STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

(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 07/30/12 and completed on 08/02/12, the sample included four (4) residents for complete review, 10 residents for focused review, and three (3) closed records for review. The sample included six (6) additional residents to verify specific concerns during the survey.	F 000	This Plan of Correction constitutes St. Aloisius Medical Center's written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is <u>not</u> an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to ensure residents remained free from physical restraints not required to treat the residents' medical symptoms for 4 of 6 sampled residents (Resident #2, #6, #7, and #9) identified with physical restraints. Failure to assess, monitor, and re-evaluate the necessity of these devices may result in decreased function and well-being and placed residents at risk for injuries related to their use. Findings include: Review of the facility policy titled "Restraints" occurred on 08/01/12. This policy, updated 06/01/07, stated, ". . . POLICY: Physical restraints are defined as any manual method or physical or	F 221	F221 1. Resident #2 horizon chair was discontinued on August 15, 2012. An assessment was completed to address need for continued use of seat belt. Resident #6 the restraint evaluation completed on August 8, 2012. Resident #7 an OT evaluation and treat order received August 22, 2012 in regard to restraint use. This evaluation will address other measures attempted before the use of the seat belt along with indications for use. The horizon chair has not been used. If an emergency occurs, the proper protocol will be followed; the nurse involved was counseled and she will	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — PRESIDENT / CEO — (X6) DATE 9-24-2012

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 221	Continued From page 1 mechanical device, material or equipment attached or adjacent to the resident's body that cannot be removed easily, which restricts freedom of movement or normal access to one's body. PROCEDURE: Physician order will be obtained. Restraint use/plan will be added to care plan and treatment book. Nursing staff will complete assessment of medical status/condition upon initiation of restraint. . . . Consents will be reviewed for completeness when reviewing care plan quarterly. Restraint evaluation and Faber Fall Assessments are completed with quarterly MDS [Minimum Data Set]. . . . OTA/PTA [occupational therapy assistant/physical therapy assistant] will review use of restraints monthly and make note of their findings and plan in their progress notes. . . ." - During the initial tour on 07/30/12 at 10:37 a.m., a supervisory nursing staff member (#9) identified Resident #7 used a seatbelt restraint. The staff member stated, "[The seat belt] is off a lot of the time because she doesn't try to get up as much," and "[The seat belt] is on from three to eleven [the p.m. shift] when there's less staff." The staff member indicated the evening shift has less staff to supervise Resident #7, so that was usually when Resident #7 wore the seat belt. Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current MDS, dated 07/06/12, identified severe cognitive impairment daily and a trunk restraint used in bed less than daily. The MDS failed to identify a trunk restraint used out of bed (seat belt), which staff implemented daily during the assessment period.	F 221	follow protocol when restraint used. Resident #9 Rock and Go chair, horizon chair, and seat belt were evaluated and discontinued on August 17, 2012. 2. All residents utilizing restraints have the potential to be affected. 3. A restraint reduction program has been initiated and a restraint nurse coordinator appointed to oversee this. The restraint policy has been revised. All residents needing restraints will have the proper procedure completed in the assessment and implementation. This is being accomplished by educating nurses at a meeting on August 30, 2012 and unit meeting on August 29, 2012 and minutes posted. The electronic record will have a reminder built into TAR to cue staff to document interventions used prior to implementing restraints. The restraint nurse coordinator will monitor all restraints on a weekly basis; this will assure	

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F 221	Continued From page 2 Current physician's orders, dated 06/25/12, stated, "Seat belt prn [as needed] . . . aftercare for healing traumatic fracture of hip [start date 01/06/12] . . . Chair alarm [start date 01/12/12, discontinue date 07/25/12] . . . Personal alarm [clip alarm] prn [start date 07/26/12] . . ." The physician's orders failed to identify a horizon chair. Resident #7's current care plan stated, ". . . Problem: Impaired mobility and ADL [activities of daily living] deficit R/T [related to] S/P [status post] right hip fracture . . . History of falls, potential for falls is unaware of safety [secondary to] Alzheimer's dementia with progression . . . Approaches . . . seat belt to WC [wheelchair] prn . . . Personal alarm prn . . ." A nurses' note, dated 05/16/12, stated, ". . . Resident in constant motion on pm's [evening shift] while in her W/C. Entering other residents' rooms attempting to take things. Was also moving very rapidly up [and] down halls and if another resident was in the way, would try to run them over. Scraping against wall [with] elbows. . . . Placed in horizon chair [a multi-positional wheelchair] for safety. . . ." During an interview on 08/01/12 at 10:52 a.m., a CNA (#7) stated the staff do not use the seat belt for Resident #7 unless the resident continually attempts to get up. The CNA (#7) stated, "Usually the clip alarm will go off if she tries to stand and that's enough to alert us. [Resident #7] doesn't try to stand as much anymore." The CNA (#7) stated the resident usually uses the Horizon chair (with a lap tray in place) in the evenings or during the night.	F 221	on going assessments are being done per policy, that they are discontinued when not being used, consents are in place, and alternatives have been trialed. In addition, the nurse will report weekly on restraint usage in the facility at Quality Assurance meetings that are held three times a week. OT/PT educated on updated restraint policy and will include review of restraints on MDS assessment. 4. September 12, 2012 5. QI monitor placed on all residents using restraints for following protocol will be done weekly x three months then monthly for one year and reviewed at the quarterly QI meeting. Director of Nursing is responsible.	9-12-12

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F 221	Continued From page 3 On 08/01/12 at 5:17 p.m., an unidentified CNA stated Resident #7 used the Horizon chair more frequently when she was first admitted to the facility, but staff do not use it as often anymore. The CNA stated if Resident #7 becomes really agitated, the staff might use it. CNA documentation for Resident #7 included a flow sheet with "Seat Belt PRN" written on it. Review of CNA charting from March 2012 through July 2012 identified the use of the seat belt during at least one shift every day except three days. CNA documentation and nurses' notes failed to identify rationale for the use of the prn restraint, as well as identify other measures attempted prior to using the seat belt. The most recent "Restraint/Safety Device Assessment," dated 01/12/12, stated, "Reason for initiation: hx [history] [of] falls [with] injuries, TTWB [toe-touch weight bearing] s/p [status post] [right] hip fx [fracture] [with] ORIF [open reduction internal fixation] [12/16/11], Alzheimer's dementia [with] progression . . . Restraint/safety device . . . seatbelt to W/C [wheelchair] . . . " Resident #7's medical record failed to include assessments/evaluations of the seatbelt restraint and/or Horizon chair since implementation on 01/06/12. Physical/Occupational Therapy (PT/OT) Progress Notes, dated 01/06/12, stated, ". . . Nursing [and] family report seatbelt use @ previous facility [secondary to] unaware of limitations [and] attempts to get up unattended. Family concerned that no seatbelt in place so did implement on [sic] prn. . . ." Resident #7's medical record failed to	F 221		

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F 221	Continued From page 4 include further assessments/evaluations from PT/OT related to the seatbelt use. PT/OT quarterly screens, dated 01/10/12, 04/04/12, and 07/06/12, failed to identify the presence of Resident #7's seatbelt or further evaluation/assessment of its use. A "Fall Risk Assessment," dated 07/06/12, stated, ". . . Narrative . . . Her falls have been when she exited the bed ususally [sic] looking for a bathroom. Uses a low bed, chair and bed alarm. Has a seatbelt to her wheelchair, will re evaluate [sic] the need for the seatbelt which she seems unaware of its use. . . ." Resident #7's medical record lacked a re-evaluation of the seat belt as stated above. Resident #7's medical record identified several falls; however, none of the falls occurred as a result of Resident #7 attempting to stand from her wheelchair. Observations throughout the survey identified the use of the seat belt restraint in the afternoons, and the use of the personal (clip) alarm in the mornings. The facility also failed to periodically re-evaluate the necessity of the seat belt, identify rationale for its continued use, and attempt less restrictive measures before implementing the prn restraint. The facility failed to assess/evaluate the utilization of the Horizon chair prior to its initiation, care plan and monitor its use, obtain physician's orders, and educate Resident #7's family regarding the risks and benefits. These failures may have resulted in the use of the restraint for staff	F 221		

