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 _____	R-C 07/25/2017

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 An on-site revisit was conducted on July 22-25, 2017 to determine compliance with the deficiencies identified during the May 30-June 7, 2017 complaint survey. The tag numbers enclosed in { } denote citations that remained not met as determined during the on-site revisit.	{F 000}		
{F 157} SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	{F 157}		9/11/17

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

Electronically Signed | 08/21/2017

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{F 157}	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on record review, review of facility policy, and staff interview, the facility failed to promptly notify the physician and/or family member of an accident or change in condition for 2 of 29 residents reviewed during the on-site revisit (Resident #3, and #34). Failure to promptly notify the physician and/or family member regarding weight loss (Resident #3) and fall (Resident #34) limited the physician and/or family member's ability to make informed decisions regarding the residents' care.	{F 157}	157: 1. Resident #3's Physician was notified of weight loss by Staff 7/16/2017 Resident #3's Family/POA was notified by Staff 7/16/2017 Staff education for nursing staff involved with notification of Family/Physician 8/15/2017 Resident # 34's Physician was notified of fall.7/26/17 Resident #34's Family/POA was notified of fall. 7/26/17 Documentation in chart regarding fall. 7/26/17 Staff education regarding falls, timely documentation and notification of	

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{F 157}	Continued From page 2 Findings include: Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on 07/25/17. This policy, revised April 2007, stated, ". . . The Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . . . an accident or incident involving the resident . . . A significant change in the resident's physical . . . condition . . ." - Review of the facility's fall tracking form occurred on 07/23/17 and identified Resident #34 experienced a fall in the facility van on 06/22/17. An Accident/Incident Report, dated 06/22/17, identified on 06/22/17 at 9:30 a.m. the resident "slipped out of wheelchair onto floor of van." The form indicated the resident sustained no injury and staff did not notify the physician or the resident's representative of the incident. During an interview on 07/24/17 at 8:00 a.m. a staff member present during the incident stated the fall occurred when staff transported the resident to an appointment in Bismarck. The resident's medical record identified Resident #34 left the facility at 6:00 a.m. on 06/22/17 and returned at 3:30 p.m. The record lacked documentation regarding the fall and failed to identify if the resident sustained an injury during the fall. - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/09/17, identified the resident is moderately impaired in daily decision making, requires set-up assistance	{F 157}	Family/POA and Physician. 8/15/17. Resident Review Committee will meet weekly to review falls. 2. All residents have the potential to be affected regarding notification of changes. 3. Staff will be educated by DON/Designee regarding notification of changes. 8/29/2017 Resident Review Committee will meet weekly to review all changes in resident status which includes: physical, mental, psychosocial , and occurrences. 8/2/2017 4. The DON/Designee will audit records to determine if documentation and notification of changes were completed. QA monitors will be performed weekly x4, monthly x3, and quarterly x3. Audit results will be reported to the QA committee quarterly. 8/31/17.	

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{F 157}	Continued From page 3 and supervision during meals, has experienced weight loss of 5% or more in the last month or 10% or more in the last 6 months, and receives a mechanically altered diet. The current care plan stated, ". . . [Resident #3] has . . . poor appetite, and unplanned weight loss. . . ." The dietary progress note, dated 07/13/17, identified, ". . . Weight [down] 40# [pounds]/6 mo [months]. Severe loss. . . . She eats in her recliner in her room. Staff set-up meals. She states she's feeling better [and] eating better, but has no appetite and no energy. . . ." The interdisciplinary note, dated 07/16/17, identified, ". . . [Physician] notified by fax. . . . Weight 129# on 07/01/17. Current weights on 07/16/17 125.4#. . . ." This was the first/only attempt facility staff made to contact Resident #3's physician regarding her severe, and continued weight loss. During an interview on 07/25/17 at 9:20 a.m., when asked if/how the facility contacted Resident #3's physician regarding her severe continued weight loss, a managerial nurse (#2) stated, "We use a physician's communication form to update the doctor." The managerial nurse (#2) reviewed the medical record and was unable to locate any physician's communication forms in Resident #3's medical record.	{F 157}		
{F 164} SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	{F 164}		9/11/17

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{F 164}	Continued From page 4 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	{F 164}		

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{F 164}	Continued From page 5 This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on observation, review of the 07/05/17 inservice addressing personal privacy and confidentiality, and resident interview, the facility failed to provide privacy during personal cares for 3 of 16 sampled resident (Resident #3, #5, and #28) observed during cares. Failure to ensure privacy during personal cares is a violation of the residents' privacy. Findings include: Review of the 07/05/17 inservice addressing personal privacy and confidentiality occurred on 07/25/17. The inservice material stated, ". . . When any staff member is entering a resident room we need to consider it their home. We knock, introduce ourselves and ask permission to enter. At any time when performing personal cares please ensure drapes, door or curtains are closed to provide privacy. . . ." Observation showed the following: * During an interview on 07/21/17 at 3:20 p.m., Resident #28 reported staff "don't always" knock and announce themselves before entering the room. Mid-interview, an unidentified staff member opened the door, entered Resident #28's room, saw she was speaking to a member of the survey team, and stated, "Oh, I'll wait" as she backed out of the room. The unidentified staff member	{F 164}	1. Staff will provide privacy for resident #3, #5, and #28. 7/31/17 2. All other residents have the potential to be affected. 3. All staff will be educated on the policy regarding privacy. 8/29/17 4. Staff will be monitored weekly x4, monthly x3, and quarterly x3 to determine if staff are knocking on resident's door, waiting for a response and then announce themselves before entering. MDS Coordinator and PTA will perform audits. Audits will also include privacy curtains when necessary and window curtains. Results of the audit will be reported at the quarterly QA meetings. 8/31/17 Results of audits will be reported at the monthly QAPI meetings. 8/24/17	

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{F 164}	Continued From page 6 failed to knock and/or announce herself prior to entering Resident #28's room. * On 07/22/17 at 6:15 p.m., a certified nursing assistant (CNA) (#38) transferred Resident #3 into the bathroom and provided her toileting cares. Both the door to the bathroom and the door to Resident #3's room remained open as the CNA (#38) assisted her to stand, completed her pericares, and adjusted her clothing. The CNA (#38) failed to close the door to Resident #3's room prior to providing Resident #3's toileting cares. * On 07/24/17 at 9:30 a.m., a nurse (#46) and CNA (#41) transferred Resident #5 into bed (which was next to the wall/open window) and provided her incontinence cares. While the CNA (#41) completed Resident #5's pericares, an unidentified staff member knocked, popped his/her head in the doorway, and cued the CNA to close the window curtains. The nurse (#46) and CNA (#41) failed to close the window curtains prior to providing Resident #5's toileting cares.	{F 164}		
{F 176} SS=F	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567	{F 176}	1. Residents #3,4,6,12,15,17,27,32,38,43,44 & 49; care plans stated that they could self-administer medications (SAM). None of the above residents were self-administering medications.	9/11/17

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{F 176}	Continued From page 7 Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents could safely self-administer medications for 12 of 12 sampled residents (Resident #3, #4, #6, #12, #15, #17, #27, #32, #38, #43, #44, and #49) identified during the on-site revisit. Failure to evaluate a resident's ability to safely self-administer medications initially and on a routine basis, may result in medication errors and adverse drug reactions. Findings include: Review of the facility policy titled "Resident Self-Administration of Medication" occurred on 07/25/17. This policy, dated 07/05/17, stated, "Policy: Each resident who desires to self-administer medication may be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. Self-administration should be written in the care plan once safety has been established. . . . 2. If the resident indicates no desire to self-administer medication, this is documented in the resident's medical record . . . 3. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility. 4. The results of the interdisciplinary team assessment are recorded on the Self-Administration Form, which is placed in the resident's medical record. 5. Reassessment is required with quarterly MDS [Minimum Data Set] and any significant change in status, which may affect the resident's ability to perform this. 6. Once competency of resident is	{F 176}	Self-Administration of Medications were removed from the care plan by MDS Coordinator. 07/26/2017 2. All care plans were checked regarding self-administration of medications. No residents are self-administering medications at this time. 3. IF a resident desires to self-administer medications, Physician orders will be obtained and an assessment will be completed by the MDS Coordinator. The Resident Review Committee will also determine if the resident□s cognitive, physical, and visual ability will allow them to carry out this responsibility. Results of assessment will be documented on the self-administration form, and will be placed in the residents chart. If residents do not have the approval to self administer medications, the Nurse and CMA are to remain with the resident to ensure the residents take the medication. 4. Random monitors will be put in place to determine if there is a Physician order and assessment form completed quarterly. Audit will be performed weekly x4, monthly x3 and quarterly x3 by the MDS Coordinator. Self administration of medication audits will be reported at the QAPI monthly meetings 8/24/17. Self administration of medication audits will be reported at the QA meetings quarterly 8/31/17.	

