DON [Director of Nursing]. Staff instructed to use Maxi lift [full body mechanical lift] assist of 2 if unable to transfer with wheeled walker assist of 1." * 08/26/14 at 4:24 p.m. (progress note) - "Assisted with transfer at approx [approximately] 3:25 p.m. as resident was attempting to get up on his own. Resident able to stand with walker with limited assist of 2 and gait belt. Took approx. 4 steps and sat self in wheelchair. . . ." * 08/27/14 at 8:05 a.m. (observation) - Observation showed Resident #5 seated on the edge of his bed in his room with a FWW in front of him. At 8:10 a.m., the CNA (#4) entered the resident's room and helped him with his shirt. Resident #5 would not allow the CNA to button his shirt so the CNA placed the FWW in front of him and left the room. * 08/27/14 at approximately 9:00 a.m. (interview) - The staff member (#5) stated she heard Resident #5's bed alarm sounding and found him	F 323		

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F 323	Continued From page 17 on the floor in his room. She and the nurse (#6) utilized the Maxi lift and transferred Resident #5 from the floor to his bed. The above observations, interviews, and progress notes identified facility staff used several methods to transfer Resident #5, none of which were care planned. Even though he experienced three falls from August 22-26 and required extensive assistance on 08/26/14, the CNA (#4) made the decision to leave Resident #5 seated on the edge of his bed with his FWW in front of him which later resulted in a fall. During an interview on 08/28/14 at 8:10 a.m., an administrative nurse (#1) stated Resident #5 declined in the past week, both physically and mentally, and experienced some falls. The nurse (#1) stated she would expect the CNAs to inform the charge nurse if Resident #5 is having difficulty with transfers and let the nurse make the decision on what method of transfer should be attempted. - Review of Resident #8's medical record occurred on August 26-28, 2014. Diagnoses included osteoarthritis, malaise, and fatigue. The resident's quarterly MDS, dated 07/01/14, identified extensive assistance of one person for transfers. The current CNA resident care guide identified Resident #8 required assistance of 1-2 staff members. Resident #8's current care plan stated, ". . . Self care deficit . . . Transfer with SBA [stand by assist] of 1 and walker. May need a boost to stand with 2 assist wehn [sic] drowsy or agitated. Ambulates to and from BR [bathroom] with FWW	F 323		

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F 323	Continued From page 18 and 1 assist. . . ." Observations and interviews identified the following: * on 08/26/14 at 7:55 a.m. (observation) - A CNA (#11) attempted to transfer Resident #8 from her wheelchair to the bed; however, Resident #8 refused to stand. The CNA stated she would try 10 minutes later with a different person. Observation at 8:50 a.m. showed Resident #8 remained in her wheelchair. * on 08/26/14 at 11:55 a.m. (observation) - Two CNAs (#11 and #16) transferred Resident #8 with a walker from her wheelchair to her bed. Resident #8 stated, "I can't [stand]." Observation showed the resident moving rapidly backwards to sit on her bed. * on 08/26/14 at 11:55 a.m. (interview) - A CNA (#16) stated "Sometimes [resident] will get up and sometimes need two people." * on 08/26/14 at 2:55 p.m. (observation) - Two CNAs (#12 and #16) transferred Resident #8 from her wheelchair to the bathroom with a wheeled walker. Resident #8 stated, "I'm scared," and "Help me." * on 08/27/14 at 12:50 p.m. (interview) - A CNA (#13) stated she and another CNA (#14) assisted Resident #8 to the bathroom and to bed at about 12:00 p.m. The CNA stated, "Nice to have two [staff members]. Wide awake, does transfer with one person. Did transfer her with two persons as sometimes she can have behaviors on the toilet." The above observaton and interviews identified facility staff used several methods to transfer Resident #8. During an interview on 08/28/14 at 8:30 a.m., an administrative staff member (#20) stated staff	F 323		