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F 221	Continued From page 5 convenience and placed Resident #7 at risk for weakness, injuries, and decreased function/well-being. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current MDS, dated 05/06/12, identified short-term and long-term memory problems and severe cognitive impairment. The MDS did not identify the use of a "chair prevents rising" type of restraint. A physician's order, dated 08/06/11, stated, "May Use Merry Walker Daily." Resident #6's current care plan stated, ". . . Impaired mobility and ADL deficit R/T impaired standing balance and severe Alzheimer's dementia . . . Potential for falls with history of fall, attempts to get up unassisted being unaware of limitations or safety issues . . . Approaches . . . Merrywalker prn supervised . . ." Observations throughout the survey showed Resident #6 using the merry walker at various times of the day. The last evaluation for Resident #6's merry walker, dated 02/09/12, stated, ". . . enables resident to ambulate and get up [and] down herself [without] assist. [assistance] . . ." The current PT/OT quarterly screen, dated 05/04/12, stated, ". . . Rsd [resident] cont [continues] to ambulate [with] merry walker, Rsd cont to sit in Reg [regular] chair at meals. . . ." The facility staff failed to re-evaluate the use of the merry walker monthly or quarterly as per policy to ensure its use remained appropriate for Resident #6.	F 221		

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F 221	Continued From page 6 - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. The current MDS, dated 06/17/12, identified severe cognition impairment, extensive assistance of two staff members for transfers and locomotion on the unit, no falls in the past three months, and a chair that prevents rising used less than daily. The MDS, dated 03/18/12, identified a trunk restraint used less than daily and a chair that prevents rising used daily. Resident #9's current physician's orders included a rock-n-go chair (a chair that prevents rising), initiated on 03/22/12, a horizon chair PRN (a chair that prevents rising), initiated on 03/19/12, and a seatbelt, initiated on 03/07/11. Resident #9's current care plan stated, ". . . Potential for falls . . . Seatbelt PRN to wheelchair . . . Personal alarm PRN. Horizon chair PRN. Rock-n-go PRN . . ." The care plan failed to idenify when facility staff should utilize the devices. The most current OT progress note, dated 12/22/11, stated, ". . . DC'd [discontinued] alarm seatbelt [secondary] to Res [Resident #9] gets agitated when alarm goes off. Implemented reg. [regular] seatbelt. . . ." The OTA/PTA failed to follow their restraint policy which stated restraints will be reviewed monthly and the findings documented in the progress notes. The most current "Restraint Consent/Safety Device" identified the facility last obtained a telephone consent from Resident #9's family	F 221		

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F 221	Continued From page 7 member on 03/07/11. The consent stated, "I/We consent to the use of said restraint or safety device: 12/15/10 Merry Walker with supervision. 1/5/11 - horizon chair prn with tray. 3-7-11 W/C [wheelchair] seatbelt prn for said reason: Restlessness with poor gait and balance at times. Resident is unaware of limitations and safety issues with her dementia . . ." Resident #9's "Restraint Device Assessment," dated 03/27/12, stated, "Evaluation . . . seatbelt to w/c PRN. horizen [sic] chair PRN . . . hx [history] of falls, unaware of safety, gets up unassisted. Unable to stand unassisted, Impaired cognition R/T [related to] Alzheimer's dementia. Becomes physically aggressive @ [at] times. Any new alternatives: horizen [sic] chair used PRN when not sitting functionally in w/c. Also has episodes of anxiety & [and] agitation, strikes out @ staff & others . . ." The assessment, dated 06/25/12, stated, ". . . seatbelt in w/c PRN . . . reason . . . Attempts to get up unassisted . . . Attempting to [decrease] use of seatbelt. Used [less than or equal to] daily during assessment . . ." The assessments failed to identify whether Resident #9 could purposely remove the seat belt or tray from the horizon chair. Resident #9's nurses notes identified the following: * 03/21/12 at 2:00 p.m. - "Resident pinched another resident. [3:00 p.m.] Up in horizon chair - restless & pounding on tray. [4:00 p.m.] Orders rec'd [received] for Haldol [antipsychotic] . . . given at this time. [8:30 p.m.] Calm & cooperative for shift up to now [after] receiving Haldol." * 03/26/12 at 8:00 p.m. - ". . . Sitting up in horizon chair. Denies any complaints or pain."	F 221		

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F 221	Continued From page 8 The above nurses notes revealed facility staff utilized the horizon chair for Resident #9's behaviors and or pain, not as a positioning device. Resident #9's "Interdisciplinary Care Plan Conference" notes, dated 03/27/12, stated, ". . . Is using a seatbelt in w/c & has a PRN horizen [sic] chair [with] tray ordered, the seatbelt is used daily . . . the horizen [sic] chair [with] tray is available when she is leaning forward & not in good position for eating and she does become anxious & agitated, physically abusive & resistive to cares @ times . . . treated for UTI [urinary tract infection] 3-22-12. Her leaning & behaviors potentially related to the UTI . . ." The note, dated 04/02/12, stated, "Behavior Meeting: . . . Is using the horizen [sp] chair PRN for positioning in evening . . ." During all days of survey except during meals, observation showed a seatbelt utilized while Resident #9 sat in her wheelchair. The nurses' notes failed to consistently identify other measures attempted prior to the use of the horizon chair. The OTA/PTA failed to assess/evaluate the use of the seat belt and horizon chair as per policy to ensure appropriate use. - Resident #2's medical record, reviewed July 30, 2012-August 2, 2012, identified diagnoses including anxiety, dementia with behaviors, and history of fall/hip fracture. The quarterly MDS, dated 07/18/12, identified severe cognitive impairment and a trunk restraint used out of bed (seat belt).	F 221		

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F 221	Continued From page 9 The current physician's orders, dated 07/12/12, stated, ". . . Chair alarm prn [order date 10/20/11] . . . Horizon chair with tray prn [as needed] [order date 06/14/12] Seat belt on w/c prn [order date 07/17/12] . . ." The current care plan stated the following, ". . . Problem: Impaired mobility . . . S/P (L) [left] hip fracture, Dementia . . . Pelvic fx [fracture] . . . unaware of limitations or safety issues. Attempts to get up unassisted . . . Plans and Approaches . . . Horizon chair [with] tray prn - restless/behaviors . . . Seatbelt on w/c prn. . . ." The Occupational Therapy (OT) Plan of Treatment, dated 07/17/12, stated, ". . . Summary: . . . Res [resident] referred to OT for w/c positioning. Resident previously in reg [regular] w/c and using horizon chair prn if lethargic. Res was attempting to get out of reg w/c if restless [and] is a fall risk. Rec [recommend] use of seat belt in w/c prn, along with horizon prn." The Progress Notes identified the following: * 07/23/12 at 6:43 a.m., "Seat belt on W/C. UP IN W/C WITH SEATBELT R/T [related to] RESTLESSNESS." * At 3:53 p.m., "Seat belt on W/C. used until laid down at 10:30." * 07/24/12 at 6:15 p.m., "Seat belt on W/C. restless - getting out of w/c per self - given a snack and had been to BR [bathroom]." * At 8:48 p.m., "Seat belt on W/C. sat in w/c and asked for help until bed time." The most recent "Restraint Device Assessment,"	F 221		

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F 221	Continued From page 10 dated 06/14/12, stated, ". . . Restraint/safety device to be used and when: horizon chair with tray prn - with behaviors - unsteady gait - attempting to transfer self." Resident #2's medical record failed to include a restraint assessment relating to the use of the seat belt. During an interview on 08/02/12 at 9:00 a.m., two managerial nursing staff members (#24 and #25) agreed staff failed to complete a "Restraint Device Assessment" relating to the use of the seat belt. When asked who decides when the prn seat belt is to be applied, they stated it is "based on the nurse's judgement." The nursing staff failed to assess/evaluate the use of the seat belt as per policy to ensure use was appropriate for Resident #2. In addition, the nurses' notes failed to consistently identify other measures attempted prior to use of the seat belt.	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care in a manner that maintained or enhanced dignity for 3 of 14 sampled residents (Resident #6, #8, and #9) and 1 supplemental resident (Resident #19). Failure to knock on residents' doors prior to entering the room and wait for a response/permission to enter	F 241	F241 1. Residents #6, #8, #9 and #19 have had notices placed on their doors that will remind staff to knock. Staff educated at Unit Meetings, Nurse's Meetings and Department Head meeting to comply with knocking and entering room policy. 2. All residents have potential for being affected. 3. A policy has been written to address proper entrance into resident's rooms and posted	