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{F 176}	Continued From page 8 determined an order shall be obtained from the physician. 7. Upon notification of the resident who can self-administer or have bedside medication by the resident, this should be noted on the MAR [Medication Administration Record]. . . ." Review of the facility policy titled "Administering Medications" occurred on 07/25/17. This undated policy, stated, ". . . 18. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. . . ." The facility's plan of correction for F176 stated, ". . . All residents currently self-administering medications must be assessed prior to 07/21/17. . . . " During an interview on 07/23/17 at 1:11 p.m., a licensed practical nurse (#23) stated no residents self administer medications. - Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 07/09/17, identified moderately impaired cognition. The current care plan stated, ". . . [Resident #3] may self administers [sic] medications after setup by Nurse or CMA [certified medication aide]. . . . Do an assessment ot [sic] determine if [Resident #3] can self administer her medication. Observe [Resident #3] takin [sic] her medication after setyp [sic] by Nurse or CMA. Document in MAR meds [medications] taken. Will monitor for decline (in) ability to self administer medications at Care	{F 176}		

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{F 176}	Continued From page 9 Conference and as needed. . . ." The July 2017 MAR stated, "May self administer meds in room or at dining room table, monitor monthly. . . ." The medical record lacked a current Self -Administration of Medication (SAM) assessment. - Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS, dated 07/11/17, identified severely impaired cognition. The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment. - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated 07/13/17, identified moderately impaired cognition. The current care plan stated, ". . . [Resident #6] self administers medications. . . . Administer medications as ordered. Allow [Resident #6] to take her meds per self after staff sets them up. Monitor that she takes all her meds. . . ." The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment. Observation on 07/22/17 at 5:50 p.m. showed Resident #6 at the dining room table with a medication cup that contained seven medications. Resident #6 stated "They are supposed to watch me take them, but no one is here." Observation showed nursing staff failed to ensure Resident #6 took all of her medications. Observation on 07/23/17 at 7:44 a.m. showed Resident #6 at the dining room table with a medication cup that contained 13 medications.	{F 176}		

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{F 176}	Continued From page 10 Observation showed no nursing staff staff present to ensure Resident #6 took all of her medications. - Review of Resident #12's medical record occurred on all days of survey. A quarterly MDS, dated 07/20/17, identified severely impaired cognition. The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment. - Review of Resident #15's medical record occurred on all days of survey. A significant change MDS, dated 05/01/17, identified intact cognition. The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment. - Review of Resident #17's medical record occurred on all days of survey. A quarterly MDS, dated 05/06/17, identified intact cognition. The current care plan stated, ". . . [Resident #17] may self administers [sic] medications after setup by Nurse or CMA . . . Do an assessment to determine if [Resident #17] can self administer her medication. If yes, observe [Resident #17] taking her medication after setup by Nurse or CMA. Document in MAR meds taken. Will monitor for decline ability [sic] to self administer meds. Will review at care conference. . . ." The July 2017 MAR stated, "May self administrate medication in room or at dining room table." The medical record lacked a current SAM assessment. - Observation of Resident #27's room occurred	{F 176}		

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{F 176}	Continued From page 11 on 07/24/17 at 9:02 a.m. and showed a plastic storage unit with three bottles of Vitamin C and one bottle of multivitamins visible on a shelf. Review of Resident #27's medical record occurred on all days of survey. A quarterly MDS, dated 06/28/17, identified the resident with severe cognitive impairment. The resident's record lacked evidence of a current SAM assessment. During an interview on 07/24/17 at 12:45 p.m. an administrative nurse (#42) confirmed Resident #27 was not considered safe to self administer medications. - Review of Resident #32's medical record occurred on 07/23/17. A quarterly MDS, dated 05/24/17, identified severely impaired cognition. The resident's current care plan stated, ". . . [Resident #32] has increasing dementia . . . and impaired judgement at times . . . [Resident #32] has periods of extreme confusion . . ." A physician's order, dated 08/24/15 stated, "May self-administer meds in room and at dining table, monitor monthly." Resident #32's record lacked evidence of a current SAM assessment. - Review of Resident #38's medical record occurred on all days of survey. A quarterly MDS, dated 06/05/17, identified severely impaired cognition. The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment. - Review of Resident #43's medical record occurred on all days of survey. A quarterly MDS,	{F 176}		

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{F 176}	Continued From page 12	{F 176}		

dated 05/20/17, identified severely impaired cognition. The current care plan stated, ". . . [Resident #43] may self [sic] medications after setup by Nurse or CMA. . . . Do an assessment to determine if [Resident #7] can self administer meds. Observe [Resident #43] taking medication after setup by Nurse or CMA. Document in MAR meds taken. Will monitor decline ability to self administer meds. Place meds in his palm for him to take with water in the other hand." The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM assessment.

- Review of Resident #44's medical record occurred on all days of survey. A significant change MDS, dated 05/17/17, identified Resident #44 has some difficulty making decisions in new situations. The current care plan stated, ". . . [Resident #44] may self administers [sic] medications after setup. . . . Do an assessment to determine if he can self administer meds. [Resident #44] prefers to place his meds on the table before he takes them. Observe [Resident #44] taking his medications. Document in MAR meds taken. Will continue to monitor for decline [sic] ability. . . ." The July 2017 MAR stated, "May self administrate medication in room or at dining room table By Mouth." The medical record lacked a current self SAM assessment.

- Review of Resident #49's medical record occurred on all days of survey. A quarterly MDS, dated 05/07/17, identified severely impaired cognition. The July 2017 MAR stated, "May self administer medication in room or at dining room table." The medical record lacked a current SAM

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{F 176}	Continued From page 13 assessment.	{F 176}		
{F 225} SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours	{F 225}		9/11/17

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{F 225}	Continued From page 14 after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567 Based on information provided by the complainants, record review, review of facility policy, and resident/staff interview, the facility failed to immediately report an allegation of	{F 225}	1. Resident #3 did not have an allegation of abuse investigated in a timely manner. Allegation of abuse investigated. 07/24/2017 Re-investigation final report submitted to North Dakota State Department of Health. 07/31/2017 2. All other residents have the potential to be affected. All allegations of abuse and	

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{F 225}	Continued From page 15 abuse to the State Agency, failed to thoroughly investigate an allegation of abuse, and failed to report the results of the abuse investigation to the State Agency within five working days of the incident for 1 of 2 abuse allegations (Resident #3) brought to the abuse committee's attention. Failure to report allegations of abuse to the State Agency and thoroughly investigate allegations of abuse placed Resident #3, as well as other residents in the facility, at risk for potential abuse/injury. Findings include: Information provided by the complainants during the May 30-June 7, 2017 complaint survey indicated the facility failed to report and/or investigate an allegation of abuse brought forward by a resident and/or staff members. The resident claimed she sustained a black eye, after a staff member (working the night shift) hit her in the face with her call light. She alleged the staff member was "upset [she assumed it was because she had to go to the bathroom in the middle of the night] and whipped the sheet over her [with the call light attached]." The complainants described Resident #3 as "[afraid to share the information]. She thinks she is going to get in trouble." Review of the facility policy titled "Abuse, Neglect, and Exploitation" occurred on 07/25/17. This policy, revised 07/05/17, stated, ". . . Each resident has the right to be free from abuse . . . When . . . reports of abuse occur . . . an investigation is immediately warrented [sic]. Components of an investigation may include . . . Interview the involved resident . . . staff members	{F 225}	neglect will be promptly investigated and reported to the North Dakota State Department of Health. 8/17/17 3. Staff will be educated on abuse policy by the DON. 08/17/2017 Policy updated and abuse packet placed at each nurse station. 08/08/2017 Icon put on computers at each nurse station. 08/08/2017 Allegations of abuse and neglect will initially be investigated by the nurse on duty. DON and QA manager will perform a more thorough investigation in the required timeline. 4. All incidents such as falls, skin tears, and bruises will be investigated by the QA manager/Designee to determine if abuse or neglect may have occurred. Audits will occur after each incident. Audit results will be reported to the QA committee quarterly.8/31/17. Audit results will be reported to the QAPI committee monthly. 8/24/17	

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{F 225}	Continued From page 16	{F 225}		

in the area . . . All statements should be signed by the person making the statement. . . . Document the entire investigation chronologically. . . The facility will make efforts to protect all residents after alleged abuse . . . When abuse . . . is suspected . . . Initiate an investigation immediately . . . Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately. . . . The facility must . . . report to the State Agency . . . no later than 24 hours if the events that cause the suspicion do not result in serious bodily injury . . . Have evidence that all alleged violations are thoroughly investigated, Prevent further potential abuse . . . or mistreatment while the investigation is in process, Report the results of all investigations to . . . the State Survey Agency, within 5 working days of the incident . . ."

The facility's plan of correction for F225 stated, ". . . The incident was reported to the DOH regarding the potential for abuse/neglect on 07/11/17. The facility was able to interview other residents and staff members to see if this was a one time occurrence or if this was a patterned event. The findings will be submitted on 07/16/17. . . . "

Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety, depression, insomnia, and incontinence. The admission Minimum Data Set (MDS), dated 03/14/17, identified moderately impaired cognition and extensive assist of one or more persons required for transfers and toileting.

The facility provided a copy of the report for the

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{F 225}	Continued From page 17 incident described above during the May 30-June 7, 2017 complaint survey. The report, dated 05/17/17 at 11:45 p.m., identified, "When asked, the resident told this nurse that [accused staff member] tossed the call light aside while straitening [sic] her covers and it hit her in the R [right] eye. [Resident #3] stated he did not do this on purpose. . . . Educated [accused staff member] not to toss call light. . . ." The [accused staff member's] written statement was attached to the accident/incident report. The facility failed to contact the State Agency immediately after receiving the allegation. The incident report failed to address how the facility thoroughly investigated the allegation of abuse which occurred during the night shift. The administrative staff member (#1) provided a second copy of the incident report, which contained an additional entry, "05/18/17, [administrative staff member (#1)] and the [social service staff member (#20)] talked with resident and CNA(certified nursing assistant) [accused of physical abuse]. Resident stated that it was an accident as CNA stated." On 07/17/17, the facility provided a second report to the State Agency regarding the incident described above. The report was signed by the administrative staff member (#1), the nurse (#6), and the social service designee (#20). The report, dated 07/11/17, identified the following: * ". . . Once the team was notified of the alleged abuse, the CNA in question was not on shift and did not pose a threat of the safety to any of the residents residing at [facility]. . . . No other residents were involved, nor was their safety in jeopardy during or after the incident, or during the investigation. . . ." * ". . . Neither the resident not the CNA was	{F 225}		

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{F 225}	Continued From page 18	{F 225}		

aware of the call light placement, unfortuneately [sic] the call light hit the resident in the face causing minor bruising. . . ."
* ". . . The charge nurse . . . documented the allegation by writing her concerns on paper and delivering to [managerial nurse #2] (this documentation cannot be located.) . . ."
* . . . [social service designee #20] notified the charge nurse on duty and noted on the report sheets, that another CNA will have to provide cares to the residents until the investigation was complete. . . . [accused CNA] was unable to work on the West End . . . until further notice, due to the on-going investigation. . . ."
* ". . . Summary of interview other staff members . . . [two day CNAs were interviewed] . . ."
* ". . . 05/18/17 - 4 PM it was deemed by the investigating team the incident was unsubstantiated. . . . The investigation was complete before the CNA's next shift. . . . The policy has been reviewed, staff notified and trained, and QA [quality assurance] - Audit has been set in place. . . ."

