STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

(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 09/17/12 and completed on 09/20/12, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000	The facility has prepared and submitted this Plan of correction because of the requirements Under state and federal law that mandate submission of a plan of correction to participate in the title 42 program. The submission of the plan of correction should in no way be considered or construed as an agreement with the allegations of non-compliance shall constitute this facility's credible allegation of compliance. This applies to tag's F241, F278, F309, F315, F323, & F371	
F 241 SS=D	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 staff failed to provide care in a manner and in an environment that maintained and enhanced each resident's dignity and respect for 2 of 11 sampled residents (Resident #2 and #10) and 4 random observations of staff entering rooms without knocking and of staff assisting during meals. These practices failed to enhance the residents' dignity, self esteem or self worth and failed to recognize their individuality. Findings include: Observation on 09/18/12 at 8:10 a.m., showed a CNA (#4) assisting Resident #2 to eat breakfast. While feeding hot cereal to the resident, the CNA wiped food from the resident's face with a spoon six times and one time the CNA placed food	F 241	1. All nursing staff were in-serviced on dignity and respect on 9/27/2012 with an emphasis on dining room assistance and resident right to privacy and the importance of knocking on a resident's door. Nursing staff will be monitoring the dining room to assure that the staff maintains an environment that enhances each resident's dignity and respect in full recognition of his or her individuality. 2. All residents have the potential to be affected. 3. Nursing staff in-serviced on dignity and respect 9/27/2012 (meeting roster for employees to sign included), and one scheduled for 10/18/2012. Dignity topic was covered with a questionnaire (included) being filled out then verbally discussed as a group as well as the other topics mentioned in item #1. Those staff members that are unable to attend will be required to review information and complete a test. 4. Random Audits will be completed by DON/designee 3x/week times 4, then weekly x4 or until 100% compliance is achieved then quarterly. Audits will be tracked through the QA nurse for team review at our monthly TQM meeting. Audit tool included are Dining Room Audit & Privacy/ Dignity Audit. 5. Completion Date:	10/24/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sara Cook	Administrator	10/12/12

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 241	Continued From page 1 removed from around the resident's mouth back into the resident's cereal bowl. A random observation on 09/19/12 at 7:47 a.m., showed a CNA (#4) assisting a resident to eat. The CNA stood and fed a resident. The CNA then obtained a stool, and while sitting the CNA pushed the resident's chin down and continued to feed the resident. A random observation during the breakfast meal on 09/18/12 at 8:25 a.m., showed a CNA (#9) used a clothing protector to wipe the face of a resident seated at a table. Observation on 09/19/12 at 10:50 a.m., showed a CNA (#5) entered four resident rooms on the east end of the facility without knocking. While Resident #10 laid asleep in bed, the CNA entered her room, took the water mug from bedside, went out of room, refilled the water mug, and entered the room to return the mug on the resident's bedside table. The CNA failed to knock prior to the two times entering the resident's room. The CNA (#5) proceeded to enter three other resident rooms (Room 3, 4 and 5) using the same technique. In room 5 a resident laid asleep in bed, and in room 4 a resident sat awake in chair with her back to the door. During an interview on 09/19/12 at 4:30 p.m., an administrative nursing staff member (#7) stated facility staff should use a napkin to wipe residents' mouths.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278	1. Resident's #2 and #8's MDS were modified and resubmitted. 2. All residents have the potential to be affected.	

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F 278	Continued From page 2 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 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 11 sampled residents (Resident #2 and #8) coded incorrectly for activities of daily living (ADL) (Resident #2)	F 278	3. Changes coded on the MDS will be communicated to the IDT team and a note made in the residents chart. 4. Random audits will be completed by DON/designee weekly x4, and then monthly until 100% compliance is achieved, then quarterly. Audits will be tracked through the QA nurse for team review at the monthly TQM meeting. Audit tool labeled MDS audit is included. 5. Completion Date:	10/24/2012

