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	355067	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on November 16, 2015 and completed on November 19, 2015 the sample included five (5) residents for complete review, twenty-two (22) 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		
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 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	F 278		12/24/15

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

Electronically Signed | 12/11/2015

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the RAI (Resident Assessment Instrument) User's Manual, and staff interview, the facility failed to complete Minimum Data Sets (MDSs) which accurately reflected the residents' status for 8 of 27 sampled residents (Resident #1, #2, #6, #7, #10, #21, #22, and #24). Failure to accurately code turning/repositioning and nutrition or hydration interventions does not allow the resident assessment to reflect their current status/needs and may result in inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M-38 and M-39 stated, ". . . M1200C Turning/Repositioning Program: 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., [example given] reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . Vitamin and mineral supplementation should only be employed as an intervention for managing skin	F 278	MDS corrections will be submitted for all of the sampled residents affected by the inaccurate coding in M1200 with nutrition and hydration interventions and a turning/repositioning program. The most current MDS for all residents will be reviewed for accuracy in those areas. Any corrections needed will be changed and submitted. Beginning December 1, 2015, the RN Care Coordinator and the Licensed Registered Dietitian complete this section together to ensure accuracy. Nurses attended meetings on December 9 to review the plan of correction and stress the importance of individualized planning and care for any skin issues. All RN Care Coordinators and Licensed Registered Dietitians will complete MDS Section M training by December 21. A minimum of six MDSs will be audited by the RN Care Coordinators weekly for the next four weeks and then one MDS will be audited weekly for the next three months. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits.	

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F 278	Continued From page 2 problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' . . ." - Review of Resident #6's medical record occurred on all days of survey. The annual MDS, dated 09/04/15, identified a turning/repositioning program and nutrition or hydration interventions to manage skin problems. The current care plan stated, "Focus: I have potential for skin breakdown r/t [related to] decreased mobility, incontinence, medication use . . . I have a hx [history] of pressure ulcers to my bottom, stage 1, pressure ulcer to buttock stage 2. . . . Interventions . . . Reposition 2-3 x [two to three times] each shift . . ." The medical record lacked an individualized turning/repositioning program and an individualized nutritional assessment to indicate a need for the interventions for the purpose of preventing or treating specific skin conditions. The quarterly MDS, dated 06/04/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration intervention for the purpose of preventing or treating specific skin conditions.	F 278		

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F 278	Continued From page 3 - Review of Resident #7's medical record occurred on all days of survey. The significant change MDS, dated 07/30/15, and the quarterly MDS, dated 04/30/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration intervention for the purpose of preventing or treating specific skin conditions. - Review of Resident #24's medical record occurred on November 18-19, 2015. The annual MDS, dated 10/03/15, and the quarterly MDS, dated 07/03/15, identified nutrition or hydration interventions to manage skin problems. The medical record lacked an individualized nutritional assessment to indicate a need for nutrition or hydration intervention for the purpose of preventing or treating specific skin conditions. - Review of Resident #1's medical record occurred on all days of survey. The annual MDS, dated 08/27/15, and the quarterly MDS, dated 05/27/15, identified total assistance of two or more persons required for bed mobility and transfers, on a turning/repositioning program, and nutrition/hydration interventions. The nutrition/hydration interventions to manage skin problems, established for Resident #1, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an individualized nutritional assessment to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.	F 278		

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Resident #1's current care plan stated ". . . I require assist of 2 staff to turn/roll side to side in bed. I have a tilt-n-space chair used for positioning per OT [occupational therapy] and wound clinic consult. . . ." The August Treatment Administration Record (TAR) also identified, "tilt n space chair - reposition q [every] 2-3 times each shift and while in bed. . . ." The resident's medical record failed to identify an individualized repositioning program.

- Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 08/24/15, and the significant change MDS, dated 06/07/15, both identified nutrition/hydration interventions. The nutrition/hydration interventions to manage skin problems, established for Resident #2, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an individualized nutritional assessment to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions.

- Review of Resident #10's medical record occurred on all days of survey. The significant change MDS, dated 09/24/15, identified total assistance of two or more persons required for bed mobility and transfers and on a turning/repositioning program. The significant change MDS, dated 09/24/15, quarterly MDS, dated 08/06/15, and the admission MDS, dated 05/13/15, all identified nutrition/hydration interventions. The nutrition/hydration interventions to manage skin problems, established for Resident #10, failed to meet the

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F 278	Continued From page 5 criteria for coding item M1200D on the MDS. The medical record lacked an individualized nutritional assessment to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. A progress note, dated 09/21/15, identified, ". . . Skin ok. Will add nour [nourishment] BID [twice daily] . . . to . . . promote healing." Resident #10's current care plan stated ". . . Assist of 1 staff to turn/roll side to side in bed. . . ." The resident's medical record failed to identify an individualized repositioning program. - Review of Resident #21's medical record occurred on November 18-19, 2015. The quarterly MDS, dated 10/25/15, identified total assistance of two or more persons required for bed mobility and transfers, on a turning/repositioning program, and nutrition/hydration interventions. The nutrition/hydration interventions to manage skin problems, established for Resident #21, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an individualized nutritional assessment to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. Resident #21's October TAR identified, "turn & [and] reposition q [every] 2-3 h [hours] document position. . . ." The resident's medical record failed to identify an individualized repositioning program.	F 278		