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F 241	Continued From page 11 does not respect residents' privacy and may negatively impact a resident's self-esteem and sense of self-worth. Findings include: - Observation on 07/30/12 at 4:47 p.m. showed a certified nursing assistant (CNA) (#6) assisted Resident #6 with toileting in the resident's bathroom. A CNA (#4) knocked on the door to the resident's room as she opened it and stated, "It's [CNA name]." The CNA (#4) failed to wait for a response/request permission to enter the room. - Observation on 07/31/12 at 1:11 p.m. showed a CNA (#2) assisted Resident #8 with toileting in the resident's bathroom. A CNA (#5) knocked on the door to the resident's room, immediately opened the door, and entered the room. The CNA (#5) failed to wait for a response/request permission to enter the room. Observation on 07/31/12 at 4:21 p.m. showed a CNA (#3) assisted Resident #8 with toileting in a public bathroom next to the activity room. An unidentified staff member opened the bathroom door; stated, "Oh! Sorry;" and quickly shut the door. The CNA (#3) failed to lock the bathroom door, which resulted in Resident #8 being unnecessarily exposed. During an interview on the afternoon of 08/02/12, a supervisory nursing staff member (#10) stated she expected staff members to knock; wait for a response; and if no response, announce themselves and slowly enter the room. - Observation on 07/31/12 at 1:25 p.m. showed	F 241	throughout the facility. This policy was presented and in-serviced to staff at the Unit Meeting on August 29, 2012, Nurse's Meeting on August 30, 2012 and Department Head meeting on August 28, 2012 and minutes posted. All resident rooms will have a sign placed on their door reminding staff to knock. 4. September 12, 2012. 5. QI monitor weekly for one month and monthly for one year to monitor compliance of entering rooms and reviewed at quarterly QI meeting. Director of Nursing is responsible.	9-12-12

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	355037	A. BUILDING _____ B. WING _____	08/02/2012

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F 241	Continued From page 12 two CNAs (#5 and #22) transported Resident #9 into the shower room for toileting. A CNA (#2) knocked on the shower room door and immediately entered just as the CNAs (#5 and #22) placed the resident on the commode. The CNA (#2) failed to wait for permission to enter the shower room. - During an interview with Resident #19 in her room on 08/02/12 at 9:30 a.m., an unidentified housekeeping staff member knocked on the door and entered immediately. The staff member failed to wait for permission to enter Resident #19's room. During an interview on 08/02/12 at 1:30 p.m., an administrative staff member (#27) stated facility staff are instructed to knock, announce themselves, wait for a reply, and then enter the room.	F 241		
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	F 278	F278 1. Residents 2, 3, 5, 6, 7, 8 and 9 had no negative outcome. MDS staff has changed method for completion of H0200 and discontinued practice of using bowel and bladder record as a toileting schedule. Resident #6 and #7 most recent MDS was corrected on August 30, 2012 in regards to restraint use, antidepressant medication and pain medication 2. All resident have potential for inadvertent miscoding of MDS.	

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F 278	Continued From page 13 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 observation, record review, review of the Long-Term 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 resident's status for 7 of 14 sampled residents regarding a toileting program (Resident #2, #3, #5, #6, #7, #8, and #9); 2 of 14 sampled residents regarding pain medications (Resident #6 and #7); 1 of 14 sampled resident Resident #6) regarding an antidepressant medication used daily; and 2 of 14 sampled residents regarding restraint use (Resident #6 and #7). Failure to accurately code the MDS for these residents limited the facility's ability to develop and implement individualized care plans consistent with the residents' needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual, April 2012, page 2-1 states, ". . . The RAI process	F 278	3. MDS staff informed of the change in protocol for completion of H0200 and discontinued the practice of using the bowel and bladder record as a toileting schedule. Audits will be done on all MDS's that have been completed for accuracy on sections H, J, N and P. 4. September 12, 2012 5. QI monitor accuracy of MDS weekly for one month then monthly for one year and review at quarterly QI meeting. Assistant Director of Nursing responsible.	9-12-12

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F 278	Continued From page 14 is the basis for the accurate assessment of each nursing home resident . . ." Page H-6 states, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: * simply tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and depression. The quarterly MDS, dated 06/17/12, identified severe cognition impairment, required extensive assistance of two staff members for toileting, always incontinent of urine, frequently incontinent of bowel, and on a scheduled toileting program. Resident #9's bowel and bladder assessment, dated 06/25/12, stated, "Resident is showing increased incontinence for bowel and bladder with showing no correct voidings as before . . ." Resident #9's "Toileting Times" record stated, "With am [a.m.] cares, After Dinner, Before Supper, HS [bedtime], and PRN [as needed]." Review of the record for July 2012 identified the following incontinence episodes: * With a.m. cares - 24 of 31 days * After dinner - 24 of 31 days * Before supper - 28 of 31 days * HS - 29 of 31 days * PRN - 31 of 31 days On 07/30/12 at 4:14 p.m., two certified nursing	F 278		

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F 278	Continued From page 15 assistants (CNAs) (#6 and #35) assisted Resident #9 onto a commode. Observation showed the resident voided on the commode and her brief saturated with urine. Observation on 07/31/12 at 8:55 a.m. showed Resident #9 seated in the dining room. A CNA (#5) stated the resident had a brief change earlier related to incontinence. At 1:25 p.m., two CNAs (#5 and #22) assisted Resident #9 to the commode. Observation showed the resident voided and her brief saturated with urine. The facility failed to implement individualized toileting times, periodically re-evaluate the effectiveness of Resident #9's toileting program, and make revisions to the program if needed bases on her assessment. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current physician orders included Tylenol 1000 milligrams (mg) three times per day (TID), Lexapro (an antidepressant) 20 mg daily, and "May Use Merry Walker Daily." Resident #6's care plan identified a toileting schedule with the following times: before breakfast by nocs (night shift), with a.m. cares, after dinner, before supper, and HS. The current MDS, dated 05/06/12, identified occasional urinary incontinence, a scheduled toileting plan, no scheduled pain medication, no antidepressant use, and no restraint use. Review of CNA documentation showed Resident #6 used the merry walker restraint every day during the MDS assessment period.	F 278		

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F 278	Continued From page 16 Observations during the survey showed the following: *07/30/12 at 4:47 p.m. - Two CNAs (#1 and #6) assisted Resident #6 to the bathroom, her brief saturated with urine, and she did not void. *07/31/12 at 10:52 a.m. - A CNA (#7) attempted to toilet Resident #6, but the resident refused. *08/01/12 at 9:30 a.m. - A CNA (#7) attempted to toilet Resident #6, but the resident refused. Facility staff failed to code a scheduled pain medication, a "chair prevents rising" restraint used daily, and a daily antidepressant on Resident #6's current MDS. Staff also failed to implement individualized toileting times, periodically re-evaluate the effectiveness of Resident #6's toileting program, and make revisions to the program, if needed, based on the assessment. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current physician orders included Meloxicam (a pain reliever) 7.5 milligrams (mg) daily (QD), and a seat belt used as needed (prn). The current MDS, dated 07/06/12, identified frequent urinary incontinence, a scheduled toileting program, no scheduled pain medication, and a trunk restraint used in bed less than daily. Resident #7's current care plan identified a toileting schedule with the following times: With a.m. cares, after dinner, before supper, HS and PRN. Review of CNA documentation showed Resident	F 278		

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F 278	Continued From page 17 #7 used the seat belt restraint every day during the MDS assessment period. Observations during the survey showed the following: *07/30/12 at 4:30 p.m. - Two CNAs (#1 and #4) attempted to toilet Resident #7, but the resident refused. *07/31/12 at 8:49 a.m. - A CNA (#15) assisted Resident #7 to the bathroom, her brief was dry and she did not void. *07/31/12 at 3:57 p.m. - Two CNAs (#21 and #22) assisted Resident #7 to the bathroom, her brief was dry and she did not void. During an interview on 07/31/12 at 8:49 a.m., a CNA (#15) stated all residents on a toileting schedule go at the same times, such as with morning cares, at bedtime, before supper, etc. This CNA stated "[Resident #7] has been on that schedule [toileting schedule described above] as long as I can remember." Facility staff failed to implement individualized toileting times, periodically re-evaluate the effectiveness of Resident #7's toileting program, and make revisions to the program, if needed, based on the assessment. Facility staff failed to code a scheduled pain medication and a trunk restraint used out of bed (seat belt) daily. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and unspecified urinary incontinence. The current MDS, dated 06/29/12, identified frequent urinary incontinence and a scheduled toileting program. Resident #8's care plan identified a toileting schedule with the	F 278		