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F 278	Continued From page 3 and behaviors (Resident #8). Failure to accurately complete portions of the MDS for sampled residents does not allow each resident's assessment to reflect the resident's accurate needs. Findings include: The Long-Term Care Facility RAI User's Manual, page E-5, stated, "Behavioral Symptom-Presence & [and] Frequency . . . Code 1 . . . if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days." Page G-5 stated, ". . . ADL Assistance . . . Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period." - Review of Resident #8's medical record occurred on September 19-20, 2012. Diagnoses included dementia, depression with anxiety, and a history of paranoid thoughts. The current MDS, dated 07/12/12, identified Resident #8 exhibited "other" behaviors one to three days during the assessment period. Review of the social progress notes, behavior logs, and nurse's notes failed to identify any physical, verbal or "other" behaviors exhibited by Resident #8 during the MDS assessment period. - Review of Resident #2's medical record occurred on all days of survey. The current MDS, dated 07/11/12, identified the resident required total assistance of one or two staff members for	F 278		

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F 278	Continued From page 4 toilet use, personal hygiene, and bathing. Review of the certified nursing assistant's (CNA's) documentation related to Resident #2's ADLs for the MDS assessment period and review of the nurses notes failed to identify the resident as totally dependent on staff for toilet use, personal hygiene, and bathing. During an interview the morning of 09/20/12, an administrative nurse (#8) could not provide any additional information related to Resident #8's behaviors. The nurse (#8) reviewed Resident #2's CNA ADL documentation and agreed the MDS was coded incorrectly.	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: 1. Based on observation, record review, staff interview, and review of manufacturer's instructions, facility staff failed to provide care and services to maintain the residents' highest practicable physical well-being for 2 of 3 sampled residents (Resident #2 and #4) and 1 supplemental resident (Resident #14) who have physician orders for thickened liquids. Failure to provide thickened liquids at the appropriate	F 309	1. Resident's #2 and #4 care plan and physicians orders were reviewed and remain appropriate. Nursing staff were educated 9/27/2012 with a follow up in-service scheduled on 10/18/2012 on proper manufacturer's direction for the beverage thickener and also educated on the importance of identifying target behaviors and assessing the reason/causative factor for the behaviors prior to administering a PRN psychotropic medication. A physicians order was obtained 9/20/2012 for Res #14 for thin consistency soda. 2. All resident who have thickened fluids or who exhibit behavioral symptoms have the potential to be affected. 3. Nursing staff were educated on proper manufactures direction for the beverage thickener 9/27/2012. The current fluid intake chart will be modified to include ounce equivalents versus only cc's to decrease confusion (chart included). A resource	

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F 309	Continued From page 5 consistency has the potential to cause choking and places residents at risk for aspiration. Findings include: Review of manufacturer's directions for the beverage thickener used by the facility occurred on 09/20/12. The directions state to add one tablespoon to 4 ounces (oz.) of fluid or two tablespoons to 8 oz. to make the fluids a nectar like consistency. Record review for Resident #2 and Resident #4 occurred from September 17-20, 2012. Record review for Resident #14 occurred on September 19-20, 2012. These residents' physician orders and care plans identified the residents are to receive nectar thick beverages. Observation on the morning of 09/18/12 showed Resident #14 drinking a thin consistency soda. Observation on 09/18/12 at 11:30 a.m. showed a physical therapy assistant (#12) put one tablespoon of beverage thickener into three separate coffee cups for Resident #2, #4, and #14. The coffee cups then were filled close to the top of the cup with either coffee or hot water. Staff interviews regarding the coffee cups identified the following: * 09/19/12 at 2:20 p.m., a CNA (#1) stated the coffee cups are around 5 oz. * 09/19/12 at 2:30 p.m., a dietary staff member (#13) stated the cups are 8 oz. * 09/19/12 at 2:40 p.m., a physical therapy assistant (#12) stated the cups were 4 ounces and she was trained to add one tablespoon of	F 309	binder was implemented Sept. of 2012 for staff on Non-pharmacological Behavior Interventions that is accessible at the East End nurses station. New resident specific behavior tracking forms are being implemented to better monitor behaviors and effectiveness of resident specific interventions regarding the behaviors (Behavior Monitoring Form included). Nursing staff were educated on necessity of documenting resident's behavior as well as interventions attempted prior to using a PRN psychoactive medication. 4. Random Audits will be completed by DON/designee 3x/week times 4, then weekly x4 or until 100% compliance is achieved then quarterly. Audits will be tracked through the QA nurse for team review at our monthly TQM meeting. Audit tool labeled Psychotropic Medication Administration Audit is included. Audit tool labeled Dining Room Audits: 2 is included for Thickened Liquids. 5. Completion Date:	10/24/2012

per phone call ε June, DON on 10-23-12/1237:
Resource binder contains Therapeutic, Behavior-Specific interventions for staff to reference. Each Res. tracking form will have behaviors identified that are specific to that Res.
Ex: Disruptive Vocalizations
Impulsiveness
Wandering/Pacing
Bathing-Associated Behaviors
Lists tips for staff to attempt before using Meds. AA