During an interview on 07/21/17 at 3:20 p.m., when asked if the staff assist residents with toileting in a timely manner, an interviewable resident (A1) responded, "I forget sometimes if I was in there [bathroom] and they [staff] complain if you're in there too many times." When asked who complains, she responded, "It's the ones that put you to bed and get you up."

During an interview on 07/23/17 at 8:40 a.m., when asked if the staff assist residents with toileting in a timely manner, an interviewable resident (G) responded, "Yeah, because I'm not supposed to go alone." When asked if night staff

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{F 225}	Continued From page 19 appear frustrated if she requested to use the bathroom more than once, she responded, "It's happened before." During an interview on 07/24/17 at 10:05 a.m., a nurse (#6) stated, "Like I said, I just signed that I read it [second report for the incident]. I interviewed [Resident #3] to see what happened, but I didn't write anything down. There is no documentation." The nurse (#6) confirmed the facility had no documentation showing the facility assitned the accused CNA to the East End during the investigation, and agreed they have no way of knowing whether or not the accused CNA provided cares to residents on the West End (including Resident #3) during the investigation. During an interview on 07/24/17 at 10:55 a.m., the social service designee (#20) reported she was unaware it was her duty to report allegations of abuse/neglect to the State Agency. She also indicated she had received no training in this area. When asked if the facility suspended the alleged CNA in an effort to ensure he did not pose a threat to the residents during the investigation, the social service designee (#20) stated, "[Administrative staff member #1] did not suspend him [alleged CNA]." The social service designee (#20) also confirmed she was unable to locate any documentation showing the following: 1) facility staff assessed Resident #3's bruise - supporting the facility's description of "minor bruising," (The bruise was still present at the time of the May 30-June 7, 2017 complaint survey.) 2) the charge nurse's notes describing the incident - supporting the facility's assertion the	{F 225}		

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{F 225}	Continued From page 20 nurse reported the incident, 3) her notes indicating another CNA would have to provide cares to residents on the West End pending completion of the investigation - supporting the facility's assertion the residents safety was not in jeopardy during the investigation, 4) her notes regarding the interviews she conducted with the day staff - supporting the facility's assertion they interviewed staff members in the area at the time of the incident. (The incident occurred during the night shift, and the facility chose to interview two staff members working the Day shift. The time/attendance records showed one of the day CNAs was not working at the time of the incident.) 5) her notes regarding the interview she conducted with the alleged CNA. 6) investigating team notes indicating other residents had been interviewed, 7) investigating team notes indicating they deemed the allegation unsubstantiated on 05/18/17 at 4:00 p.m. (Prior to the alleged CNA's next scheduled night shift; the following day.) 8) investigation team notes indicating facility staff had reviewed the abuse policy, trained it's staff members, and put an audit in place on 05/18/17. The facility failed to provide evidence staff had thoroughly investigated the abuse allegation. Failure to report allegations of abuse to the State Agency, failure to thoroughly investigate an allegation of physical abuse, and falsifying a record, placed Resident #3, as well as other residents in the facility, at risk for abuse/injury.	{F 225}		
{F 250} SS=E	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	{F 250}		9/11/17

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{F 250}	Continued From page 21 (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide medically-related social services for 23 of 33 resident records (Resident #3, #4, #5, #6, #9, #11, #15, #16, #17, #18, #24, #25, #27, #28, #32, #33, #34, #35, #38,#43, #44, #45, and #49) reviewed during the on-site revisit. Failure to monitor and evaluate residents' psychosocial status on a regular basis may result in unmet psychosocial needs and negatively impact the overall well-being for all residents. Findings include: - Review of residents' medical records occurred on all days of survey and identified a lack of social service progress notes. The most recent social service documentation occurred on the following dates: * Resident #3: 06/29/16 * Resident #4: 08/17/16 * Resident #5: 08/30/16 * Resident #6: 10/26/16 * Resident #9: 07/26/16 * Resident #11: 04/06/16 * Resident #15: 01/19/17 * Resident #16: No social service notes in record (admission date 03/15/17) * Resident #17: 04/29/16 * Resident #18: 04/06/27 * Resident #24: 04/14/16 * Resident #25: 02/02/17: "[Family] have	{F 250}	1. Residents # 3, 4, 5, 6, 9, 11, 16, 17, 18, 24, 25, 27, 28, 32, 33, 34, 35, 38, and 43: Progress notes were completed and placed on resident□s charts by Social Worker. 08/18/2017 Documentation noted in Resident #25□s chart regarding resident psychological status. 08/18/2017. Resident #15,44,45, and 49□s progress notes have been completed and placed in resident charts. 8/18/17. 2. All residents have the potential to be affected. 3. Social Worker educated on the timeliness of resident progress notes and timeliness of documentation regarding any resident□s change in psychological status 8/18/17. All Social Services progress notes will be placed in the resident□s record in a timely manner. 9/3/17 . Social Worker Consultant visited on 8/24/17. 4. DON/QA manager will audit 10 charts quarterly to determine compliance. 9/3/17. Audit results will be reported to the QAPI committee monthly. 6/24/17. Audit results will be reported to the QA committee quarterly. 8/31/17	

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{F 250}	Continued From page 22 permission to take [Resident #25] to lunch" The social service designee (#20) failed to provide any documentation regarding the resident's psychosocial status for the 02/02/17-07/25/17 time period. * Resident #27: No social service notes in record (admission date 09/28/16) * Resident #28: 07/06/16 * Resident #32: 06/01/16 * Resident #33: 08/17/16 * Resident #34: 02/25/16 * Resident #35: No social service notes in record (admission date 09/28/16) * Resident #38: 03/08/17 * Resident #43: 06/01/16 * Resident #44: 02/10/17 * Resident #45: 07/20/16 * Resident #49: 02/09/16 During an interview on 07/24/17 at 9:36 a.m., a Social Services staff member (#20) stated she writes social services notes quarterly with each care conference and when Minimum Data Sets are completed. She stated, "I know I'm behind."	{F 250}		
{F 272} SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	{F 272}		9/11/17

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{F 272}	Continued From page 23 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE	{F 272}	1. Resident #4's CAAs were not signed off in a timely manner.	

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{F 272}	Continued From page 24 FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and review of the Centers for Medicare & Medicaid Services (CMS) Submission Reports, the facility failed to ensure the Registered Nurse (RN) Coordinator signed and dated the Care Area Assessment (CAA) Process in a timely manner for 1 of 1 sampled resident (Resident #4) with a comprehensive assessment submitted on 07/23/17. Failure to complete the CAA process within the required time frame may result in a delay in developing the resident's plan of care. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, page 2-24 stated, ". . . The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD [Assessment Reference Date] (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA [Significant Change in Status Assessment] were met. This date may be the same as the MDS completion date, but not earlier than MDS completion." The Long-Term Care Facility RAI User's Manual, revised October 2016, page V-5 stated, "Coding Instructions for V0200B . . . V0200B2, Date. Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed . . . . within 14 days of the Assessment Reference Date	{F 272}	2. All CAAs since 7/25/17 were checked for timeliness and signed by the RN. CAAs were checked by MDS Coordinator. Compliance noted. 07/31/2017 3. MDS Coordinator, RN, and all disciplines were educated regarding CAA process and timeliness. 07/31/2017 4. CAAs will be checked for timeliness and signatures prior to submission. QA/DON will review all CAAs weekly x2 months, and then monthly x3, then quarterly x3. Audit results will be reported to the QA committee quarterly. 8/31/17.	

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{F 272}	Continued From page 25 (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI." On 07/24/17, review of the CMS Submission Report, dated 07/23/17, showed the facility submitted a new record (SCSA) for Resident #4, with an assessment reference date (ARD) of 04/24/2017, and a CAA(s) completion date (Item V0200B2) of 07/19/2017. The RN Coordinator failed to complete the CAA review within 14 days of the Assessment Reference Date (A2300) as required by the RAI User's Manual.	{F 272}		
{F 278} SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	{F 278}		9/11/17

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{F 278}	Continued From page 26 (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567 MEDICARE PART A Prospective Payment System (PPS) DISCHARGE ASSESSMENTS 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), review of the Centers for Medicare & Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to complete Part A Prospective Payment System (PPS) Discharge assessments within the allowed timeframe for 6 of 6 sampled residents (Resident #3, #4, #8, #14, #16, #22, and #33) when the resident's Part A stay ended. Failure to complete the Part A PPS Discharge assessments when the residents' Medicare Part A stay ended resulted in no accurate assessment of these residents'	{F 278}	F278 – H300 Coding Urinary Incontinence 1. Resident #3 was not coded correctly in section H300 on the MDS. Modification and submission completed 8/29/17 by MDS Coordinator. 2. All MDSs were checked for all residents regarding accuracy of section H300 by MDS Coordinator. 07/28/2017 3. MDS Coordinator was educated on Section H300 coding by Certified MDS Consultant on 7/5/17, 7/17/17, 7/18/17, and 7/19/17. MDS Coordinator also educated on 8/2/17. ADL forms in place for each shift to document whether the resident is continent or incontinent. 4. Random audits will be performed to determine if section H300 is coded correctly. Audits will be completed weekly x4, monthly x3, and quarterly x3 by	