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F 278	Continued From page 18 following times: before breakfast by nocs, with a.m. cares, after dinner, before supper, and HS. Observations during the survey showed the following: *07/30/12 at 4:35 p.m. - Two CNAs (#1 and #6) assisted Resident #8 to the bathroom, her brief was saturated with urine, and she voided. *07/31/12 at 1:11 p.m. - A CNA (#2) assisted Resident #8 to the bathroom, her brief was saturated with urine and she voided. *07/31/12 at 4:21 p.m. - A CNA (#3) attempted to toilet Resident #8, but the resident refused. *08/01/12 at 9:40 a.m. - A CNA (#23) attempted to toilet Resident #8, but the resident refused. *08/01/12 at 1:30 p.m. - A CNA (#26) attempted to toilet Resident #8, but the resident refused. Facility staff failed to implement individualized toileting times, periodically re-evaluate the effectiveness of Resident #8's toileting program, and make revisions to the program, if needed, based on the assessment. - Resident #2's medical record, reviewed July 30-August 2, 2012, identified diagnoses of anxiety, dementia with behaviors, kidney failure, and urinary retention. The quarterly MDS, dated 07/18/12, identified severely impaired cognition, extensive assistance of one person required for toileting, and on a scheduled toileting program. The Urinary Incontinence Care Area Assessment (CAA), dated 04/18/12, stated, "Resident was continent of bowel and bladder during assessment but has episodes of bowel and bladder incontinence when is unable to get to bathroom in time. She is on a toileting schedule to maintain her continence and avoid getting up	F 278		

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F 278	Continued From page 19 unassisted." Resident #2's current care plan stated the following, ". . . Problems . . . Alteration in elimination . . . Plans and Approaches . . . Toileting schedule, Requires assist to toilet . . ." The "Toileting Times Record" identified "Before Bkfst by NOCS, With am Cares, After Dinner, Before Supper, and HS." Observations and interviews identified the following: * During interview on 07/31/12, a nursing staff member (#19) reported toileting Resident #2 at 1:20 p.m. The resident brief was dry and voided in the toilet. * During interview on 07/31/12, a nursing staff member (#20) reported toileting Resident #2 at 2:22 p.m. The resident was incontinent of urine and voided in the toilet. * Observation on 07/31/12 at 2:40 p.m., showed Resident #2 as incontinent prior to being placed on the toilet, and voided in the toilet. During interview on 08/02/12 at 9:00 a.m., two administrative nursing staff members (#24 and #25) stated, "She [Resident #2] just gets up and tries to go to the bathroom. She has no pattern." The facility failed to implement an individualized toileting times, periodically re-evaluate the effectiveness of Resident #2's toileting program, and make revisions to the program, if needed based on the assessment. - Resident #3's medical record, reviewed July 30-August 2, 2012, identified diagnoses of anxiety, dementia with behaviors, and history of	F 278		

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F 278	Continued From page 20 urinary tract infection (UTI). The quarterly MDS, dated 06/01/12, identified severe cognitive impairment, required extensive assistance of one person for toileting, and on a scheduled toileting program. The Urinary Incontinence CAA, dated 03/07/12, stated, "She requires staff to initiate toileting with resident being unaware of her toileting needs and requires assist to transfer and ambulate to bathroom along with clothes management, cleansing and incontinence care. She was started on a toileting schedule." Resident #3's current care plan stated the following, ". . . Problems . . . Alteration in elimination . . . Plans and Approaches . . . Toileting schedule . . . Requires assist to toilet . . ." The "Toileting Times Record" identified "Before Bkfst by NOCS, With am Cares, After Dinner, Before Supper, and HS." Observations and interviews identified the following: * Observation on 07/31/12 at 8:40 a.m. showed an unidentified CNA assisted Resident #3's to the bathroom. She brief was saturated with urine and she voided in the toilet. * During an interview on 07/31/12, an unidentified nursing staff member reported toileting Resident #3 at 1:20 p.m. The resident was incontinent of urine and voided in the toilet. * Observation on 07/31/12 at 4:55 p.m. and on 08/01/12 at 10:45 a.m., showed Resident #3 was incontinent prior to being placed on the toilet, and voided in the toilet. * Observation on 08/01/12 at 12:27 p.m., showed Resident #3 as continent prior to being placed on the toilet, and voided in the toilet.	F 278		

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F 278	Continued From page 21 During interview on 08/02/12 at 9:00 a.m., two managerial nursing staff members (#24 and #25) agreed Resident #2 and Resident #3's toileting programs were identical and failed to reflect each resident's unique voiding pattern. The facility failed to establish an individualized toileting program based on Resident #3's voiding pattern. - Review of Resident #5's medical record occurred July 30 - August 2, 2012 The resident's diagnoses included dementia and cerebral vascular accident (CVA). The significant change MDS, dated 06/06/12, identified severely impaired cognition, required extensive assistance of one person for toileting, frequently incontinent of urine and occasionally incontinent of bowel, and on a scheduled toileting program. Resident #5's bowel and bladder assessment, dated 06/06/12, stated, ". . . She is frequently incontinent of bladder with an occasional correct voiding. . . ." The resident's Urinary Incontinence CAA, dated 06/12/12, stated, ". . . Resident has numerous factors that contribute to her urinary incontinence. Do not expect an improvement but will care plan to maintain her current ability. She will be continent of bladder at times and has been doing fairly well with bowel continence. . . ." Resident #5's current care plan stated the following: "Problem: Alteration in elimination due bladder incontinence . . diurectic [sic] use . . . urinary urgency . . . Objective: Resident will remain continent of bladder 50% of the time. . . . Approaches: Toileting schedule. . . ."	F 278		

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F 278	Continued From page 22 Review of the "Toileting Times Record," completed by CNAs for July 2012, showed no consistency/pattern in Resident #5's infrequent continence. Review of the record for July 2012 identified the following incontinence episodes: *Nocs 1st Rounds - 21 of 31 days *Before Breakfast by Nocs - 25 of 31 days *After Breakfast - 29 of 31 days *Before Dinner - 25 of 31 days *After Supper - 25 of 31 days *HS - 30 of 31 days The "Toileting Times Record," completed by CNAs, identified "Nocs 1st Rounds, Before Bkfst by Nocs, After Breakfast, Before Dinner, After Dinner, Before Supper, After Supper, and HS." The facility failed to establish an individualized toileting program based on Resident #5's voiding pattern. During interview on 07/31/12 at 11:05 a.m., a CNA (#28) stated toileting Resident #5 as "hit or miss . . . continent all day, or can void and forty five minutes later incontinent . . . depends." During interview on 07/31/12 at 4:25 p.m., a CNA (#21) stated Resident #5 as "mostly incontinent" on the evening shift, after supper and before bed, when the resident is toileted, or the resident states, "I have to go and is already incontinent." During an interview on the afternoon of 08/01/12, an MDS nurse (#9) stated she miscoded the MDSs related to restraint use, pain medication, and antidepressant use. The MDS nurse (#9) confirmed her unawareness of the specific requirements of a toileting schedule.	F 278		

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F 309 SS=G	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: 1. Based on record review and staff interview, the facility failed to provide the necessary care and services to ensure treatment for 1 of 1 sampled resident (Resident #2) diagnosed with a pelvic fracture. Failure to complete a comprehensive pain assessment, implement interventions, and evaluate the effectiveness of the interventions related to pain management resulted in Resident #2 receiving unnecessary psychoactive medications for agitation. Findings include: The "Nursing Weekly Assessment . . . Charting Tips" stated, "PAIN - use 1-10 scale, or mild, moderate, severe - have resident describe - sharp, stabbing, dull, - Location - does it radiate? - Frequency - daily, frequently, only at night - if they report pain and you offer them medication do they refuse it - does anything make pain better or worse IF THEY REPORTED PAIN DID YOU DO ANYTHING - ACTION/RESULT! . . . COMMUNICATION/ADL ABILITIES - . . . can they make needs known, do they make requests for pain medication . . . MOOD & BEHAVIORS - BE	F 309	F309 Pain 1. Resident #2 pain has been addressed. The citation was presented and reviewed at Medical Staff meeting on August 15, 2012 and all health care providers were present. The citation was reviewed at the Nurse's Meeting on August 30, 2012 and educated on the importance of monitoring, documenting and reporting of resident's pain. An in-service has been scheduled for September 5, 2012 by our consultant pharmacist to present information on pain and anti-anxiety medications. 2. All residents have the potential to experience pain. 3. All residents will have a comprehensive pain assessment upon admission. Residents who trigger for pain through the MDS or exhibit frequent pain will have a comprehensive pain assessment completed. If indicated by results of comprehensive pain assessment focus charting will	

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	355037	A. BUILDING _____ B. WING _____	08/02/2012