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F 309	Continued From page 6 beverage thickener into a coffee cup for residents on nectar thick liquids before filling the cups. Facility staff failed to add two tablespoons of thickener to the 8 oz. coffee cups as per manufacturer's instructions to make beverages nectar thick. During an interview on 09/20/12 at 7:45 a.m., a nurse (#14) stated Resident #14 receives approximately 3 cans of regular consistency soda a day, and at 8:05 a.m., this nurse (#14), a unit manager (#15), and a dietary manager (#16) stated Resident #14's medical record lacked a physician order for Resident #14 to receive thin consistency soda. During an interview on 09/20/12 at 8:55 a.m., a physical therapy assistant (#12) stated a few days after resident #14 was admitted to the facility (June 2012) she spoke with a speech therapist who gave the okay for Resident #14 to have thin consistency soda. 2. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 2 of 3 sampled residents (Resident #2 and #4) identified by the facility with behaviors and who received an antianxiety medication. Failure to identify target behaviors, assess the reason/causative factor(s) for behaviors, and establish accurate on-going monitoring of the behaviors has the potential for these residents not to obtain their highest practicable physical, mental, and psychosocial well-being. Findings include:	F 309		

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F 309	Continued From page 7 - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included anxiety, dementia, and confusion. Medications included Xanax (antianxiety) 0.25 milligrams (mg) at 6:00 p.m. and as needed (PRN). Review of the current Minimum Data Set (MDS), dated 07/11/12, identified Resident #2 exhibited physical and verbal behaviors and wandering one to three times a week. The resident's current care plan identified the following interventions related to behaviors and/or anxiety: * Certified nursing assistants (CNAs) will record changes in mood/behavior on Mood & Behavior Log. The social worker will discuss documentation with the physicians' assistant (PA). * Reassure Resident #2 during periods of distress/anxiousness. Speak in a calm voice; validate feelings. * Remind the resident that the behavior is not appropriate. * Remove the resident from the situation; allow time to calm down. * Assess changes in mental status. * Touch hands/shoulder to show caring or provide comfort. Provide one to one interaction and talk about events. * Respond in a calm voice; maintain eye contact. Remove from area if the resident is verbally abusive to others. * Assess potential cause of wandering, (need for toilet, water, food, or pain). Provide divisional activities. Record behavior. Redirect when wandering. Use wander guard to monitor daily. Use alarms to monitor attempts to rise.	F 309		

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F 309	Continued From page 8 * Assess need for PRN antianxiety medication if interventions do not relieve anxiety. * Assess and record behaviors. Determine pattern of behavior (time of day, precipitating factors/situations). Review of Resident #2's PRN medication administration records (MARs), behavior flow sheets, and the nurses notes from May 2012 through September 19, 2012, identified 14 times facility staff administered PRN Xanax without evidence of non-pharmacological interventions attempted prior to administration. The facility staff failed to describe specific behaviors Resident #2 displayed, the possible triggers/causes for the behavioral symptoms, and the interventions used to address them, if any, prior to the administration of Xanax. Failure to identify possible causative factors which precipitated behaviors does not allow the facility to look for patterns in Resident #2's behaviors or develop and implement creative individualized interventions to decrease the behaviors. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety, depression, dementia with psychosis, and Wernicke aphasia (difficulty understanding others when communicating). Physician orders included 0.5 mg Ativan prn for anxiety, 10 mg Buspar three times a day for anxiety, and 5 mg Zyprexa for psychosis. Review of Resident #4's current care plan printed by the facility on 03/28/12, states ". . . Socially inappropriate/disruptive behavior demonstrated . . . Interventions . . . Gently remind [Resident's	F 309		