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{F 278}	Continued From page 27 status and their needs at that time. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, page 2-45 stated, ". . . The ARD [Assessment Reference Date] (A2300) for a standalone Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days) . . . Part A PPS Discharge Assessment (A0310H = 1) . . . Must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days). . . ." - On 07/24/17, review of the CMS Submission Reports, dated 07/20/17, 07/21/17, and 07/23/17, showed the facility failed to complete Part A PPS Discharge assessments in a timely manner for the following six residents: *Resident #3 - ARD 03/16/17 and completion date 07/19/17 *Resident #4 - ARD 04/21/17 and completion date 07/19/17 *Resident #8 - ARD 05/25/17 and completion date 07/19/17 *Resident #16 - ARD 03/22/17 and completion date 07/19/17 *Resident #22 - ARD 03/24/17 and completion date 07/19/17 *Resident #33 - ARD 02/02/17 and completion date 07/19/17 During an interview on the afternoon of 07/24/17,	{F 278}	QA/Designee. 09/03/2017. Audit results will be reported at the Quarterly QA meetings. F278 – ARD 1. ARD date was not appropriate for residents #3, 4, 15, and 33. Resident 3, 4, 15, 33. MDSs were modified to reflect the correct ARD date. 2. All residents have the potential to be affected. 3. Staff were educated by MDS Coordinator. 07/26/2017 MDS Coordinator was educated by Certified MDS Consultant. 07/5/2017, 07/17/2017, 07/18/2017, 07/19/2017. MDS Coordinator was also educated on 8/2/17. Certified MDS Consultant consulted with Joan Coleman with the North Dakota State Department of Health. 4. All MDSs will be audited by QA/Designee to ensure the ARD date is correct. 09/03/2017. Audit results will be reported to the Quarterly QA committee. 8/31/17 F278 Assessment Accuracy 1.PPS Discharge Assessments for resident #3, 4, 8, 14, 16, 22, and 33 were completed and submitted on 7/19/17. PPS Discharge Assessments will be completed in a timely manner. Any PPS Discharge Assessments not completed in a timely manner will be completed as	

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{F 278}	Continued From page 28 a licensed nurse (#1) stated he was previously unaware of the need to complete Part A PPS Discharge assessments, and confirmed these assessments were completed late. ASSESSMENT REFERENCE DATE 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and review of the Centers for Medicare & Medicaid Services (CMS) Submission Reports, the facility failed to set the Assessment Reference Date (ARD) within the appropriate timeframe for 4 of 4 sampled residents (Resident #3, #4, #15, and #33). Failure to set an ARD within the appropriate timeframe results in a change in the look-back period and alters the actual assessment timeframe. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, page 5-11 stated, ". . . the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples . . . An assessment was completed by the team and entered into the software based on the ARD . . . Three weeks later, the IDT [interdisciplinary team] determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD . . . This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur. . . ."	{F 278}	required. 2. All residents have the potential to be affected. 3. Certified MDS Consultant educated MDS Coordinator. 07/5/2017, 07/17/2017, 07/18/2017, 07/19/2017. PCC initiated on 8/1/17. 4. All PPS assessments will be audited by QA/Designee. 09/03/2017. Audit results will be reported at the quarterly QA meeting. 8/31/17 F278: Z0400 & 20500 1. MDS for Residents #4 and 22 submitted on 07/23/2017 did not include electronic signatures. MDS program did not have the electronic signature functionality setup for authentication. The Certified MDS Consultant RN removed the RN signatures that were not electronically authenticated, reviewed MDSs and signed her name. 7/5/17 Certified MDS Consultant educated MDS Coordinator. 07/5/2017, 07/17/2017, 07/18/2017, 07/19/2017. MDS Coordinator was also educated on 8/2/17. Certified MDS Consultant spoke with Joan Coleman from the North Dakota State Department of Health regarding issues. 2. As of 08/01/2017, no residents have the potential to be affected. 3. Point Click Care has been	

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{F 278}	Continued From page 29 - On 07/24/17, review of the CMS Submission Reports, dated 07/20/17, 07/21/17, and 07/23/17, showed facility staff changed the following ARDs: *Resident #3 - original ARD 03/14/17, modified the ARD to 03/13/17 *Resident #15 - original ARD 01/24/17, modified the ARD to 01/23/17 *Resident #33 - original ARD 02/10/17, modified the ARD to 02/09/17 - On 07/24/17, review of the CMS Submission Report, dated 07/23/17, showed the facility submitted a new record (Significant Change in Status Assessment [SCSA]) for Resident #4, with an ARD of 04/24/17. Facility staff completed this assessment on 07/19/17. - On 07/24/17, review of the CMS Submission Report, dated 07/21/17, showed the facility submitted a new record for Resident #15, with an ARD 01/20/17. Facility staff completed this assessment on 07/19/17. Facility staff failed to follow the RAI User's Manual instructions when changing the ARDs of the Minimum Data Sets listed above. SECTION H300 - URINARY CONTINENCE 3. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to accurately code Section H: Bladder and Bowel for 1 of 29 records reviewed (Resident #3) during the on-site revisit. Failure to accurately complete the MDS for residents does not allow each resident's	{F 278}	implemented as the new MDS program. PCC has the capability for authenticated electronic signatures. 08/01/2017 4. Signatures are monitored by the QA/Designee prior to submission. QA/DON will monitor all MDSs for authentic RN signatures. Audit results will be reported to the Quarterly QA committee. 8/31/17.	

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{F 278}	Continued From page 30	{F 278}		

comprehensive assessment to reflect their individual needs or the care provided.

Findings include:

The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page H-1 - H-13, stated, ". . . H0300: Urinary Continence . . . always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. . . ."

- Review of Resident #3's medical record occurred on all days of survey. Review of the July 2017 toileting/continence documentation showed Resident #3 was continent (without any episodes of incontinence) throughout the 7-day look-back period. The quarterly MDS, dated 07/09/17, failed to accurately reflect her continent status, instead identifying her as "frequently incontinent."

SECTION Z0400 AND Z0500 - ATTESTATION STATEMENT AND SIGNATURE OF REGISTERED NURSE COORDINATOR

4. Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to ensure staff who completed any part of the Minimum Data Set (MDS) entered their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed; and failed to ensure the registered nurse (RN) verified that item Z0400 contained attestations for all MDS sections completed for 2 of 2 sampled residents (Resident

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{F 278}	Continued From page 31 #4 and #22) with MDSs submitted on 07/23/17. Failure to complete the attestation statement and verify the attestation statement does not ensure all sections of the MDS are completed and accurate. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page Z-6 - Z-8, stated, ". . . Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting. I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. . . . Legally it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a	{F 278}		

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{F 278}	Continued From page 32 section of the MDS is required to sign the Attestation Statement . . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed. Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information . . . Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a sub-set of item within a section should identify which item(s) he/she completed within that section . . . Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion . . . Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. . . . [the RN assessment coordinator is to] 1. Verify that all items on this assessment are complete. 2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections. . . . For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date will generally be later than the date(s)	{F 278}		

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{F 278}	Continued From page 33 at Z0400, which documents when portions of the assessment information were completed by assessment team members . . . ." - Review of Resident #4's medical record occurred on July 24-25, 2017. A significant change MDS, with an Assessment Reference Date (ARD) of 04/24/17 and Z0500B date of 07/19/17, lacked completion of item Z0400. None of the staff members who completed any part of the MDS entered their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. Furthermore, the registered nurse who signed and dated the MDS at Z0500 failed to verify that item Z0400 (signature of persons completing the assessment) contained attestation for all MDS sections. - Review of Resident #22's medical record occurred on July 24-25, 2017. A Medicare Part A Prospective Payment System (PPS) Discharge MDS, with an ARD of 03/24/17 and a Z0500B date of 07/19/17, lacked completion of item Z0400, with the exception of a signature, title, and date for GG0170. None of the staff members who completed any other part of the MDS (excluding GG0170) entered their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. Furthermore, the registered nurse who signed and dated the MDS at Z0500 failed to verify that item Z0400 (signature of persons completing the assessment) contained attestation for all MDS sections. SIGNATURES (Z0400 & Z0500) 5. Based on record review, review of the	{F 278}		

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{F 278}	Continued From page 34 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), review of the Centers for Medicare & Medicaid Services (CMS) Submission Reports, and staff interview, the facility failed to ensure Minimum Data Sets (MDSs) contained authentic signatures; and failed to ensure the facility had security measures in place to protect the staff's electronic signatures for 2 of 2 sampled residents (Resident #4 and #22) with MDSs submitted on 07/23/17. Failure to ensure MDSs contained authentic signatures resulted in inaccurate MDSs. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 2 page 2-7, stated, ". . . Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs. . . . In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active	{F 278}		

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{F 278}	Continued From page 35 clinical record. Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record . . ." During an interview on 07/23/17 at 5:05 p.m., a licensed nurse (#1) stated the facility's MDS program did not provide unique identifier's for staff signatures. The licensed nurse (#1) explained staff members may type and select other staff member's names and input them for the MDS completion signature. He said since the facility does not have a policy on electronic signatures, the Registered Nurse (RN) electronically signs the completion of the MDS, the MDS Coordinator prints off the MDS, and the RN manually signs it. During an interview on the morning of 07/25/17, an administrative staff member (#2) stated the facility's MDS electronic record system lacks the capability for electronic signature authentication. - Review of Resident #4's medical record occurred on July 24-25, 2017. A significant change MDS with an ARD of 04/24/17 and a Z0500B date of 07/19/17, showed the electronic name of the registered nurse in item Z0500A. The MDS lacked hand-written signatures resulting in the failure to authenticate the completion of the MDS. On 07/24/17, review of the CMS Submission Report showed the facility submitted this Significant Change in Status Assessment (SCSA) for Resident #14 to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) on 07/23/17.	{F 278}		