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F 278	Continued From page 6 - Review of Resident #22's medical record occurred on November 18-19, 2015. The quarterly MDS, dated 08/23/15, and the annual MDS, dated 02/23/15, both identified nutrition/hydration interventions. The nutrition/hydration interventions to manage skin problems, established for Resident #22, failed to meet the criteria for coding item M1200D on the MDS. The medical record lacked an individualized nutritional assessment to determine whether or not this resident should receive nutrition or hydration interventions for the purpose of preventing or treating specific skin conditions. During an interview on 11/19/15 at 9:34 a.m., an administrative nurse (#5) confirmed the medical records lacked sufficient evidence to support the coding of the MDSs.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility skills validation checklist, and review of professional literature, the facility failed to ensure 1 of 5 sampled residents (Resident #1) observed being fed received the care and services	F 309	A swallow study was ordered the resident affected by this practice. The Speech/Language Therapist will determine appropriate texture and feeding techniques for this resident. The Licensed	12/24/15

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F 309	Continued From page 7 necessary to attain the highest degree of safety possible. Failure to ensure a resident demonstrating signs/symptoms of dysphagia was alert, positioned properly prior to being fed, and was fed at an appropriate rate, resulted in the resident aspirating. Findings include: Review of the facility form "Certified Nursing Assistant (CNA) Skills Validation: Assisting Resident to Dine" occurred on 11/19/15. This skills validation checklist, dated September 2015, stated, ". . . Before assisting resident, resident is in an upright sitting position . . . NA [Nursing Assistant] student sits facing resident during assisting. . . . NA student asks resident if they are ready for next bite of food or sip of beverage. . . ." Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, pages 8-9, 15, 125, 128, and the educational handouts identified, ". . . If a patient isn't alert, it may be better to delay the intervention [meal] until later. . . . A patient showing drooling . . . usually means he isn't swallowing his secretions . . . Coughing and choking are very obvious symptoms of dysphagia . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle . . . The 90 degree position allows the patient to control material in the oral cavity with a minimal impact of gravity. This position must be maintained during and following the meal. Repositioning is frequently required during the meal. . . . Pillows may need to be placed . . . to achieve the correct position. . . . Controlling the bolus size is important in relation to how much a patient can hold in the oral cavity	F 309	Registered Dietitians will observe all residents with a diagnosis of dysphagia during a meal to ensure proper positioning, diet texture, and appropriate feeding techniques. Licensed Nurse and CNA education will be provided through the nursing newsletter on December 16, 2015. The information will contain a new nursing procedure named "Assisting Residents to Dine." Staff will sign to indicate receipt and understanding of the information. Concerns with positioning and dysphagia during meals were discussed at the licensed staff meetings on December 9. A daily audit of dining areas will be completed by a licensed nurse daily for one week and weekly for three months. The Director of Nursing Services will report the results to the Quality Review Team and determine the frequency of continued audits.	

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F 309	Continued From page 8	F 309		

as well as how much the valleculae and pyriform sinuses [parts of the throat] can hold. As long as the bolus size is controlled to a small amount . . . the bolus can rest in the valleculae and pyriforms without aspiration during a delayed swallowing response. . . ."

Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, blindness, and reflux. The annual Minimum Data Set (MDS), dated 08/27/15, identified severely impaired cognitive skills, extensive assistance of one person during meals, mechanical/therapeutic diet, and no symptoms of a swallow disorder.

The current care plan stated, ". . . Interventions: . . . EATING: I require assist of 1 for eating I eat in the parlor. I am able to feed myself for few short bites, then need assist I use bed side table. . . . Report to the dietitian if I have difficulty with chewing my food. . . ."

Dining room observations showed the following:
* 11/17/15 at 8:39 a.m., a CNA (#6) stood on Resident #1's left side and attempted to feed her. Resident #1 sat in her tilt-in-space wheelchair with her head turned to the right side, chin down, (directing any food/drink to the right side of her oral cavity), and her eyes closed. The CNA (#6) grabbed the top of Resident #1's head, pulled and held her head in a neutral position, and placed a teaspoon of scrambled eggs in her mouth even though Resident #1 was minimally responsive to cues. The CNA (#6) then let go of her head allowing it to once again fall forward and to the right (an indication the resident was not alert). Resident #1 coughed on two occasions

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(an indication she did not swallow her secretion and secretions had entered her airway). The CNA (#12) continued to feed Resident #1 in this manner even though the resident was minimally responsive to cues and was demonstrating signs/symptoms of dysphagia/aspiration.
* 11/18/15 at 11:50 a.m., a nurse (#7) fed Resident #1 as she sat in her tilt-in-space wheelchair. The nurse (#7) offered two-to-three additional teaspoons of food to Resident #1, even though she was still chewing and had not swallowed the previous bite. Resident #1 began drooling (an indication she did not swallow her secretions.) The nurse (#7) continued to feed Resident #1 in this manner even though she was demonstrating signs/symptoms of dysphagia.
* 11/18/15 at 8:12 a.m., a CNA (#6) fed Resident #1. Resident #1 sat in her tilt-in-space wheelchair supported by pillows at her side. Resident #1 chewed a bread crust for two-to-three minutes, drooled, cleared her throat, and/or coughed on four occasions (an indication she did not swallow her secretion and secretions had entered her airway). The CNA (#6) continued to feed Resident #1 even though she was demonstrating signs/symptoms of dysphagia/aspiration.