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F 309	Continued From page 9 name] that (BEHAVIOR) is not appropriate . . . Provide medication as ordered . . . Record behaviors on Behavior Tracking From. Monitor pattern of behavior (time of day, precipitating factors, specific staff or situations) . . . Remove from situation; allow time to calm down . . . Problem . . . [Resident's name] is receiving antianxiety drugs on a regular basis . . . Interventions . . . Provide quiet atmosphere with one-on-one support during periods of increased anxiety. Allow [Resident's name] to talk about event and causes, if known . . . Problem . . . At times, displays loud, disruptive anger. Is on antipsychotic and antianxiety drugs for this . . . Interventions . . . offer one on one interventions of taking [Resident's name] for a walk or outdoors when weather permits. Allow her to "vent". Offer reading, music, combing her hair, putting on jewelry, doing her nails - things that make her feel "special". Try a variety of interventions until she has calmed down . . ." The medication administration record showed prn Ativan provided for agitation or restlessness on May 15, 2012; August 4, 2012; and August 9, 2012. The resident's medical record lacked documentation of non-pharmacological interventions attempted prior to the administration of the prn Ativan. During an interview on 09/19/12 at 4:30 p.m., an administrative nurse (#7) agreed non-pharmacological intervention should be attempted prior to the administration on medications.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	1. Both Res #2 and #9 have new I&O forms for staff to record both intake and output each shift. Resident #9 is independent in	

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F 315	Continued From page 10 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 2 sampled residents (Resident #2 and #9) with indwelling catheters and a history of urinary tract infections (UTIs). Failure to monitor a residents' fluid intake and urinary output does not allow nursing staff to monitor for complications related to an indwelling catheter or UTIs. Findings include: Review of the facility policy titled "Foley Catheter Irrigation" occurred on 09/20/12. This undated policy stated, ". . . All residents with a Foley [indwelling] catheter will have output monitored closely and recorded in the resident's permanent record . . ." Review of the facility policy titled "Acute UTI Protocol Care Plan" occurred on 09/20/12. This undated policy stated, ". . . Push fluids (unless medically contraindicated) . . . Place on Intake	F 315	emptying his catheter reservoir. Nursing educated him on the importance of tracking I&O and offered to supply a form for the resident to record his intake and output on. After discussing importance, res #9 indicated he would prefer to call staff into his room to record I&O for him. 2. All residents with a catheter have the potential to be affected. 3. Nursing staff were in-serviced on the importance of recording I&O for any resident with an indwelling catheter. New I & O forms were implemented 10/8. Updated form is included labeled Intake and Output. 4. Random Audits will be completed by DON/designee 3x/week times 4, then weekly x4 or until 100% compliance is achieved then quarterly. Audits will be tracked through the QA nurse for team review at our monthly TQM meeting. Audit tool labeled Catheter I&O Audit is included. 5. Completion Date:	10/24/2012

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WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 315	Continued From page 11 and Output (I&O) . . . Increase fluid intake to [2000 cubic centimeters (cc) in 24 hours] unless medically contraindicated . . ." Kozier and Erb's Fundamentals of Nursing: Concepts, Process, and Practice 9th edition, 2012, pages 1313-1314, stated, "Measuring Urinary Output. Normally, the kidneys produce urine at a rate of approximately 60 ml [milliliters] per hour or about 1500 ml per day. . . . Urine outputs below 30 ml per hour may indicate low blood volume or kidney malfunction and must be reported. . . . Urinary output is approximately equal to fluid intake . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic kidney disease, prostate cancer, and a history of UTIs. Medications included Keflex (an antibiotic) 500 milligrams (mg) four times a day for 10 days, initiated on 09/04/12. A urine culture report, dated 09/07/12, verified Resident #2 had a UTI. The most current Minimum Data Set (MDS), dated 07/11/12, identified Resident #2's required extensive assistance of one staff member for eating. The resident's care plan failed to identify the UTI diagnosed 09/04/12, and failed to identify a fluid restriction. Observation on all days of survey showed the resident had an indwelling catheter. Review of Resident #2's current care plan stated, "08/24/12 - At risk for infection R/t [related to] indwelling catheter . . ." Review of Resident #2's I&O record for	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/20/2012