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{F 278}	Continued From page 36 - Review of Resident #22's medical record occurred on July 24-25, 2017. A Medicare Part A PPS Discharge MDS with an ARD of 03/24/17 and a Z0500B date of 07/19/17, showed the electronic name of one staff member at Z0400A, and the electronic name of the registered nurse in item Z0500A. The MDS lacked hand-written signatures resulting in the failure to authenticate the completion of the MDS. On 07/24/17, review of the CMS Submission Report showed the facility submitted this Part A PPS Discharge assessment for Resident #22 to the QIES ASAP on 07/23/17. Failure to ensure MDS's contained electronic signatures with unique identifiers or ensure printed MDS's contained the RN's hand-written signature resulted in unauthenticated MDSs.	{F 278}		
{F 280} SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	{F 280}		9/11/17

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{F 280}	Continued From page 37 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	{F 280}		

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{F 280}	Continued From page 38 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 18 of 33 resident records reviewed during the on-site revisit (Resident #3, #4, #5, #6, #9, #11, #12, #15, #16, #17, #24, #27, #28, #32, #33, #38, #43, and #44). Failure to revise care plans	{F 280}	1. Residents #3, 4, 5, 6, 9, 11, 12, 15, 16, 17, 24, 27, 28, 32, 33, 38, 43, and 44: Care plans were reviewed for accuracy and updated to accurately reflect the level of assistance required by the MDS Coordinator. 07/31/2017 2. All Resident care plans were assessed for accuracy and updated as necessary by MDS Coordinator and other disciplines of the MDS Team. MDS team educated on 08/02/2017 3. Staff education will be done for all	

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{F 280}	Continued From page 39 limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 07/25/17. This policy, dated 07/05/17, stated, ". . . 6. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . . 9. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." The facility's plan of correction (POC) for F280 stated, ". . . Resident . . . #3, #9, #11, #16 . . . #33's care plans were reviewed/revised. . . . Completion Date 07/21/17. . . . " The facility's POC indicated the facility provided staff education on 07/05/17 regarding individualized care plan updates. During an interview on the afternoon of 07/24/17 a quality assurance nurse (#2) confirmed the facility failed to provide this education. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated the following: * ". . . [Resident #3] may self administers [sic] medications after setup by Nurse or CMA [certified medication aide]. . . . Do an assessment ot [sic] determine if [Resident #3] can self administer her medication. . . ." The medical record lacked a current Self -Administration of	{F 280}	disciplines that are involved with the care plan again on 8/29/17 . Care plans will be updated when changes occur by all disciplines. Care plans will be reviewed quarterly and with significant changes by all disciplines. 09/03/2017 4. 10 records will be checked quarterly by the QA manager/Designee. Audit results will be reported to the QA committee quarterly. 8/31/17. Audit results will be reported to the QAPI committee monthly. 8/24/17.	

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{F 280}	Continued From page 40 Medication (SAM) assessment. * ". . . Offer a regular diet . . . Offer a mech [mechanical] soft diet with honey thickened liquids. . . . Assist with meals if needed. . . ." The current physician's orders identified, ". . . Diet: Mechanical Soft. . . ." The medical record lacked a physician's order for "honey-thickened liquids." The quarterly MDS, dated 07/09/17, identified the resident requires set-up assistance and supervision during meals, and receives a mechanically altered diet. The entries regarding the residents current diet and level of assistance required during meals conflict with each other, the physician's orders, and 07/09/17 MDS. * ". . . [Resident #3] use [sic] the bathroom independently in her room. She is continent. . . ." The quarterly MDS, dated 07/09/17, identified the resident is frequently incontinent and required extensive assistance of one person for toileting. The care plan conflicts with the 07/09/17 MDS. The medical record also lacked a current bladder assessment and individualized toileting plan, if appropriate. * ". . . [Resident #3] is independent with transfers. . . . is independent with ambulation using a walker . . ." The quarterly MDS, dated 07/09/17, identified the resident requires extensive assistance of two or more persons for transfers and locomotion on/off the unit. The care plan conflicts with the 07/09/17 MDS. - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: Residents [sic] having increased weakness. Interventions: Staff may use STS [sit-to-stand] lift to transfer to/from toilet for resident safety. . . ."	{F 280}		

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{F 280}	Continued From page 41 The current "Care Sheet" (a guide certified nursing assistants [CNAs] use during their shift) identified Resident #4 required assistance of one person and no lift for transfers. Review of therapy's transfer status list showed Resident #4 required assistance from one person for transfers. During an interview on 07/25/17 at 10:32 a.m., a CNA (#12) stated Resident #4 requires a STS mechanical lift and one person only for toileting. Otherwise Resident #4 requires assistance of one staff member to transfer. - Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 06/01/17, identified the resident is always incontinent and required total assistance of one person for toileting. The current care plan stated, ". . . [Resident #5] requires extensive assist with adls . . . [Resident #5] requires limited assist of one staff for all adls [Activities of Daily Living]. . . ." These two entries conflict with each other, as well as the 06/01/17 MDS. - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, ". . . Problems: [Resident #6] requires assist with adls r/t immobility, deformity in ankles, and Arthritis. . . . Interventions . . . Two assist with transfers and toileting using sit to stand lift. . . ." The current "Care Sheet" identified Resident #6 required assistance of one person and no lift for transfers.	{F 280}		

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{F 280}	Continued From page 42 Review of therapy's transfer status list showed Resident #6 required a sit-to-stand mechanical lift and one person for transfers. Observations during the survey showed the following: *7/22/17 at 4:50 p.m.: One CNA (#12) toileted Resident #6 utilizing a sit-to-stand mechanical lift. *07/23/17 at 9:49 a.m.: Two CNAs (#43 and #37) toileted Resident #6 utilizing a sit-to-stand mechanical lift. *07/23/17 at 12:58 p.m.: One CNA (#12) transferred Resident #6 from her wheelchair to the toilet with a sit-to-stand mechanical lift. A second CNA (#43) provided assistance in the middle of the observation. Both CNAs (#43 and #12) transferred Resident #6 with a sit-to-stand mechanical lift from the toilet to the wheelchair. *07/24/17 at 8:30 a.m.: One CNA (#44) toileted Resident #6 utilizing a sit-to-stand mechanical lift. Failure to ensure the care plan reflected Resident #6's current transfer status resulted in CNAs determining how much assistance Resident #6 required. Resident #6's current care plan also stated, ". . . Problem: [Resident #6] self administers medications. . . . Interventions . . . Allow [Resident #6] to take her meds [medications] per self after staff sets them up. Monitor that she takes all her meds. . . ." The medical record lacked a current SAM assessment. During an interview on 07/23/17 at 10:34 a.m., a licensed practical nurse (#6) stated he was going to start updating residents' care plans on 07/24/17.	{F 280}		

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{F 280}	Continued From page 43 - Review of Resident #9's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/25/17, identified the resident is severely impaired in daily decision making, always incontinent and required total assistance of two staff for toileting. The current care plan stated, ". . . Problem: [Resident #9] rely's on staff for all adls [activities of daily living] r/t [related to] severe TBI [Traumatic Brain Injury], dementia, and immobility. . . . Interventions: Two staff members totally assist [Resident #9] with all transfers and toileting using a sit to stand lift..." - Review of Resident #11's medical record occurred on all days of survey. The current care plan stated the following: * ". . . Toileting - [Resident #11] requires limited assistance. . . ." The quarterly MDS, dated 07/01/17, identified the resident requires extensive assistance of one person for toileting. The care plan conflicts with the 07/01/17 MDS. * ". . . Is able to self transfer. . . . Propells [sic] self in wheelchair throughout facility. . . ." The quarterly MDS, dated 07/01/17, identified the resident requires extensive assistance of one person for transfers and locomotion on/off the unit. The care plan conflicts with the 07/01/17 MDS. - Review of Resident #12's medical record occurred on all days of survey. The quarterly MDS, dated 07/20/17, identified the resident is frequently incontinent and requires extensive assistance of two or more persons for toileting. The current care plan stated, ". . . [Resident #12] requires . . . assist with toileting . . . Check for	{F 280}		

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{F 280}	Continued From page 44 incontinence routinely day and noc [night]. . . ." Resident #12's care plan failed to accurately reflect the number of staff and/or level of assistance he required for toileting. * ". . . [Resident #12] . . . Uses sit to stand lift at this time with assist of two . . . other times 1 or 2 staff [with] gait belt . . ." Observations on 07/24/17 at 8:45 a.m. and 8:55 a.m., showed one CNA transferring Resident #12 utilizing a sit-to-stand lift. The two entries on the care plan conflict with each other as well as observation. - Review of Resident #15's medical record occurred on all days of survey. The current care plan lacked an ADL category. The care plan failed to identify the assistance Resident #15 required for toileting, transfers, ambulation, and personal cares. - Review of Resident #16's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: Transfers . . . [Resident #16] is totally dependent on the staff. . . . Interventions . . . [Resident #16] is to be transferred utilizing a mechanical lift and assist of 2. Transfer using the transfer board/lift devices . . ." The current "Care Sheet" identified Resident #16 required assistance of one person and no lift for transfers. Review of therapy's transfer status list lacked Resident #16's transfer status. Observation on 07/23/17 at 10:42 a.m. showed a CNA (#45) transferred Resident #16 utilizing a gait belt.	{F 280}		

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{F 280}	Continued From page 45	{F 280}		

Resident #16's care plan also stated, ". . . Problem . . . Is in wheelchair, with a cast on. . . . Problem: Impaired Bed Mobility . . . Interventions . . . Floor mats as indicated . . . Apply TED [anti-embolism stocking] hose as ordered. . . . Apply heal [sic] protector boots as indicated. Apply trapeze to bed to aid [Resident #16] in self positioning. . . ."

Observation of Resident #16's room on 07/23/17 at 10:42 a.m. showed no evidence of a fall mat or a trapeze. During this observation, a CNA (#11) stated Resident #16 does not wear TED hose or heel protector boots.

Observation throughout the survey showed Resident #16 did not have a cast. During an interview on 07/23/17 at 8:04 a.m., a licensed nurse (#23) stated Resident #16's cast was removed approximately one month ago.

- Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: [Resident #17] may self administers [sic] medications after setup by Nurse or CMA (Certified Medication Aide) . . . Interventions: Do an assessment to determine if [Resident #17] can self administer her medication. If yes, observe [Resident #17] taking her medication after setup by Nurse or CMA. Document in MAR [medication administration record] meds taken. Will monitor for decline ability [sic] to self administer meds. Will review at care conference. . . . Problem: Resident requires extensive assist with adls [activities of daily living] r/t [related to] heart problems, weakness, and immobility. . . . Interventions: Resident requires

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{F 280}	Continued From page 46 two assist with sit to stand lift for all transfers and toiletting [sic]. . . ." The medical record lacked a current SAM assessment. During an interview on 07/23/17 at 1:11 p.m., a licensed nurse (#23) stated no residents self administer medications. The current "Care Sheet" identified Resident #17 required assistance of one person and no lift for transfers. Review of therapy's transfer status list showed Resident #17 required a sit-to-stand mechanical lift and one person for transfers. - Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, "Problem: [Resident #24] at risk of impaired skin integrity r/t incontinence, immobility, and edema. . . . Interventions . . . [Resident #24] has cushion in w/c [wheelchair] for comfort." Observation on 07/26/17 at 10:35 a.m. showed two CNAs (#37 and #43) transferred Resident #24 onto the toilet. No cushion was observed in the wheelchair. Prior to transferring the resident back into the wheel chair, the CNA (#37) folded a cloth pad and placed it in the wheelchair, not a cushion, as per the care plan. - Observation on 07/22/17 at 2:45 p.m. showed an isolation cart outside the door of Resident #27's room and a "Contact Isolation" sign on the door. The resident's current care plan failed to identify the isolation precautions.	{F 280}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 280}	Continued From page 47	{F 280}		

A problem, dated 09/28/16, identified the resident had a history of a stage 3 pressure ulcer. Interventions for the problem included ". . . cushion in wc (ROHO [a type of cushion inflated with air]). . ." Observations on all days showed Resident #27 had a cloth pad folded in half on his wheel chair seat, but failed to identify a ROHO cushion.

- Review of Resident #28's medical record occurred on all days of survey. The quarterly MDS, dated 07/09/17, identified the resident is always continent and requires extensive assistance of one staff member for toileting. Facility staff provided two copies of Resident #28's current care plan. The copies stated, ". . . . . occasionally incontinent . . . Allow [Resident #28] to manage her incontinence as she has been doing. . . Assist with toiletting [sic] per her request. . . . One extensively assists with . . . toileting . . . Remind [Resident #28] to empty bladder before meals, at bedtime, and before activities" The care plan conflicts with the 07/09/17 MDS, and failed to accurately reflect the level of assistance Resident #28 required for toileting.

- Review of Resident #32's medical record occurred on 07/23/17. A quarterly MDS, dated 05/24/17, identified the resident had severe cognitive impairment. The resident's current care plan stated, ". . . Resident is able to self-administer meds. . . ." Staff failed to update the care plan to reflect the resident's current status. Refer to F176.

- Resident #33's medical record, reviewed on 07/24/17, identified the facility failed to review

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{F 280}	Continued From page 48 and revise Resident #33's care plan regarding the resident's daily alcohol intake as a risk/contributing factor for his falls. - Review of Resident #38's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 06/05/2017, identified the resident is severely impaired in daily decision making, always continent and required extensive assistance of one staff for toileting. The care plan stated: ". . . Problem: At Risk For Falls R/T. . . Interventions: . . . Respond promptly to calls for assist to the toilet . . ." Record review identified Resident #38 experienced a fall on 06/09/17 and 06/13/17 while attempting to self transfer to the toilet. The current care plan failed to address the resident required assistance with toileting. - Review of Resident #43's medical record occurred on all days of survey. A quarterly MDS, dated 05/20/17, identified severely impaired cognition, frequently incontinent and required extensive assistance of one staff for toileting. The current care plan stated, "Problems: [Resident #43] may self administers (sic) medications after setup by Nurse or CMA. Interventions: Do an assessment to determine if [Resident #43] can self administer meds. Observe [Resident #43] taking medication after setup by Nurse or CMA. Document in MAR meds taken. Will monitor decline ability to self administer meds. Place meds in his palm for him to take with water in the other hand." The medical record lacked a current SAM assessment. The current care plan also stated, ". . . Problem: Resident requires (sic) assist with adls due to impaired vision. . . Interventions: . . .	{F 280}		

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{F 280}	Continued From page 49 Independent with toileting and ambulation. . . " (this conflicts with the MDS which identified Resident #43 needs extensive assistance of one staff for toileting). The care plan failed to address Resident #43's urinary incontinence, and implement interventions to enable the resident to remain as continent as possible. - Review of Resident #44's medical record occurred on all days of survey. The current care plan stated the following: * ". . . [Resident #44] may self administers [sic] medications after setup. . . . Do an assessment to determine if he can self administer meds. . . ." The medical record lacked a current self SAM assessment. * ". . . [Resident #44] is frequently incontinent of bladder . . . requires two assist and sit to stand lift for all toileting in bathroom by the nurses station. Offer toileting before meals, activities, bedtime, and prn [as needed]. . . . Check for incontinence routinely at noc [night] . . ." The significant change MDS, dated 05/17/17, identified the resident is always incontinent and requires extensive assistance of one person for toileting. The care plan conflicts with the 05/17/17 MDS, and failed to accurately reflect the level of assistance Resident #44 required for toileting. The medical record also lacked a current bladder assessment and individualized toileting plan, if appropriate	{F 280}		
{F 312} SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	{F 312}		9/11/17

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{F 312}	Continued From page 50 This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on observation, record review, review of facility policy and procedure, and family interview, the facility failed to ensure residents received the necessary services required to maintain good nutrition for 4 of 16 sampled residents (Resident #3, #11, #12, and #44) observed during meals. Failure of the facility to provide cues and/or assistance during meals has the potential to affect the residents' ability to maintain their caloric intake and/or nutritional status. Findings include: Review of the facility policy titled "Assistance with Meals" occurred on 07/25/17. This policy, dated December 2008, stated, ". . . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. . . ." The facility's plan of correction for F312 stated, ". . . Two CNAs [certified nursing assistants] were assigned to cue/assist residents during meals in an effort to maintain their intake/nutritional status. . . . " - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/09/17, identified moderately impaired reasoning skills,	{F 312}	F312 ADL Care for Dependent Residents 1. Facility staff did not provide assistance when necessary during meals for the following residents: #3, 11, 12 and 44. Residents were observed in the dining room. Resident #3 will have setup help, cueing or supervision for meals. Documentation will be noted. 08/15/2017 Resident 11, 12, and 44 were assessed. During assessment period, these residents were able to eat independently after set up help. Dietary and Nursing continue to assess with monitors in place. 08/21/2017 2. All residents have the potential to be affected. 3. Nursing and Dietary staff will be educated to observe all residents at mealtimes and to report if they may need assistance. If noted, staff are to report to DON or QA manager so interventions can be put in place. Staff will also be educated regarding Dysphagia and signs and symptoms. Education will occur on 8/28/17. All resident weights will be obtained weekly and reviewed weekly by the Resident Review Committee. Dietician and Physician will be contacted for further interventions when necessary. 4. QA monitors will be put in place for residents #11, 12, and 44 by Dietary Manager and QA. 08/21/2017. Results of	

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{F 312}	Continued From page 51 requires set-up assistance and supervision during meals, has experienced weight loss of 5% or more in the last month or 10% or more in the last 6 months, and receives a mechanically altered diet. The current care plan stated, ". . . [Resident #3] has a need for adequate nutrition r/t [related to] . . . poor appetite, and unplanned weight loss. . . . Offer a regular diet . . . Assist with meals if needed. . . ." The progress notes, dated March 27-July 16, 2017, indicated Resident #3 lost 40 pounds within six months (severe weight loss), continued to slowly lose weight, preferred to eat in her room, required staff assistance to set-up her meal trays, and consumed her meals when encouraged to do so. Observation on 07/22/17 at 5:55 p.m. and 07/23/17 at 8:00 a.m., showed Resident #3 sat in her recliner in her room, feeding herself following tray set-up. Staff failed to supervise Resident #3's meals and/or provide assistance as needed. - Review of Resident #11's medical record occurred on all days of survey. The quarterly MDS, dated 07/01/17, identified intact cognition and requires extensive assistance during meals. The current care plan stated, ". . . [Resident #11] has a need for adequate nutrition R/T. . . Hx [history] of weight loss. . . continues to have a slow weight loss due to poor intake . . . Regular diet. . . . encourage her to eat her meal. . . ." Observation showed the following: * 07/22/17 at 5:55 p.m., Resident #11 sat in her wheelchair in the dining room, feeding herself following tray set-up. Her meal included a	{F 312}	weight audits and weight issues will be reported to the QA committee quarterly. 8/31/17. Results of audits will also be reported to the QAPI committee monthly. 8/24/17	

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{F 312}	Continued From page 52 chicken patty and tomato slices. Resident #11 took bites of the chicken patty, which she held between her fingers. She also took bites of the tomato slices which she held in her hand. Resident #11 coughed twice and ate less than 50% of the meal. * 07/23/17 at 8:00 a.m., Resident #11 sat in her wheelchair in the dining room, feeding herself following tray set-up. Her meal included biscuits/gravy which the resident struggled to cut. Resident #11 cleared her throat three times, coughed twice, and ate less than 25% of her biscuits/gravy and less than 50% of her entire meal. Facility staff failed to cut Resident #11's chicken patty, tomato slices, and biscuits into bite sized pieces, failed to encourage her to eat her meal, and failed to recognize the signs/symptoms of dysphagia Resident #11 demonstrated during the meal. - Review of Resident #12's medical record occurred on all days of survey. The quarterly MDS, dated 07/20/17, identified severely impaired cognition and requires set-up assistance during meals. The current care plan stated, ". . . [Resident #12] has a need for adequate nutrition r/t dementia. . . . Regular diet. . . ." Observation showed the following: * 07/22/17 at 5:55 p.m., Resident #12 sat in his wheelchair in the dining room, feeding himself following tray set-up. A family member assisted him throughout the meal. * 07/23/17 at 8:00 a.m., Resident #12 sat in his wheelchair in the dining room, feeding himself following tray set-up. His meal included biscuits/gravy and orange slices. Resident #12	{F 312}		