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F 323	Continued From page 19 transfered Resident #8 with one person if she is cooperating and if not they transfer her with 2 persons. If she is sleepy and tired, staff transfer Resident #8 with 2 persons; however they do not talk to the nurse every time unless the resident is combative. HAZARDOUS CHEMICALS 2. Based on observation, review of material safety data sheets (MSDSs), and staff interview, the facility staff failed to maintain an environment free of hazardous chemical supplies on 3 of 3 resident care areas (Stations 1, 2 and 3) and 1 of 1 laundry room. Accessible hazardous chemicals place cognitively impaired and wandering residents at risk for accidents/injury. Findings include: During the environmental tour on the afternoon of 08/27/14 with a maintenance supervisor (#21), the following occurred: Observation of the environment on Station 1 revealed the following: - 08/27/14 at 1:20 p.m. - an unlocked cabinet beneath the sink in the soiled utility room contained a gallon bottle of Dimension III One Step Disinfectant Cleaner. Observation of the environment on Station 2 revealed the following: - 08/27/14 at 1:40 p.m. - an unlocked cabinet beneath the sink in the soiled utility room contained a gallon bottle of Dimension III One Step Disinfectant Cleaner. Observation of the environment on Station 3 revealed the following: - 08/27/14 at 1:55 p.m. - an unlocked cabinet	F 323		

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F 323	Continued From page 20 beneath the sink in the soiled utility room contained a gallon bottle of Dimension III One Step Disinfectant Cleaner. Observation in all three soiled utility rooms showed the disinfectant connected by a hose to the sink faucet. A button on the faucet, when pressed, dispensed disinfectant into the water flowing from the faucet. Observation of the environment in the laundry area revealed the following: - 08/27/14 at 2:05 p.m. - a closet with no door in the soiled laundry room contained a gallon bottle of Virex II 256 One Step Disinfectant Cleaner and Deodorant and a gallon bottle of Hilex Bleach. During an interview on the afternoon of 08/27/14, two laundry staff members (#22 and #23) stated the laundry room entrance is not locked when unoccupied during the day. Review of the MSDSs on the above-stated chemicals identified the following: *Dimension III One Step Disinfectant Cleaner - ". . . Hazards identification: . . . DANGER. CORROSIVE. CAUSES IRREVERSIBLE EYE DAMAGE. CAUSES EYE AND SKIN BURNS. HARMFUL IF INHALED, SWALLOWED OR ABSORBED THROUGH SKIN . . ." *Virex II 256 One Step Disinfectant Cleaner and Deodorant - ". . . Hazards identification: . . . DANGER. CORROSIVE. CAUSES SKIN AND EYE BURNS. HARMFUL FATAL IF SWALLOWED . . ." *Hilex Bleach - ". . . Hazards identification: . . . DANGER. CORROSIVE. MAY CAUSE SEVERE BURNS OR DAMAGE TO EYES. MAY CAUSE SEVERE SKIN BURNS OR IRRITATION . . ."	F 323		

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F 323	Continued From page 21 During an interview on the afternoon of 08/27/14, a maintenance supervisor (#21) stated hazardous chemicals should be stored in a locked area. During an interview on 08/28/14 at 8:30 a.m., a maintenance supervisor (#21) stated the facility had no policy on storage of chemicals.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store and prepare food under safe and sanitary conditions in 1 of 1 kitchen. These practices have the potential to increase the risk of food borne illness and can affect all residents who eat food stored and prepared in these areas. Findings include: Review of the facility's policy titled, "Cleaning Slicers," occurred on the morning of 08/28/14. This undated policy stated, ". . . Slicer will be cleaned and sanitized after each use. . . ."	F 371	Dietary staff reeducation on the procedure for cleaning the meat slicer was completed by 9-10-14. Equipment within the department at risk for contamination of food borne pathogens will also be reviewed by dietary manager to insure that all equipment is cleaned per food safety and sanitation policy and procedure. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nutritional Services until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than quarterly will be completed to assure compliance has been maintained. On 9-3-14, Ecolab serviced the LSH dietary department's quaternary sanitizer dispenser and a new dispenser was installed. The "Manual Washing" policy was reviewed and updated. The dietary staff that will be responsible to test the strength of the sanitizer were re-educated on this requirement 9-10-2014. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nutritional Services until 100% compliance is achieved, then monthly for 3 consecutive months. After compliance has been achieved, periodic QA studies not less than semi-annually will be completed to assure compliance has been maintained.	10-2-14