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F 315	Continued From page 12 September 01-19, 2012 identified the following: * 1st - Intake 120 ml; Output 250 ml * 2nd - Output 400 ml * 3rd - Output 250 ml * 4th - Output 650 ml * 5th - Intake 360 ml; Output 900 ml * 6th - Intake 690 ml; Output 650 ml * 7th - Intake 660 ml; Output 550 ml * 8th - Output 250 ml * 9th - Intake 420 ml; Output 720 ml * 10th - Intake 510 ml; Output 400 ml * 11th - Output 250 ml * 12th - Output 300 ml * 13th and 14th - no documentation of intake or output * 15th - Output 600 ml * 16th, 17th, and 18th - no documentation of intake or output * 19th - Intake 600 ml; Output 600 ml During an interview on 09/19/12 at 9:50 a.m., a CNA (#4) stated Resident #2 had 400 ml of urine output on 09/18/12 around 5:30 a.m. The facility staff failed to document Resident #2's intake for 12 of 19 days and output for five of 19 days. Failure to monitor Resident #2's I&O, especially during the time of the UTI, does not allow nursing staff to monitor for complications related to an indwelling catheter or UTI. - Review of Resident #9's medical record occurred on September 19-20, 2012. A urine culture report, dated 06/05/12, verified a UTI and the physician ordered an antibiotic for seven days. Review of Resident #9's I&O records from March	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 13 2012 through September 19, 2012 identified only four days (June 1st, 2nd, 3rd, and 11th) facility staff documented the resident's I&O. During an interview on 09/19/12 at 3:45 p.m., a licensed nurse (#17) stated the CNAs are expected to document the I&O of residents with an indwelling catheter daily and especially the residents with a UTI.	F 315		
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, policy and procedure review, record review, and staff interview, the facility failed to provide a timely assessment for potential risk of injury and intervention for 1 of 1 sampled resident (Resident #1) who slid down or from in his wheelchair and geri chair while his seat belt remained fastened; failed to properly utilize a gait belt during a transfer for 1 of 4 sampled residents (Resident #2), and for 2 of 3 sampled residents (Resident #1 and #8) and 1 of 1 supplemental resident (Resident #15) observed transferred with a mechanical sit to stand lift. Failure to assess for potential risk of injury and provide interventions may result in the resident becoming entangled in the seat belt and cause	F 323	1. Resident #1 had a trial of a new positioning chair starting 9/18/2012. OT was able to assess the chair for appropriateness, safety, and restraint reduction. Starting on 9/20/12, nursing staff was educated on new positioning chair one on one with CPTA. Resident #1 is in his new chair and restraint free as of 9/20/2012 (copy of In-service Roster included). By 10/6/2012, resident's #1, #8 and #15 were reassessed by PT for appropriateness and safety of the standing lift for transfers, and/or to recommend another appropriate means for transfer. Resident #2 was evaluated by PT for transfers10/4/2012. 2. All residents who require assistance with transfers have the potential to be affected. 3. Nursing staff were in-serviced 9/27/2012 by CPTA on proper sit to stand transfers in addition to a review of the policy "Use of a Portable Stand-Up Lifting Machine". Education was provided on proper use of the gait belt during the in-service and the gait belt policy was reviewed. A follow up in-service is scheduled for 10/18/2012. The facility is currently restraint free. 4. Random Audits will be completed by DON/designee 3x/week times 4, then weekly x4 or until 100% compliance is achieved then quarterly. Audits will be tracked	

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	355042	A. BUILDING _____ B. WING _____	09/20/2012

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F 323	Continued From page 14 harm/injury. Failure to utilize assistance devices or mechanical sit to stand lifts correctly may result in residents experiencing injury and/or pain. Findings include: Review of the facility's policy, "Use of Restraints," occurred on the morning of 09/20/12. The policy, dated December 2008, stated, ". . . a. Restraint shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. . . ." Review of the facility's policy, "Using a Portable Stand Up Lifting Machine," occurred on the morning of 09/20/12. The policy, dated April 2007, stated, ". . . Basic Standing Transfer - the Resident must: . . . Have ability to hold onto both Lift arms. Be able to put both feet on the foot pad and bear weight on both legs . . . 2. Basic Standing Transfer . . . Fasten the inner safety belt snuggly. . . ." - Review of Resident #1's medical record occurred on September 17-20, 2012. Diagnoses included severe closed head injury with residual [right] hemi paresis (paralysis), significant cognitive impairment, and anxiety. Resident #1's most recent quarterly Minimum Data Set (MDS), dated 07/23/12, identified a trunk restraint used and the resident required extensive assistance of two or more persons for transfers. The annual MDS Care Area Assessment for Physical Restraints, dated 10/25/11, stated, ". . . [Resident's name] tends to wiggle out of recliner and climb out of geri chair. He does have dementia which may prevent him	F 323	through the QA nurse for team review at our monthly TQM meeting. Audit tool labeled Transfer/ Standing Lift Audit is included. 5. Completion Date:	10/24/2012