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{F 312}	Continued From page 53 struggled to cut the biscuits and gravy without staff assistance. He dropped food in his lap, ate food from his clothing protector, and spit food items out of his mouth and hid them under his plate. The resident ate 50% of his meal. Facility staff failed to cut Resident #12's biscuits/gravy into bite sized pieces and failed to recognize the behaviors/possible signs/symptoms of dysphagia Resident #12 demonstrated during the meal. - Review of Resident #44's medical record occurred on all days of survey. The significant change MDS, dated 05/17/17, identified difficulty reasoning in new situations and requires set-up assistance during meals. The current care plan stated, ". . . [Resident #44] has a need for adequate nutrition . . . [Resident #44] requires assist with all adls [activities of daily living] r/t CVA [cerebrovascular accident] . . . Regular diet. . . . Set up all meals including cutting up food and opening all containers. He will feed himself. . . ." During an interview on 07/22/17 at 5:35 p.m., a confidential family member (U) reported staff "only prep the residents' trays." The family member (#1) then stated, "I assist Resident #44 [during meals]." Observation on 07/23/17 at 8:00 a.m., showed Resident #44 sat in his wheelchair in the dining room, feeding himself following tray set-up. His meal included biscuits/gravy, which he was unable to cut, and orange slices. He ate 100% of the orange slice. The biscuits remained on his plate, untouched. Facility staff failed to cut Resident #44's biscuits/gravy into bite sized pieces.	{F 312}		
{F 315}	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI,	{F 315}		9/11/17

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{F 315} SS=E	Continued From page 54 RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced	{F 315}		

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{F 315}	Continued From page 55 by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to assess residents' bowel and bladder patterns to maintain continence for 18 of 29 residents reviewed (Resident #2, #3, #4, #5, #6, #9, #11, #12, #16, #18, #24, #27, #34, #38, #43, #44, #45, and #49). Failure to assess bowel and bladder patterns and implement routine toileting consistent with these patterns may result in avoidable incontinence and urinary tract infections (UTIs) and does not allow residents to attain/maintain their highest practicable physical and psychosocial well-being. Findings include: Review of the facility policy titled "Urinary Continence and Incontinence-Assessment and Management" occurred on 07/25/17. This policy, revised 02/24/10, stated, ". . . 9. The Unit Manager will complete an assessment . . . and summarize an individual's continence status. The Evaluation will be completed on admission, annually & with significant change in condition. Residents will also be evaluated with a 3-day monitor whenever there is a change in cognition, physical ability or urinary tract infection. . . ." - Review of Resident #2's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated 07/19/17, identified the resident is severely impaired in daily decision making, always incontinent, and required extensive assistance of one person for toileting. The current care plan stated, ". . . [Resident #2] dribbles urine daily, especially in the mornings r/t [related to] joint	{F 315}	1. Resident #2, 3, 4, 5, 6, 9, 11, 12, 16, 18, 24, 27, 34, 38, 43, 44, 45, & 49; ADL Charting which includes whether resident is continent or incontinent will be reviewed by MDS Coordinator. 09/3/2017 B&B assessment will be initiated for the above residents by MDS Coordinator. B&B assessment will be completed with quarterly MDS and with significant changes by MDS Coordinator. 09/03/2017 3 day B&B monitor will be initiated for the above residents to determine B&B pattern by MDS Coordinator or designee. 09/03/2017 Toileting frequency and transfer will be care planned by MDS Coordinator. 09/03/2017 2. All residents have the potential to be affected. 3. Staff education at mandatory in-service. Staff members that do not attend the mandatory meeting will be required to read the policy and sign acknowledging understanding of policy. 08/29/2017 B&B Assessment completed on all residents 09/03/2017, and then quarterly or with significant change by MDS Coordinator. 09/03/2017. MDS Coordinator will review ADL charting	

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{F 315}	Continued From page 56 stiffness and use of a diuretic. . . . One CNA to check [Resident #2] for incontinence; change brief if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier. Pericare done routinely and with each incontinent episode of urine/stool. . . . Remind [Resident #2] to use bathroom before meals, at bedtime, and before activities. . . ." Review of the July 2017 toileting/continence documentation showed Resident #2 frequently incontinent. The facility failed to assess Resident #2's urinary incontinence to determine the need for an individualized toileting plan. - Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 07/09/17, identified the resident is moderately impaired in daily decision making, frequently incontinent, and required extensive assistance of one person for toileting. The current care plan stated, ". . . [Resident #3] use [sic] the bathroom independently in her room. She is continent. . . ." The care plan conflicts with the 07/09/17 MDS, which identified her as being "frequently incontinent" and requiring "extensive assistance of one staff member for toileting." Review of the July 2017 toileting/continence documentation showed Resident #3 usually continent. This conflicts with the 07/09/17 MDS, which identified her as being "frequently incontinent." The facility failed to assess Resident #3's incontinence to determine the need for an individualized toileting plan. Resident #3's ADL (activities of daily living) documentation also showed staff charted	{F 315}	regarding incontinence to determine continence or incontinence. 3 day B&B monitor will be initiated for all residents for 3 days by MDS Coordinator, DON, or designee. 09/03/2017. B&B monitor will be completed with significant changes including UTI□s. Care plans updated regarding toileting and methods of transfer. 09/03/2017 4. Random audits will be completed weekly x4, monthly x3, and quarterly x3 to determine if resident is toileted per individualized care plan. Audit will be performed by MDS Coordinator and PTA. 09/03/2017. Audit results will be reported at the QA committee meeting quarterly. 8/31/17. Audit results will be reported at the QAPI committee meeting monthly. 8/24/17.	

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{F 315}	Continued From page 57 Resident #3's urinary continence/incontinence once per shift (days, evenings, nights) under the heading "snacks/supplements." During an interview on 07/25/17 at 8:40 a.m. a licensed practical nurse (#6) stated the charting found under the heading "Snack/Supplement" was actually incontinence charting. He stated "they just chart it under supplements." This practice does not ensure accurate information is obtained for review of the residents' continence/incontinence. When interviewed, on 07/25/27 at 8:56 a.m., an administrative staff member (#25) and an administrative nurse (#42) confirmed staff should use the correct form (with incontinence as the heading) when charting the residents' continence status. - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 07/13/17, identified the resident is severely impaired in daily decision making, frequently incontinent, and required extensive assistance of two staff members for toileting. The current care plan stated, ". . . Self care deficit - Limited/extensive assistance required with ADLs R/T [related to] impaired balance, advanced age, and weakness . . . Extensive assist with . . . toileting . . ." Review of the July 2017 toileting/continence documentation showed Resident #4 frequently incontinent. The facility failed to assess Resident #4's urinary incontinence to determine the need for an individualized toileting plan.	{F 315}		

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{F 315}	Continued From page 58 - Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 06/01/17, identified the resident is cognitively intact, always incontinent, and required total assistance of one person for toileting. The current care plan stated, ". . . [Resident #5] requires extensive assist with adls . . . r/t weakness, arthritis, and impaired vision. . . . [Resident #5] requires limited assist of one staff for all adls. . . ." These two entries conflict with each other. The care plan also conflicts with the 06/01/17 MDS, which identified her as requiring "total assistance of one staff member for toileting." Review of the July 2017 toileting/continence documentation showed Resident #5 always incontinent. The facility failed to assess Resident #5's urinary incontinence to determine the need for an individualized toileting plan. Resident #5's ADL documentation also showed staff charted Resident #5's urinary continence/incontinence once per shift (days, evenings, nights) under the heading "snacks/supplements." - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 07/13/17, identified the resident is moderately impaired in daily decision making, always incontinent, and required total assistance of two persons for toileting. The current care plan stated, ". . . [Resident #6] is incontinent of bladder daily r/t use of Lasix [diuretic medication], and inability to toilet self. . . . Select clothing that is easily removed. [Resident #6] is toileted routinely in large bathroom . . . She wheels	{F 315}		

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{F 315}	Continued From page 59 herself to the bathroom after meals and at bedtime. She is checked and changed routinely at noc [night]. [Resident #6] uses briefs for incontinence at all times. . . ." Review of the July 2017 toileting continence documentation showed Resident #6 always incontinent. The facility failed to complete an assessment for Resident #6's urinary incontinence to determine the need for an individualized toileting plan. - On all days of survey a strong urine odor was noted in Resident #9's room. This odor was present out into the hallway. Review of Resident #9's medical record occurred on all days of survey. The quarterly MDS, dated 07/25/17, identified the as severely impaired in daily decision making, always incontinent and required total assistance of two or more staff members for toileting. The current care plan stated, ". . .[Resident #9] rely's [sic] on staff for all adls r/t severe TBI [Traumatic Brain Injury], dementia, and immobility. . . . Two staff members totally assist [Resident #9] with all transfers and toileting using a sit to stand lift . . ." The facility failed to assess Resident #9's urinary continence to determine the need for an individualized toileting plan. In addition, the care plan failed to address Resident #9's urinary incontinence, and implement interventions to enable the resident to remain as continent as possible. - Review of Resident #11's medical record occurred on all days of survey. The quarterly	{F 315}		