The facility failed to:
* ensure Resident #1 was awake/alert prior to feeding,
* position Resident #1 as close to 90 degrees as possible prior to feeding,
* control the rate of presentation, and
* recognize Resident #1's signs/symptoms of dysphagia and/or aspiration (excessive chewing, drooling, throat clearing, coughing).

Failure to implement the above interventions

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F 309	Continued From page 10 placed Resident #1 at increased risk of and/or resulted in her aspirating during meals.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 the necessary services for 1 of 18 sampled resident (Resident #15) and one supplemental resident (Resident #31) who required set up assistance with the meal tray. Failure to provide assistance by not opening nutritional supplements at meal time may cause weight loss and malnutrition. Findings include: - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia and Parkinson's disease. Medications included Remeron (antidepressant) 7.5 mg (milligrams) for appetite/wt (weight) loss and eight ounces of Ensure two times a day for wt loss administered with medication pass. Resident #15's physicians orders included supplements per dietitian. Resident #15's quarterly Minimum Data Set (MDS), dated 10/25/15, identified moderately impaired cognition and set up help for eating.	F 312	The Licensed Registered Dietitian will evaluate Resident 15 and Resident 31 to ensure the appropriate level of assistance is provided during dining. All residents will be observed by the Dietitian during at least one meal to observe proper assistance with meal set-up, which includes the opening of supplements. Licensed nurse meetings were held on December 9, 2015 to discuss concerns in this area. CNA staff will be provided with information on the opening of supplements when the residents need assistance through the nursing newsletter on December 16. Staff will sign to indicate receipt and understanding of the information. The dining room audit form will be updated to include the opening of supplements for residents who need assistance. A daily audit of dining areas will be completed by a licensed nurse daily for one week and then weekly for three months. The Director of Nursing	12/24/15

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F 312	Continued From page 11 Resident #15's current care plan stated, ". . . I have an ADL [activities of daily living] self-care performance deficit . . . Eating: I am able to: eat independently after my tray is set-up. . . I am at high nutritional risk . . . Provide and serve snacks/supplements as ordered: BID [twice a day] w/ [with] meds [medication], lunch (X2) [times two] and supper (X2) . . ." Observation on 11/17/15 at 11:20 a.m. showed Resident #15 seated at the dining room table eating his lunch. An unopened strawberry Mighty Shake (nutritional supplement) and a can of Ensure (nutritional supplement) sat in front of him. The mighty shake and ensure remained unopened throughout the meal. Observation on 11/17/15 at 5:20 p.m. showed Resident #15 seated at the table eating his dinner. An unopened Mighty Shake sat in front of him, and remained unopened throughout the meal. Observation on 11/18/15 at 11:30 a.m. showed Resident #15 leaving the dining room table. The resident's vanilla Mighty Shake and can of Ensure remained unopened sitting on the table. During an interview on 11/18/15 at 11:30 a.m. a licensed nurse (#2) stated Resident #15 does not want the supplements opened and we return them to the dietary cart after the meal. During an interview on 11/18/15 at 11:40 a.m. a supervisory nurse (#1) stated she expected staff to open Resident #15's nutritional supplements at mealtime as part of tray set up.	F 312	Services will report the results to the Quality Review Team and determine the frequency of continued audits.	

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VALLEY ELDERCARE CENTER	2900 14TH AVE S GRAND FORKS, ND 58201

(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 312	Continued From page 12 Observation on 11/18/15 at 5:10 p.m. showed Resident #15 leaving the table after eating supper. A certified nursing assistant (#4) stated she mixed Resident #15's Mighty Shake with his milk and he drank approximately 75% of the Mighty Shake. Nursing charting record for November 01-18, 2015 identified Resident #15 refused his supper supplement one time, consumed 100% three times, 50% two times and 11 days lacked documentation. The staff failed to identify the amount of the lunch supplement intake for November 01-18, 2015. During an interview on 11/19/15 at 8:45 a.m. a licensed nurse (#3) stated Resident #15 takes eight ounces of Ensure everyday at 7:15 a.m. and 7:30 p.m. during medication pass. This nurse further stated Resident #15 will drink 100% and on rare occasion refuses the supplement. - Observation on 11/15/18 at 5:15 p.m. showed Resident #31 eating at the dining room table with an unopened Mighty Shake and a can of Ensure. When leaving the dining table, the resident took the can of Ensure with her and left the unopened Mighty Shake. An unidentified CNA stated Resident #31 will drink the Ensure later in her room and does not like the Mighty Shake.	F 312		