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F 309	Continued From page 24 DESCRIPTIVE! restless . . ." - Resident #2's medical record, reviewed July 30-August 2, 2012, identified diagnoses including anxiety, dementia with behaviors, falls, and history of left hip and pelvic fractures. The quarterly Minimum Data Set (MDS), dated 07/18/12, identified severely impaired cognition, limited assistance required for transfers and walking in room, history of falls, and scheduled and/or prn [as needed] pain medications. The current care plan stated the following, ". . . Problem: . . . Pelvic fx [fracture] . . . Alteration in comfort . . . Assess location, characteristics and severity of pain, Observe for verbal and nonverbal signs of pain, Medicate for pain as ordered, Monitor for relief of pain . . . Assist resident to identify things that precipitate pain . . ." Review of Resident #2's medical record identified the following: * 04/22/12 at 10:05 a.m., "Found sitting on floor - says she hurts all over - but moves about well - walks - was some hesitation (L) leg!" . . . at 1:00 p.m., "c/o [complains of] more severe pain (L) leg - [Dr.] notified - Resident to ER [emergency room] - Xray done" . . . at 2:30 p.m., "Back to room - more comfortable" . . . at 5:40 p.m., "Pain: denied pain, not until tried to stand . . . unable to stand . . . c/o pain left leg [with] trying to stand . . ." * 04/23/12 at 2:15 a.m., "ROM [Range of motion]: WNL [within normal limits] but left leg stiff . . . Pain: left leg" . . . at 10:00 a.m., "Pain: all over" . . . at 8:00 p.m., "Pain: generalized . . ." The physician's progress report, dated 04/23/12, stated, ". . . She was taken over [sic] the ER and	F 309	be initiated, Unit manager informed and the data will be communicated to the health care provider and any interventions implemented. The citation was presented at the Medical Staff meeting on August 15, 2012 and reviewed. All health care providers were present. The citation reviewed at Nurse's Meeting on August 30, 2012 and educated on the importance of monitoring, documenting and reporting resident's pain. An in-service has been scheduled by our consultant pharmacist on September 5, 2012 to present information on pain and anti-anxiety medications. Nurses also instructed to document offers of prn pain medication and resident's response. A pain management policy has been developed. This policy was presented to nursing staff at the Nurse's Meeting on August 30, 2012 and minutes posted. Training on pain management policy will be completed with all nurses. The pain management policy provided to health care	

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F 309	Continued From page 25 her hip was x-rayed. It was negative . . . Physical Assessment: . . . Pelvic bones appear stable. No pain with walking motion." Review of Resident #2's medical record identified the following: * 04/24/12 at 4:20 a.m., "Pain: (L) side . . . Comments: stated why can't I move my (L) leg - however she had just ambulated to [and] from the BR [bathroom]" . . . at 10:00 a.m., "Pain: left leg . . ." * 04/25/12 at 12:01 a.m., "Pain: left leg" . . . at 7:40 a.m., "Pain: left leg . . . stated weakness with standing - assist to [change] position" . . . at 7:45 p.m., "Pain: left leg." * 04/26/12 at 12:40 a.m., "Unable to settle. Very anxious about not feeling well. [Up and down] multiple x's [times]. Ativan provided for coverage. Also provided [one] Tylenol for pain." . . . at 3:10 a.m., "She was again up to the BR [and] requested something for pain" . . . "Up to BR x 2 b/4 [before] 10:00 a.m. Called for help - [and] waited for help b/4 going to BR . . . When walking to BR - stepped [with] (L) foot - - dragged (R) [right] foot!" . . . "gait slow, c/o (R) leg pain, drags (R) foot." * 04/28/12 at 1:00 p.m., ". . . Remained in bed thru [through] out the shift except to amb [ambulate] to toilet [with] walker [and one] assist . . ." * 04/30/12, "Monitor . . . for cont. [continued] pain to (L) leg." * 05/01/12, "Resident c/o having terrible pain in hip/leg. Tylenol ES [extra strength] given [at] 2:30 p.m., resident states she doesn't think it will help . . . Resident cont to complain of pain in L) hip/leg. Also res [resident] seems very anxious d/t [due to] pain - prn anxiety med [medication] given,	F 309	providers. 4. September 12, 2012. 5. QI monitor for all residents who trigger for pain weekly for one month then monthly for two months and review at quarterly QI meeting. The Director of Nursing will be responsible.	9-12-12

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F 309	Continued From page 26 resident continued to be anxious, restless - warm pack placed to L hip/leg [without] relief. Res unable to sit in chair comfortably - Res has been unable to settle down to sleep . . ." * 05/02/12 at 12:15 a.m., "Resident has been very anxious [secondary to] her (L) leg pain. She can't understand why it doesn't get better. She has a very difficult time finding a comfortable position. Ativan given to help with the anxiety." * 05/04/12 at 6:00 p.m., ". . . states she doesn't feel well . . . pain all over [and] in left leg." * 05/06/12 at 5:00 p.m., ". . . Favors left leg [and] c/o pain [with] weight bearing or movement - up for supper . . . but slept the rest of the shift." * 05/08/12, ". . . Stary [sic] eyed . . . She stated she just wasn't hungry anymore." * 05/09/12, "Resident rested most of the morning, up and ate some dinner then rested." . . . "w/c for mobility for distance." * 05/10/12, "Seems very tired! Says she just can't take her pills!" . . . at 5:00 p.m., "Appetite is very poor - unable to get her to take fluids . . ." The physician's progress report, dated 05/10/12, stated, ". . . She does state her legs hurt her at times . . . Nursing has concerns regarding her decrease in activity . . . We will get a CT [computerized tomography] of her hips . . ." The radiology report, dated 05/11/12, identified "fractures involving the inferior and superior pubic ramus on the left with fractures also present in the pubic symphyseal region." The electronic medication administration record (eMAR), dated April 2012 - May 2012, identified the following: * 04/22/12 at 11:40 a.m., "Hydrocodone . . . pain	F 309		

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F 309	Continued From page 27 due to her fall" * 04/23/12 at 2:16 a.m., "Hydrocodone . . . left leg" * 04/24/12 at 11:54 a.m., "Hydrocodone . . . pain everywhere" * 04/26/12 at 12:35 a.m., "Ativan . . . anxious about not feeling well - up and down" . . . at 3:14 a.m., "Hydrocodone . . . c/o L hip/leg pain. Had refused scheduled (spit out) but was really hurting and took this one" * 04/28/12 at 3:43 p.m., "Ativan . . . agitation" * 04/30/12 at 8:35 a.m., "[Nurse practioner] . . . updated on residents . . . pain cont L leg" * 05/01/12 at 5:28 p.m., "Tylenol . . . stated she has pain in her left hip that is driving her crazy" . . . at 5:29 p.m., "Ativan . . . anxiety over the pain she is having in her left hip . . . at 9:12 p.m., "Ativan . . . very little relief r/t [related to] pain in legs" . . . at 9:14 p.m. "Tylenol . . . res cont to complain of pain" * 05/02/12 at 12:11 a.m., "Ativan . . . anxious - lots of pain with no med to give" . . . at 5:31 a.m., "Ativan . . . partially effective - still lots of pain" . . . at 1:00 p.m., "Resident has been complaining, as documented, of pain that has not been relieved by current medications. Spoke with [Nurse Practitioner] regarding this and orders received . . . Tramadol" * 05/04/12 at 6:06 p.m., "Tylenol . . . c/o pain in legs and all over" * 05/05/12 at 3:03 a.m., "Tylenol . . . pain to legs" . . . at 11:37 p.m., "Ativan . . . unable to sleep" * 05/06/12 at 1:29 a.m., "Ativan" * 05/09/12 at 1:19 a.m., "Tylenol . . . c/o bilat [bilateral] leg pain" . . . at 9:29 p.m., "Ativan . . . Tylenol . . . only took part of medication, is lying quietly and calm in bed with eyes closed"	F 309		

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F 309	Continued From page 28 Review of Resident #2's medical record identified the following: * Ativan 0.5 mg [milligram] prn [every six hours as needed] for anxiety (Ordered 10/20/11) * Tylenol 1000 mg tid [three times daily] and prn [one extra in 24 hours] for pain (Ordered 04/30/12 - increased from 500 mg twice daily beginning 10/20/11) * Hydrocodone 7.5-200 mg every eight hours and prn [one extra in 24 hours] for pain (Ordered 03/27/12) * Tramadol HCL 50 mg prn for femur fracture (Ordered 06/01/12 - decreased from 100 mg three times daily beginning 05/02/12) * Fentanyl Transdermal 25 mcg/hr [micrograms/hour] for femur fracture (Ordered 07/23/12 - increased from 12 mcg/hr beginning 06/01/12) Failure of facility staff to assess, identify, and treat Resident #2's continued and increasing pain resulted in the resident experiencing avoidable pain and resulted in the resident being medicated with an antianxiety medication in an effort to treat Resident #2's anxiety related to unresolved pain. 2. Based on record review, review of facility information, review of a professional reference, and staff interview, the facility failed to provide interventions to promote regular bowel elimination for 4 of 14 sampled residents (Resident #6, #7, #8, and #9). Failure to implement the bowel program according to the facility's protocol resulted in the manual extraction of stool for Resident #8, and may result in unrelieved constipation for other residents. Findings include:	F 309	F309 Bowel Elimination 1. Residents #6, 7, 8 and 9; nursing staff are monitoring daily for bowel movements. Bowel Management Program has been revised and instituted. Slips have been sent to Dietary August 27, 2012 to assess for need of dietary intervention. Physicians were notified on August 27, 2012 and reviewed these resident's plan of care.	