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F 323	Continued From page 15 from understanding that he will fall. . . . A geri chair is used with a safety belt. He is in his wheelchair only at meal times. . . positioning straps [shoulder straps] are used to promote position . . ." Review of Resident #1's Interdisciplinary Notes stated the following: *05/25/12, 4:15 p.m. - Res [resident] found sitting on floor in front of geri chair in day area, seat belt still buckled, ROM [range of motion] gd [good] all extremities, [no] c/o [complaints of] pain or discomfort." *06/12/12, no time - "Late entry for 06/09/12 and 06/10/12. Res caught sliding [down] in geri chair x [times] 2 over weekend, nearly sliding out of chair, seat belt still buckled. . . . Res never touched floor either time." *06/24/12, 6:45 p.m. - ". . . Res slid out of w/c, under seat belt at 1500 [3:00 p.m.] [No] injury." *07/18/12, 7:15 a.m. - ". . . Resident very agitated in recliner [with] safety belt. Safety belt broken work order placed at 9:20 a.m. this a.m. Safety belt tied double knot by strap. . . ." *08/13/12, 8:00 p.m. - ". . . Resident location was at the East Day Area, and had been in his geri chair prior to falling out. He had a lap belt in place, and a tab alarm in place." *08/14/12, 5:20 p.m. - "Was made aware that on 08/13/12 at 2000 (8:00 p.m.), resident had slipped out of his w/c with his lap belt still buckled. Staff were immediately instructed that resident would be required to be directly supervise at all times when in geri chair pending evaluation of current restraint use and positioning in geri chair for safety." Resident #1's, "My Daily Living Needs," dated	F 323		

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F 323	Continued From page 16 08/01/12, stated, "Seat belt is to be used in w/c only for transports; take seat belt off while feeding him. Place in geri chair on East end by small TV area for supervision between meals. Attempt to keep him in line of vision for closer observation/resident safety when in geri chair." An interdisciplinary note, dated 08/14/12, 9:00 a.m. stated, "Per S.O. [standing order] will have OT [occupational therapy] eval [evaluation]/reassessment for his geri chair for safety." Facility staff failed to provide the requested OT evaluation. The facility failed to assess Resident #1's safety for approximately three months (05/25/12 - 08/14/12). Observation on 09/18/12 at 7:55 a.m. showed a certified nursing assistant (#9) feeding Resident #1 his breakfast meal in his wheelchair. The staff member failed to remove the resident's seat belt. Observations throughout the survey, September 17-20, 2012, showed Resident #1 in a geri chair with a seat belt in place. Observation on 09/18/12 at 2:15 p.m. showed two CNAs (#1 and #10) utilized a sit to stand mechanical lift and transferred Resident #1 from his geri chair to the toilet and the CNAs (#1 and #11) transferred the resident back to his geri chair. Observation during the transfers showed the CNAs failed to tighten the harness around the resident's waist, the harness slid up under Resident #1's axilla (armpits), and caused his elbows to lift outward at a 90 degree angle to his shoulders. A CNA (#11) attempted to move the resident's right arm affected by hemi paresis and the resident stated, "Oww."	F 323		