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F 371	Continued From page 22 Review of the facility's policy titled, "Manual Dishwashing," occurred on the morning of 08/28/14. This undated policy stated, ". . . Sanitize sink - 1. Dispense water/sanitizer solution into sink to fill to appropriate level. 2. Red button pushed flush to the faucet will dispense sanitizer with the water . . . 4. Sanitizer strength (measured with manufacturer approved test strips) should fall between 150-400 ppm [parts per million]. These guidelines are posted in the back of the chemical room in the kitchen. 5. Dietary manager or cook will check appropriate strength on at least weekly basis or as needed." The dietary tour of the kitchen occurred on 08/27/14 at 8:10 a.m. with an administrative dietary staff member (#23). Observation showed a covered meat slicer, identifying this equipment as clean and ready for use. When the administrative staff member (#23) removed the cover from the meat slicer, a meat residue was observed along the rear surface of the blade. Further observation showed the third sink in the three compartment sink, used to wash and sanitize utensils and equipment, filled with sanitizing solution. The administrative dietary staff member (#23) used a test strip to measure the concentration of sanitizer in the solution. The concentration measured more than 500 ppm. Sanitizing solutions with a strength more than 400 ppm have the potential to leave a toxic residue on surfaces. During an interview on 08/27/14 at 8:10 a.m., a cook (#24) stated the cooks test the sanitizing solution in the three compartment sink and she did not test the solution after she filled the third	F 371		

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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 371	Continued From page 23 sink on 08/27/14. Observation on 08/28/14 at 7:45 a.m. showed an administrative dietary staff member (#25) used a test strip to measure the concentration of the sanitizing solution in the three compartment sink and obtained a measurement more than 500 ppm. The administrative staff member (#25) stated there may be a problem with the regulator on the faucet for dispensing water/sanitizer. During an interview on the morning of 08/28/14, an administrative dietary staff member (#23) confirmed staff should clean and sanitize meat slicers before storing and prepare/use sanitizing solution within the required ppm range.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	The refrigerator in Station #1's med room was removed on 8-27-2014. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nursing on the two remaining refrigerators until 100% compliance in temperature is achieved, then monthly for 3 consecutive months. After compliance has been achieved, periodic QA studies not less than semi-annually will be completed to assure compliance has been maintained.	10-2-14

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 _____	08/28/2014

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F 431	Continued From page 24 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional references, and staff interview, the facility failed to store medications under proper temperature controls in 1 of 3 medication refrigerators (Stations 1). Failure to maintain the refrigerator temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: The Physicians' Desk Reference, PDR Network, 67th edition 2013, page 2055, stated, ". . . Store Xolair under refrigerated conditions 2-8 [degrees] C [Celsius] (36-46 [degrees] F [Fahrenheit]). . . ." Page 2098, stated, ". . . Keep all unopened NovoLog in the refrigerator between 36 [degrees] to 46 [degrees] F (2 [degrees] to 8 [degrees] C). . . . Page 2105, stated, ". . . Unused NovoLog Mix 70/30 should be stored in a refrigerator between 2 [degrees] C and 8 [degrees] C (36 [degrees] F to 46 [degrees] F). . . ."	F 431		