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F 309	Continued From page 29 Review of the facility document "NIGHT NURSE DUTIES 11PM [11:00 p.m.] TO 7AM [7:00 a.m.]" occurred on 08/02/12. This undated document stated, ". . . check bowel elimination records-make a list of residents who need a laxative-count every third day . . ." Taylor, Lillis, and LeMone, "Fundamentals of Nursing, The Art & Science of Nursing Care," 4th ed., Lippincott Williams & Wilkins, Pennsylvania, page 1193, states "Nursing measures for patients without specific bowel elimination problems are directed toward the patient's achievement of the following goals. . . . Have a soft, formed bowel movement every 1 to 3 days without discomfort . . ." During an interview on 08/01/12 at 4:30 p.m., a supervisory nursing staff member (#13) stated constipation is generally managed by giving prune juice on the second day without a bowel movement and giving a suppository on the third day without a bowel movement. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a history of constipation. Current physician's orders included Milk of Magnesia (MOM) (a laxative) 30 milliliters (ml) prn (as needed), Dulcolax (a stool softener) 10 milligram (mg) suppository prn, and Senna S (a laxative) two tablets in the morning and one tablet at bedtime (HS). Resident #8's current care plan stated, ". . . Alteration in elimination [secondary to] bowel and bladder incontinence R/T [related to] Alzheimers [sic] dementia . . . slowed mobility . . . Gets up	F 309	2. All residents have the potential to be affected. 3. Nursing staff monitors all residents for bowel elimination daily. Physicians were notified of the deficiency. Routine bowel care orders are being implemented for all residents. Bowel Management Program and the Routine Bowel Care Orders were reviewed at the nurse's meeting on August 30, 2012. Unit supervisors will monitor bowel elimination records and the use of interventions. Unit supervisors will send a dietary alert to the LRD to assess for dietary bowel interventions when noted three days without stool occurring. 4. September 12, 2012. 5. QI monitor of the bowel elimination record on identified residents weekly for three months and random selection of residents weekly for three months for adhering to the Bowel Management Program. Report at quarterly	

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F 309	Continued From page 30 from toilet before she evacuates bowels - constipation . . . OBJECTIVE . . . Resident will have adequate bowel elimination through . . . 10/17/12 . . . Approaches . . . Duccolax [sic] suppos [suppository] prn constipation . . . Fruit Mix BID [twice per day] . . . MOM 30 [mL] prn . . . Senna S [two] tabs [tablets] in a.m., [one] @ HS . . ." Review of the daily report log (used by the nurses to give report to the next shift) for 04/19/12 revealed the following hand-written entry next to Resident #8's name: "Had Manual BM [bowel movement] Removal." Resident #8's medical record did not include any information related to the above incident, and facility staff were unable to provide additional information. Review of Resident #8's BM records showed the following inconsistencies related to the management of the resident's constipation according to facility policy: *April 7-8, 2012: No BM for two days, suppository given on the 9th (day three), no interventions attempted prior to the suppository *April 10-13, 2012: No BM for four days, prune juice given on the 11th and 12th, nothing given on the 13th, and a suppository given on the 14th (day five) with results *April 15-17, 2012: No BM for three days, suppository given on the 18th with results unclear. *April 19, 2012: (Manual extraction of stool at noted above on the daily report log) *April 20-21, 2012: No BM for three days; prune juice given on the 19th, 20th, and 21st; suppository given on the 22nd (day four) with	F 309	QI meeting. Director of Nursing is responsible.	9-12-12

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F 309	Continued From page 31 results *May 8-12, 2012: No BM for five days, no interventions given. Resident #8 had an extra large BM on the 13th (day six) *May 14-19, 2012: No BM for six days, no interventions given. A hand-written note on the May 20th daily report log stated, "Last BM 5/13*. . . . Needs supp [suppository] in a.m. . . ." Records showed that Resident #8 had a large BM on the 20th (day seven) without intervention *May 22-27, 2012: No BM for six days, no interventions given. Resident #8 had a large BM on the 28th (day seven) *May 29-June 1, 2012: No BM for four days, suppository given on the 2nd (day five) with results *June 3-5, 2012: No BM for three days, MOM given on the 5th (day three), suppository given on the 6th (day four) with results *June 7-10, 2012: No BM for four days, suppository given on the 11th (day five) with results *June 12-14, 2012: No BM for three days, suppository given on the 15th (day four), no interventions attempted prior to the suppository *June 19-20, 2012: No BM for two days, suppository given on the 21st (day three), no interventions attempted prior to the suppository *June 22-24, 2012: No BM for three days, suppository given on the 25th (day four), no interventions attempted prior to the suppository *July 4-6, 2012: No BM for three days, prune juice given on the 5th and again on the 6th, suppository given on the 7th (day four) with results *July 25-27, 2012: No BM for three days, prune juice given on the 26th, no intervention on the 27th, prune juice again given on the 28th, and a	F 309		

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F 309	Continued From page 32 BM on the 28th *July 29-30, 2012: No BM for three days, prune juice given on the 30th and 31st, suppository given August 1 (day four) with results. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current physician's orders included Dulcolax 5 mg once a day, MOM 30 ml prn, and Dulcolax suppository 10 mg prn. Resident #6's current care plan stated, ". . . Constipation . . . hx of having loose stools [with] possible IBS [irritable bowel syndrome] & incontinence prio [sic] to admission . . . OBJECTIVE . . . Resident will have adequate bowel elimination the majority of the time through 8-8-12 . . . Approaches . . . Dulcolax suppository rectally prn constipation . . . Senna fruit mix one tablespoon daily . . . Dulcolax tab one po [by mouth] daily . . .MOM 30 [ml] po prn bowel care . . . Senna tea one half cup prn constipation . . ." Review of Resident #6's BM records showed the following inconsistencies related to the management of the resident's constipation according to facility policy: *April 12-13, 2012: No BM for two days, suppository given on the 14th (day three), no interventions attempted prior to the suppository *April 15, 2012: No BM, suppository given on the 16th (day two) with results *April 23-25, 2012: No BM for three days, prune juice given on the 25th (day three), and a BM on the 26th *April 27-29, 2012: No BM for three days, suppository given on the 30th (day four), no interventions attempted prior to the suppository	F 309		

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F 309	Continued From page 33 *May 9-11, 2012: No BM for three days, no interventions given. Resident #6 had a small BM on the 12th (day four). *May 21-22, 2012: No BM for two days, suppository given on the 23rd (day three), no interventions attempted prior to the suppository *June 6-8, 2012: No BM for three days, suppository given on the 9th (day four), no interventions attempted prior to the suppository *June 23-25, 2012: No BM for three days, suppository given on the 26th (day four), no interventions attempted prior to the suppository - Review of Resident #7's medical record occurred on all days of survey. Diagnoses include Alzheimer's disease. Current physician's orders included Dulcolax suppository 10 mg prn, MOM 30 ml prn, and Senna S 2 tablets once a day. The resident's current care plan stated, ". . . Problem: . . . Constipation . . . Objective . . . Resident will have adequate elimination every 2-3 days thru [sic] 10-24-12 . . . Approaches . . . MOM 30 [mL] po PRN constipation . . . Senokot S 2 tabs po daily . . . 1 tbsp [tablespoon] fruit mix dly [daily] . . . Prune Juice dly [with] breakfast . . . Ducolax [sic] suppos [rectally] PRN constipation . . ." Review of Resident #7's BM records showed the following inconsistencies related to the management of the resident's constipation according to facility policy: *May 28-30, 2012: No BM for three days, no interventions given. Resident #7 had a large BM on the 31st (day four) - Review of Resident #9's medical record	F 309		