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F 323	Continued From page 17 During an interview on 09/19/12 at 4:30 p.m., an administrative nursing staff member (#7) stated, "No question of Resident #1's risk for harm, resident had to be in a direct supervised area." The staff member stated facility staff should adjust/tighten the chest strap when standing a resident in a mechanical sit to stand lift. - Review of Resident #2's medical record occurred on all days of survey and diagnoses included a history of falls. The resident's care plan stated, "Transfers . . . requires extensive assistance. . . . Two staff are to transfer [Resident #2] using a gaitbelt for a manual lift . . ." Observation on 09/18/12 at 11:25 a.m. showed a certified nursing assistant (CNA) (#4) applied a gait belt around Resident #2's waist and she and another CNA (#5) transferred the resident from his wheelchair to his bed. Observation showed the CNA (#5) used the gait belt appropriately and the CNA (#4) lifted under Resident #2's right armpit to stand him upright rather than utilizing the gait belt. During an interview on the morning of 09/20/12, an administrative nurse (#7) stated she expected facility staff to utilize a gait belt and not lift under a resident's armpits. - Review of Resident #8's medical record occurred on September 19-20, 2012 and diagnoses included osteoarthritis. Observation on 09/18/12 at 4:00 p.m. showed two CNAs (#1 and #3) assisted Resident #8 to transfer from a wheelchair to a recliner using a	F 323		

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F 323	Continued From page 18 stand lift. During the transfer the resident stated, "Ouchie" while the harness buckled around the resident's body slipped up under her axillas (armpits) and caused her elbows to lift outward at a 90 degree angle to her shoulders. Observation on 09/19/12 at 1:10 p.m. showed two CNAs (#4 and #6) utilized a sit to stand mechanical lift and transferred Resident #8 from her wheelchair to the toilet and back to her wheelchair. Observation during the transfers showed the CNAs failed to tighten the harness around the resident's waist, the harness slid up under Resident #8's axilla (armpits), and caused her elbows to lift outward at a 90 degree angle to her shoulders. - Observation on 09/19/12 at 10:30 a.m., showed two CNAs (#1 and #2) assist Resident #15 to transfer from a wheelchair to a recliner using a stand lift. The resident stated, "It hurts." when the staff raised the resident to a standing position. During the transfer as the harness around the resident's waist slipped up under her axilla around the resident's body slipped up into the residents axilla (armpits), and caused the resident's elbows to lift outward at a 90 degree angle to her shoulders. A CNA (#2) asked the resident if it hurt and the resident stated, "Yes."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Nursing 1. Nursing staff were in-serviced on 9/27/2012 on wearing gloves for retrieving the scoop out of the thickener. 2. All residents who require thickened fluids have the potential to be affected. 3. Random Audits will be completed 3x/week times 4, then weekly x4 or until 100% ~~compliance is achieved then quarterly.~~	

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, review of policies and procedures, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen, and at 2 of 2 nursing stations (East and West). The facility failed to store utensils and dishes in a sanitary manner, failed to clean a meat slicer prior to storage, and failed to serve juice from a properly functioning machine. These practices placed residents at risk for contamination of food and beverages during preparation which can lead to foodborne illness. Findings include: Review of the dietary policy titled "Dietary Department Guidelines" occurred on 09/20/12. This policy, dated 11/03/11, states, ". . .The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness . . . Handling of all food items during the preparation process will be minimized. This may be accomplished by using clean kitchen tools or by wearing clean gloves for each task. . . . Any food item that becomes contaminated by exposure to employee hands . . . will be immediately discarded. . . . All food preparation equipment, dishes, and utensils must be maintained in a clean, sanitary, and safe manner . . . All dishes, utensils, and food preparation equipment will be stored dry, covered, or	F 371	Audits will be tracked through the QA nurse for team review at our monthly TQM meeting. Audit tool labeled Dining Room Audits:2 is included. 4. Completion Date: 10/24/2012 Dietary 1. Educate staff on sanitation policy. Staff reviewed policy and guidelines with Dietary Manager on 9/21/12. In-service to be done on 10-15-12. a. Meat slicer was re-cleaned on 9/21/12. Slicer will be cleaned and sanitized then checked by another Dietary employee when used and documented as such. b. Fan cleaned 9/17/12 and cleaned weekly per cleaning schedule and documented as such. c. All dishes, glassware, utensils, and equipment will be dried per policy before storage. This is done by placing items on drying trays or remaining on wash racks until completely dry and this will be documented as such. • Dishwasher service was called and on 9/26/12 service was done on the dishwasher which replaced worn parts as well as re-set/ calibrated chemical agents including the rinse aid chemical for better drying. This will be checked again in October. Routine checking and monitors are documented as such. d. Thickener scoops will be washed, sanitized, and dried after each meal service and placed in baggie for storage which will be documented as such. e. The juice machine was serviced earlier in September and parts came in which	