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F 431	Continued From page 25 The Nursing Drug Handbook, 2013, page 644-646, stated, "gabapentin . . . Patient Teaching . . . Tell patient to keep oral solution refrigerated." Pharmacia & Upjohn Inc., Kalamozoo, MI, 2003 Sep. [September] prescribing information for Xalatan (latanoprost) sterile ophthalmic solution, stated, ". . . Storage: Unopened bottles refrigerate at 2-8 [degrees] C . . ." Observation of the Station 1 medication room on 08/27/14 at 4:20 p.m. identified the thermometer in the refrigerator showed a temperature as 52 degrees F. An unidentified maintenance staff member checked the refrigerator with a different thermometer and obtained a temperature of 52 degrees F. An interview with the staff nurse (#27) present, identified staff do not monitor the temperature of the Station 1 refrigerator. Further review of the medication refrigerator showed facility staff stored the following medications and supplements in the refrigerator: * 2 boxes of Lantus SoloStar insulin pens, for two different residents, one box contained three pens and the other one pen. * 1 box containing one NovoLog Flexpen. * 2 boxes of NovoLog 70/30 Flexpen, for two different residents, one box contained four pens and the other five pens. * 1 bottle of gabapentin syrup. * 4 boxes, containing one bottle each, of Latanoprost Ophthalmic Solution, for one resident. * 1 box, containing one bottle, of Timolol Maleate	F 431		

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F 431	Continued From page 26 Ophthalmic Solution, for one resident. * 2 bottles Xolair Omalizumab for subcutaneous use, for one resident. * 2 cartons of Hormell Plus 2, one opened, dated 8/24. The other, unopened, identified by the nurse (#27) with an 8/8 thaw date. The nurse (#27) disposed of the unopened carton, as she identified the product as expired. * 1 package of ensure pudding. Failure to maintain refrigerator temperatures between 36-46 degrees F had the potential for the medications to lose their efficacy/potency, and for the supplements to experience spoilage due to storage at too high a temperature.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	The glucometer, the canister and the insulin pen were cleaned on 8-26-14. Nursing staff will be re-educated in the general principles of infection control and cleaning of the glucometer on 9-25-2014. QA (Quality Assurance) studies will be completed weekly under the direction of the Director of Nursing until 100% compliance is achieved. After compliance has been achieved, periodic QA studies not less than quarterly will be completed to assure compliance has been maintained.	10-2-14

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F 441	Continued From page 27 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff followed infection control practices for 2 of 2 observations of glucose monitoring for Resident #9. Failure to disinfect the glucometer, the canister of test strips, and an insulin pen before placing them in the medication cart has the potential to spread infection to residents and staff. Findings include: - On 08/26/14 at 11:15 a.m., observation showed a nurse (#28) checked Resident #9's blood sugar with a glucometer. The nurse (#28) returned to the medication room, placed the glucometer on top of the medication cart. She then dropped the canister of test strips on the floor, picked them up and placed it on the medication cart. The nurse (#28) left the medication room to administered Resident #9's insulin. On returning to the	F 441		

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F 441	Continued From page 28 medication room, the nurse (#28) placed the glucometer and canister of test strips into a drawer of the medication cart. The nurse (#28) failed to sanitize the glucometer after testing Resident #9's blood and failed to sanitize the canister of test strips after dropping it on the floor. - On 08/26/14 at 5:18 p.m., observation showed a nurse (#28) checked Resident #9's blood sugar using a glucometer. The nurse (#28) returned to the medication room and placed the glucometer on top of the medication cart. The nurse obtained Resident #9's insulin pen and returned to the resident's room to administer the insulin. After administering the insulin, the nurse (#28) dropped the insulin pen on the floor in the resident's room. The nurse (#28) returned to the medication room, and placed the insulin pen and the glucometer in a drawer of the medication cart. The nurse (#28) failed to sanitize the glucometer after testing Resident #9's blood and failed to sanitize the insulin pen after dropping it on the floor. During an interview on 08/26/14 at 5:55 p.m., an administrative nursing staff member (#10) identified the facility expects staff to sanitize the glucometer after measuring a resident's blood glucose and expects staff to sanitize items dropped on the floor prior to putting them away. During an interview on 08/27/14 at 2:46 p.m., an administrative nurse (#1) confirmed the facility expected the nurse (#28) to sanitize the glucometer after use, and to sanitize the canister of test strips and insulin pen after being on the floor, before placing them into the medication cart.	F 441		