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ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 309	Continued From page 34 occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. Medications included Senna S two tablets twice a day (increased from one tablet daily to one tablet in the morning and two tablets at bedtime on 05/01/12 and increased again on 06/29/12 to the current dosage), and Ultracet (a pain medication which may cause constipation). Resident #9's current care plan stated, ". . . Alteration in elimination . . . has constipation . . . Objective: Resident will have adequate bowel elimination every 2-3 days . . . Approaches: Senna S . . . Ducolax suppository 10 mg [rectally] PRN constipation. MOM 30 cc [cubic centimeters] PRN constipation. Senna Fruit mix daily . . ." Review of Resident #9's BM records showed the following inconsistencies related to the management of the constipation according to facility policy and staff interview: *April 30-May 3, 2012 - No BM for four days, MOM given on the 3rd (day four) without results, suppository given on the 4th (day 5) with results. *May 6-8, 2012 - No BM for 3 days, suppository given on the 9th (day four) with results. *May 16-18, 2012 - No BM for 3 days, suppository given on the 19th (day four) with results. *May 22-24, 2012 - No BM for 3 days, suppository given on the 25th (day four) with results. The facility failed to implement a consistent bowel management program to help prevent constipation and attempt less invasive interventions before administering suppositories.	F 309		

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F 309	Continued From page 35 During an interview on the afternoon of 08/01/12, a supervisory nursing staff member (#10) agreed bowel management was inconsistent and staff should attempt other interventions before administering a suppository.	F 309		
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: Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 5 of 14 sampled residents (Resident #2, #7, #8, #9, and #10) and 4 supplemental residents (Resident #18, #20, #21, and #22) observed without wheelchair foot pedals in place. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and/or injuries to residents. Findings include: - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoarthritis, and generalized weakness. The current Minimum Data Set (MDS), dated 06/29/12, identified severe cognitive impairment and extensive	F 323	F323 1. Residents #2, #7, #8, #10, #18, and #22 were screened by OT and have had holders placed on their wheelchairs for storage of pedals to be used for transport. These holders will cue staff for need of pedals if resident is unable to lift their feet. Residents #9 and #20 were screened by OT and have had pedals placed for use on wheelchairs. Resident #21 screened by OT and had a change in wheelchair that has pedals present. 2. All residents using wheelchairs have the potential to be affected. 3. The Wheelchair Transportation policy has been revised to include use of storage devices for pedal to be placed on wheelchairs for residents.	

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F 323	Continued From page 36 assistance from one person for transfers and locomotion. Observation on 07/30/12 at 4:35 p.m. showed a CNA (#1) transported Resident #8 to the dining room and failed to use the wheelchair foot pedals. During the transport, Resident #8's feet brushed along the floor. The CNA (#1) stated, "Lift your feet." Observation showed the resident lifted her feet off the ground briefly, but then lowered them again, and they continued to brush along the floor. Observation on 07/31/12 at 11:11 a.m. showed a CNA (#11) transported Resident #8 to the activity room in her wheelchair without foot pedals in place. The CNA stated, "Lift your feet, [resident name]. You're dragging your feet." Resident #8 was not fully awake, and her feet brushed along the floor during the observation. The resident did not lift her feet after prompting from the CNA. Observation on 07/31/12 at 1:11 p.m. showed a CNA (#2) transported Resident #8 to her room in her wheelchair without foot pedals in place. Observation showed Resident #8's feet brushed along the floor; and at one point, the toes of her left foot bent backwards and skipped along the floor. The CNA stated, "Lift your feet, [resident name]. I don't like your feet dragging like that." The resident was unable to lift her feet, and the CNA continued to transport the resident down the hall. Observation on 07/31/12 at 4:21 p.m. showed a CNA (#3) transported Resident #8 from the bathroom to the activity room in her wheelchair without foot pedals in place. During the transport,	F 323	needing pedals for wheelchair transport. This will cue staff and have readily available pedals for transport. Staff education on updated policy at the Unit Meeting on August 29, 2012, Nurse's Meeting on August 30th and Department Head meeting on August 28th and minutes posted. Staff educated on the pedal for wheelchair transportation by OT August 30, 2012 and information posted. OT will assess wheelchair needs during their MDS assessment and as otherwise indicated. 4. September 12, 2012. 5. QI will be done on residents being transported correctly when in wheelchair monthly for one year and reviewed at quarterly QI meeting. The Director of Nursing will be responsible.	9-12-12

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F 323	Continued From page 37	F 323		

Resident #8 abruptly planted her feet on the floor, and the wheelchair jerked to a stop. The CNA stated, "Can you lift your feet, [resident name]?" The resident lifted her feet slightly, but they continued to brush along the floor.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, osteoarthritis, and chronic pain. The current MDS, dated 07/06/12, identified severe cognitive impairment and extensive assistance from two or more people for transfers and toilet use. The resident's current care plan stated, "Using commode and two staff to toilet," and "Extensive assist with toileting."

Observation on 07/31/12 at 8:42 a.m. showed a nurse (#12) transported Resident #7 to her room in her wheelchair without foot pedals in place. The resident's legs were crossed, and her right foot brushed along the floor. The nurse stated, "Lift your feet a little bit." Observation showed the resident was asleep and did not lift her feet.

Observation on 07/30/12 at 4:30 p.m. showed two CNAs (#1 and #4) transported Resident #7 to the bathroom in her wheelchair without foot pedals in place. Observation showed the resident attempting to walk/self propel as the CNA (#1) pushed her. The resident's feet caught on the floor. The CNA stated, "Can you lift your feet," and "She always tries to walk [when staff push her]." The resident lifted her feet briefly, but then lowered them, and they again caught on the floor.

Observation on 07/31/12 at 8:49 a.m. showed a CNA (#15) transported Resident #7 to the bathroom and assisted her with toileting. The

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F 323	Continued From page 38 CNA used a gait belt to assist the resident to stand and pivot on to the commode. The resident was unsteady on her feet, and the CNA stated, "Stand up straight, [resident name]." The CNA failed to obtain assistance from another staff member as per Resident #7's care plan. During an interview on the afternoon of 08/01/12, a supervisory nursing staff member (#12) agreed transporting residents without foot pedals in place was unsafe. - Resident #2's medical record, reviewed July 30, 2012-August 2, 2012, identified diagnoses including anxiety, dementia with behaviors, and history of hip fracture. The resident's quarterly MDS, dated 07/18/12, identified severely impaired cognition and limited assistance of one person required for locomotion on unit. Observation on 08/01/12 at 12:50 p.m. showed a CNA (#18) transporting Resident #2 to the restorative therapy room in her wheelchair. Resident #2's feet/shoes caught and bounced on the flooring as staff transported her. - Resident #18's medical record, reviewed July 30, 2012-August 2, 2012, identified diagnoses including osteoarthritis, osteopenia, and history of hip and pelvic fractures. Observation on 07/30/12 at 4:20 p.m. showed a CNA (#14) transporting Resident #18 from the facility's entrance to her room in her wheelchair. Resident #18's right heel caught and bounced on the flooring as staff transported her down the first hallway. Resident #18 lifted her right foot/shoe for the remainder of the transport.	F 323		

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F 323	Continued From page 39 - Resident #21's medical record, reviewed August 1-2, 2012, identified diagnoses including anxiety, dementia, osteoarthritis, osteopenia, and history of vertebral compression fracture. The resident's quarterly MDS, dated 07/17/12, identified moderately impaired cognition and extensive assistance of one person required for locomotion on unit. Observation on 08/01/12 at 12:23 p.m. showed a CNA (#16) transporting Resident #21 to her room in her wheelchair. Resident #21's left heel slid along the surface of the flooring as staff transported her. - Resident #22's medical record, reviewed July 31, 2012-August 2, 2012, identified diagnoses including anxiety, dementia, osteoarthritis, osteoporosis, and Parkinson's disease. The resident's significant change MDS, dated 07/10/12, identified severely impaired cognition, total assistance of one person required for locomotion on unit, and assistance required off unit. Observation on 07/31/12 at 8:50 a.m. showed a CNA (#17) transporting Resident #22 to her room in her wheelchair. Resident #22's heels slid along the surface of the flooring as staff transported her. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. The current MDS, dated 06/17/12, identified severe cognitive impairment and required extensive assistance of two or more staff	F 323		