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	355042	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 20 upside-down when completely dry. . . . All areas of the dietary department will be cleaned on a regular schedule. Logs/schedules will be kept of cleaning tasks as they are completed. . . ." Review of the dietary policy titled "Weekly Cleaning Jobs" occurred on 09/20/12. This undated document stated, ". . . 1. Dishwashing room . . . Clean dishwasher, hood, fan, and walls by counters . . . 3. Clean and wipe lower shelves. Clean under all juice boxes . . ." Observation in the main kitchen on 09/17/12 at 12:35 p.m. showed the following: * a meat slicer stored with dried food particles * a fan with dust and black residue on the blades and plastic surrounding the blades. This fan was turned on and next to clean dishes. Review of "Dietary Schedule" logs identified the last time the dishwashing room cleaning task occurred was 07/30/12. Observation of powdered beverage thickener stored with a serving utensil inside the container occurred on: * 09/18/12 at 7:55 a.m. at the West nursing station * 09/18/12 at 10:00 a.m. at the East nursing station * 09/18/12 at 10:25 a.m. and 11:30 a.m. in a cupboard at the West nursing station * 09/18/12 at 4:15 p.m. at East nursing station where a certified medication assistant (CMA) (#18) reached in bare handed to retrieve the scoop and used the scoop to dish up thickener into a cup * 09/19/12 at 7:25 a.m. at the West nursing station	F 371	prompted the service person to return and repair the machine on 9/20/12. Routine cleaning and inspection is documented as such. 2. All residents have the potential to be affected. 3. Monitoring checklists to ensure that cleaning, maintenance, and other routine items are done and deficiency will not re-occur. Staff will complete checklists daily and Dietary Manager will monitor checklist tasks are being done. Re-education on the cleaning checklists for Dietary Staff will occur at the 10/15/12 Dietary In-service. 4. The cleaning of the meat slicer, fan, and thickener scoops, as well as the drying of dishes and the juice machine function/ inspection will have QA tracking forms. QA's will be done weekly for 1 month, then monthly for 3 months or until 100% compliance is achieved then PRN as needed. QA's will be reported and reviewed at the monthly TQM meeting to ensure monitoring and correction has been achieved. QA tools labeled Thickener Scoop Storage, Dish and Glass Storage, Juice Machine Checklist, Fan Cleaned, and Meat Slicer Cleaning are included. 5. Completion Date:	10/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 21 Observation in the main kitchen on 09/19/12 at 12:40 p.m. showed the following: * 10 plastic dessert cups stacked with water in between them. A dietary manager removed the dessert cups to be rewashed. * Two containers of powdered thickener had scoops set on top of their lids. The scoops had white powder on them. During an interview at this time, a dietary staff member (#13) stated she used one scoop to dish up thickener and did not wash it prior to placing the scoop on top of the container. Staff failed to identify the last time either of the two scoops had been washed. * A leaking juice machine with 3 dish clothes wrapped around pipes which ran to concentrated juice boxes. The boxes sat on open shelving underneath a counter visible from across the kitchen. The dish clothes showed wet and dried juice spots. One box of juice concentrate stuck to the shelf with dried juice around the box. A pool of juice laid on the shelf next to three concentrated juice boxes and ran behind the counter onto the floor. The floor showed a dried sticky surface next to the wet juice. * A meat slicer stored with dried food particles Observation on 09/19/12 at 1:30 p.m. showed scoops stored in a can of powdered hot chocolate stored in a cupboard on the East end nursing station, and in a can of beverage thickener on the West end. During an interview at this time, a dietary manager (#16) stated the scoops are stored in the thickener and she expected staff to wear gloves when using the product. The facility failed to clean the utensils stored in the powdered beverage thickener and failed to	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 22 ensure staff utilized gloves while scooping powdered thickener. During an interview on 09/20/12 at 6:55 a.m., a dietary manager (#16) stated the juice machine had been broken for over a week and a company had worked on repairing the juice machine a week and a half ago due to it leaking. The facility failed to ensure the juice provided from the machine had been stored in manner to prevent contamination by wrapping leaking pipes with dish clothes and allowing juice to pool on a shelf where juice concentrates were stored.	F 371		