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F 323	Continued From page 40 members for transfers and locomotion. Observation on 08/01/12 at 12:55 p.m. showed Resident #9 in the dining room sleeping in her wheelchair. A CNA (#7) then transported the resident to the hall and stated, "What's that noise?" Observation showed Resident #9's feet bent backwards and her toes dragged on the floor. Another CNA (#31) stated, "It's her feet," and obtained the resident's foot rests for her wheelchair. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. The current MDS, dated 05/31/12, identified moderately impaired cognition and required extensive assistance of one staff member for transfers and locomotion. On 07/31/12 at 1:15 p.m., two CNAs (#11 and #30) transported Resident #10 from the TV/lounge area to the hall outside her room. Observation showed the resident's feet brushed along the floor during the transportation. The CNAs failed to instruct the resident to lift her feet or obtain foot rests. Observation on 08/02/12 at 12:00 p.m., showed an unidentified CNA transporting Resident #10 to the dining room. Observation showed Resident #10 was not fully awake, and her feet brushed along the floor during the observation. - A random observation on 07/31/12 at 10:45 a.m. showed a CNA (#15) transporting Resident #20 to the activity room in her wheelchair. The resident's feet brushed along the floor during the	F 323		

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F 323	Continued From page 41 observation. During an interview on the afternoon of 08/02/12, an administrative nurse (#13) stated she expected facility staff to utilize foot rests when transporting residents in wheelchairs. Facility staff members failed to place the foot pedals on the residents' wheelchairs, cue the residents to lift their feet/shoes, and ensure the residents' feet/shoes cleared the floor during transport to avoid catching the residents' feet on the flooring.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 1. Resident #9 nursing staff educated on anti-anxiety medications by consultant pharmacist on September 5, 2012. 2. All residents on anti-anxiety medications have the potential to be affected. 3. Nursing staff educated on anti-anxiety medications by consultant pharmacist on September 5, 2012. Review of the citation was presented at Nurse's Meeting on August 30, 2012. The electronic MAR has a pop-up built in to alert nurses to document indication for administration and results.	

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F 329	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure an adequate indication for the administration of lorazepam (an antianxiety medication) for 1 of 4 sampled residents (Resident #9) who exhibited behaviors and received an antianxiety medication. Failure to adequately assess Resident #9's behavior and implement non-pharmacological interventions and monitor the effectiveness of the interventions resulted in Resident #9 receiving an unnecessary antianxiety medication. This practice did not allow Resident #9 to reach her highest practicable mental, physical, and psychosocial well-being. Findings include: Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and anxiety. Medications included lorazepam 0.5 milligrams (mg) twice a day and as needed (PRN), Remeron (antidepressant) 22.5 mg daily, Seroquel (antipsychotic) 100 mg three times a day, and Ultracet (pain medication) four times a day. Review of Resident #9's Medication Administration Record (MAR) and progress notes identified lorazepam administered at the following times and reasons: * The MAR identified lorazepam administered on 07/08/12 at 23:57 (11:57 p.m.). The progress note, dated 07/09/12 at 02:13 (2:13 a.m.), stated,	F 329	Minutes of the meeting were posted. 4. September 12, 2012. 5. QI monitor for the proper use of all anti-anxiety medication monthly for one year and review at the quarterly QI meeting. Director of Nursing is responsible.	9-12-12

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F 329	Continued From page 43 "Resident was combative and trying to crawl out of bed. Is now resting quietly in bed with her eyes closed." * The MAR identified lorazepam administered on 07/18/12 at 23:59 (11:59 p.m.). The progress note, dated 07/19/12 at 04:24 (4:24 a.m.), stated, "Had been very restless trying to climb out of bed at 23:30 [11:30 p.m.], is not resting with eyes closed." * The MAR identified lorazepam administered on 07/21/12 at 21:41 (9:41 p.m.). The progress note, dated 07/22/12 at 00:36 (12:36 a.m.), stated, "Resident is resting quietly in bed with eyes closed." * The MAR identified lorazepam administered on 07/29/12 at 03:35 (3:25 a.m.). The progress note, dated 07/29/12 at 03:25 (3:25 a.m.), stated, "Restless and humming." During an interview on 08/02/12 at 4:30 p.m., an administrative nurse (#13) stated Resident #9's humming is usually a predecessor to behaviors such as crying and crawling out of bed. Observation on 07/31/12 at 9:25 a.m. and 11:10 a.m., and on 08/01/12 at 8:25 a.m., showed Resident #9 seated in her wheelchair, either in the activity room or the dining room, humming. Observation showed no disruptive behaviors present. The facility failed to adequately assess Resident #9 and try alternative interventions (such as pain interventions, washing dishes, or assisting her out of bed for a while) to help with Resident #9's "behaviors" before administering lorazepam.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F371 1.a. All cuts of meat will be thawed in separate tubs. b. No wooden utensils will be	

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F 371	Continued From page 44 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, facility guideline, professional literature review, and staff interview, the facility failed to store and prepare food under safe and sanitary conditions in 1 of 1 kitchen and 2 of 2 activity rooms (Unit A and B). These practices have the potential to increase the risk of foodborne illness and can affect all residents who eat food stored in these areas. Findings include: Review of the guideline, titled "Minimum Safe Internal Temperatures," posted in the kitchen stated, "Product: Ground or flaked meats including hamburger - Internal Temperature: 155 [degrees] F [Fahrenheit] for 15 seconds and Product: Beef . . . roasts - Internal Temperature: 145 [degrees] F for 4 minutes. The 2009 FDA [Food and Drug Administration] Food Code, Public Health Reasons, page 386, stated, ". . . Raw animal foods shall be separated based on succession of cooking temperatures since cooking temperatures . . . are based on	F 371	used in food preparation. c. Only use cutting boards with smooth, cleanable surfaces. 2. All residents eating at the facility have the potential to be affected. 3. a. LRD informed Dietary staff of thawing all cuts of meat in separate tubs on August 29, 2012. b. LRD informed Dietary staff and Activity staff that no wooden utensils may be used in food preparation on August 29, 2012. c. LRD informed Dietary staff and Activity staff that only smooth, cleanable cutting boards may be used in food preparation on August 29, 2012. 4. Corrective action will be taken by September 12, 2012. 5.a. A QI monitor on thawing of all cuts of meat in separate tubs will be performed monthly for one year and the results will be reported quarterly to the QI	

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F 371	Continued From page 45 thermal destruction data and anticipated microbial load . . ." Raw meats should be stored so that meats requiring higher cooking temperatures are stored below meats which require lower cooking temperatures." The 2009 FDA Food Code, Public Health Reasons, page 447, stated, "The limited acceptance of the use of wood as a food-contact surface is determined by the nature of the food and the type of wood used. Moist foods may cause the wood surface to deteriorate and the surface may become difficult to clean." - An initial dietary tour of the kitchen occurred on 07/30/12 at 10:45 a.m. with two administrative dietary staff members (#32 and #33). Observation of the walk-in cooler showed three ten pound closed plastic bags of raw hamburger thawing in a plastic container with a fourteen pound closed package of raw beef roast. Observation showed one of the bags of hamburger inverted, twist-tied end down, in approximately one inch of meat juices. Observation of the walk-in freezer showed a paper sign with scattered black residue on its surface, attached to the door of a walk-in freezer. The exterior of a gallon container of Lecithin Granules (fat-like substance) supplement stored on a shelf also showed scattered black residue. - A dietary tour occurred on 08/02/12 at 8:30 a.m. with three administrative dietary staff members (#32, #33, and #34). Observation of the kitchen showed the following: Facility staff had removed the sign on the walk-in freezer and the gallon container of supplement remained.	F 371	committee at regular scheduled meetings by the LRD. b. A QI monitor on not using wooden utensils for food preparation will be performed monthly for one year and the results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD. c. A QI monitor on only using smooth, cleanable cutting boards for food preparation will be performed monthly for one year and the results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD.	9-12-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 371	Continued From page 46 *A fan in the kitchen dish room blowing air over clean dishes. The fan contained a buildup of dust on its blades. Observation of the activity rooms showed the following: Activity Room Unit A *One rubber scraper with rough, uncleanable edges. *Two wooden spoons. Activity Room Unit B *Two plastic cutting boards with rough, visibly soiled, uncleanable surfaces. *Nine wooden spoons. During the dietary tour on 08/02/12 at 8:30 a.m., the administrative dietary staff member (#32) confirmed the fan should be cleaned and stated the cleaning schedule did not include fans. The staff member also confirmed the scraper and cutting boards had non-smooth, uncleanable surfaces and the wooden spoons "harbor bacteria."	F 371		