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{F 315}	Continued From page 60 MDS, dated 07/01/17, identified the resident is cognitively intact, occasionally incontinent, and requires extensive assistance of one person for toileting. The current care plan stated, ". . . Toileting - [Resident #11] requires limited assistance. . . . She may need assistance . . . changing her pull-up. . . . may be incontinent, staff are to provide hygiene after toileting to prevent skin breakdown. . . ." The care plan conflicts with the 07/01/17 MDS, which identified her as requiring "extensive assistance of one staff member for toileting." Review of the July 2017 toileting/continence documentation showed Resident #11 occasionally incontinent. The facility failed to assess Resident #11's urinary incontinence to determine the need for an individualized toileting plan. - Review of Resident #12's medical record occurred on all days of survey. The quarterly MDS, dated 07/20/17, identified the resident is severely impaired in daily decision making, frequently incontinent, and requires extensive assistance of two or more persons for toileting. The current care plan stated, ". . . [Resident #12] requires assist with adls . . . r/t Alzheimer's Disease. . . . assist with toileting . . . He wears pull ups under his underwear. . . . Check for incontinence routinely day and noc [night]. . . ." Resident #12's care plan failed to accurately reflect the number of staff and/or level of assistance he required for toileting. Review of the July 2017 toileting/continence documentation showed Resident #12 frequently incontinent. The facility failed to assess Resident	{F 315}		

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{F 315}	Continued From page 61 #12's urinary incontinence to determine the need for an individualized toileting plan. - Review of Resident #16's medical record occurred on all days of survey. The quarterly MDS, dated 06/15/17, identified the resident is moderately impaired in daily decision making, always incontinent, and required extensive assistance of one staff member for toileting. The current care plan stated, ". . . Toileting - [Resident #16] is totally dependent on the staff. . . . Monitor for incontinence. Change pads/briefs as needed. Provide hygiene after voiding/BMs [bowel movements] to prevent skin breakdown. Apply moisture barriers. . . ." Review of the July 2017 toileting/continence documentation showed Resident #16 frequently incontinent. The facility failed to assess Resident #16's urinary incontinence to determine the need for an individualized toileting plan. - Review of Resident #18's medical record occurred on all days of survey. A quarterly MDS, dated 05/04/17, identified the resident with severe cognitive impairment, occasionally incontinent of bladder, always continent of bowel, and requiring extensive assistance with toileting. The current care plan stated, ". . . requires extensive assist of one staff member for adls . . . Offer toileting routinely and per her request. . . ." Review of the July 2017 toileting/continence documentation showed Resident #18 incontinent on all days in July. Record review identified staff charted Resident #18's urinary continence/incontinence under the heading "snacks/supplements." The facility failed to	{F 315}		

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{F 315}	Continued From page 62	{F 315}		

assess Resident #18's incontinence to determine the need for an individualized toileting plan.

- Review of Resident #24's medical record occurred on all days of survey. The significant change MDS, dated 07/19/2017, identified the resident is severely impaired in daily decision making, frequently incontinent and required extensive assistance of two or more staff for toileting. The current care plan stated, ". . . Problem: Urinary Continence: [Resident #24] is frequently incontinent r/t use of Lasix and immobility. . . Interventions: Dress in clothing that is easily removed for toileting . . . Problem: [Resident #24] requires assist with adls r/t Osteoporosis, and Disc Degeneration. . . Interventions: . . . She doesn't always use her call light for assist. Monitor her and offer assist with toileting. [Resident #24] to toilet in big bathroom with sit-stand lift and assist of one person for safety . . ."

Review of the July 2017 toileting continence documentation showed Resident #24 frequently incontinent. The facility failed to assess Resident #24's urinary continence to determine the need for an individualized toileting plan.

- Review of Resident #27's medical record occurred on all days of survey. A quarterly MDS, dated 06/28/17, identified the resident with severe cognitive impairment, always continent of bladder, occasionally incontinent of bowel, and requiring extensive assistance with toileting.

Review of the July 2017 toileting/continence documentation showed Resident #27 incontinent on all days in July. The facility failed to assess

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{F 315}	Continued From page 63 Resident #27's incontinence to determine the need for an individualized toileting plan. - Review of Resident #34's medical record occurred on July 23-24, 2017. A quarterly MDS, dated 07/17/17, identified the resident with severe cognitive impairment, always incontinent of bladder, always continent of bowel, and requiring extensive assistance with toileting. The current care plan stated, "Incontinent of urine daily . . . Check for incontinence routinely throughout the day and change if wet/soiled. . . ." Review of the July 2017 toileting/continence documentation showed Resident #34 always incontinent of bladder. The facility failed assess Resident #34's incontinence to determine the need for an individualized toileting plan. - Review of Resident #38's medical record occurred on all days of survey. The quarterly MDS, dated 06/05/17, identified the resident is severely impaired in daily decision making, always continent and required extensive assistance of one person for toileting. The current care plan failed to address the resident required assistance with toileting. The care plan stated: ". . . Problem: At Risk For Falls R/T. . . Interventions: . . . Respond promptly to calls for assist to the toilet . . ." Record review identified Resident #38 experienced a fall on 06/09/17 and 06/13/17 while attempting to self transfer to the toilet. Review of the July 2017 toileting continence documentation showed Resident #38 usually continent. The facility failed to assess Resident #38's urinary continence to determine the need	{F 315}		

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{F 315}	Continued From page 64 for an individualized toileting plan to reduce her risks for falls when attempting to self-transfer to the toilet. - Review of Resident #43's medical record occurred on all days of survey. The quarterly MDS, dated 05/20/17, identified the resident is severely impaired in daily decision making, frequently incontinent and required extensive assistance of one person for toileting. The current care plan stated, ". . . Problem: Resident requires assist with adls due to impaired vision. . . Interventions: . . . Independent with toileting and ambulation. . . " (this conflicts with the MDS which identified Resident #43 needed extensive assistance of one staff for toileting. Review of the July 2017 toileting continence documentation showed Resident #43 frequently incontinent. The facility failed to assess Resident #43's urinary continence to determine the need for an individualized toileting plan. - Review of Resident #44's medical record occurred on all days of survey. The significant change MDS, dated 05/17/17, identified the resident had some difficulty with daily decision making in new situations, always incontinent, and requires extensive assistance of one person for toileting. The current care plan stated, ". . . [Resident #44] is frequently incontinent of bladder r/t CVA [cerebrovascular accident/stroke] . . . at risk for impaired skin integrety [sic] r/t . . . incontinence . . . requires assist with all adls r/t CVA . . . Dress in clothing that is easily removed for toileting. . . . [Resident #44] wears a brief to manage his incontinence. . . . requires two assist and sit to stand lift for all toileting in bathroom by	{F 315}		

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{F 315}	Continued From page 65 the nurses station. Offer toileting before meals, activities, bedtime, and prn [as needed]. . . . Check for incontinence routinely at noc [night] along with peri care and skin monitoring. . . ." The care plan conflicts with the 05/17/17 MDS, which identified him as "always incontinent" and requiring "one staff member for toileting." Resident #44's care plan also failed to accurately reflect the level of assistance he required for toileting. Review of the July 2017 toileting/continence documentation showed Resident #44 incontinent. The facility failed to assess Resident #44's urinary incontinence to determine the need for an individualized toileting plan. - Review of Resident #45's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/11/2017, identified the resident is cognitively intact, always continent and required extensive assistance of one staff for toileting. The current care plan stated: ". . . Problem: [Resident #45] dribbles urine daily possibly due to stress incontinence . . . Interventions: Check for incontinence; change if wet/soiled, Clean skin with mild soap and water. Apply moisture barrier . . . Problem: Resident requires extensive assist of one for adls r/t impaired balance, contracture, and fall risk . . . Interventions: . . . assist with toileting . . . Problem: [Resident #45] will self transfer to the restroom @ [at] times. . . Interventions: A voice/alarm for [Resident 45] wheelchair has been placed to alert [Resident 45] . . ." Record review identified Resident #45 experienced a fall on 07/22/17 while attempting to self transfer to the toilet.	{F 315}		

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{F 315}	Continued From page 66 Review of the July 2017 toileting continence documentation showed Resident #45 usually incontinent (This conflicts with the MDS which identified her as always continent). The facility failed to assess Resident #45's urinary continence to determine the need for an individualized toileting plan to reduce her incontinence and reduce her risks for falls when attempting to self-transfer to the toilet. - Review of Resident #49's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/07/2017, identified the resident is severely impaired in daily decision making, frequently incontinent and required limited assistance of one staff for toileting. The current care plan stated, ". . . Problem: [Resident #49] is frequently incontinent of urine r/t dementia . . . Interventions: . . . Check for incontinence; change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier. . . . Remind [Resident #49] to empty bladder before meals, at bedtime, and before activities . . . Dress in clothing that is easily removed for toileting." Review of the July 2017 toileting continence documentation showed Resident #49 occasionally incontinent. The facility failed to assess Resident #49's urinary continence to determine the need for an individualized toileting plan.	{F 315}		
{F 323} SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	{F 323}		9/11/17

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{F 323}	Continued From page 67 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. TRANSFERS/ADEQUATE SUPERVISION and ASSISTIVE DEVICES 1. Based on observation, record review, review of facility policy and procedure, review of manufacturer's guidelines, and staff interview, the facility failed to ensure each resident received	{F 323}	F323 Falls/Transfers 1. Resident #3, 6, 11, 12, 38, 44, 45 did not receive adequate supervision and assistive devices to prevent accidents. The above residents were assessed: Resident #3: Walker and assist of 1 Resident #6: W/C – Sit to Stand Resident #11: W/C – Walker and assist of 1 Resident #12: W/C – Sit to stand Resident #44: Deceased Resident #38: Walker and	

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{F 323}	Continued From page 68 adequate supervision and assistive devices to prevent accidents for 5 of 16 sampled residents (Resident #3, #6, #11, #12, #44) observed during transfers. Failure to ensure the appropriate amount of assistance and proper use of a sit-to-stand mechanical lift, walker, and wheelchair brakes, during transfers placed the residents at risk for falls. Findings include: - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/09/17, identified the resident has moderately impaired reasoning skills and requires extensive assistance of two or more persons for transfers and locomotion on/off the unit. The current care plan stated, ". . . At Risk For Falls R/T [related to] hx [history] of falls . . . [Resident #3] is independent with ambulation using a walker, which she keeps handy. She is independent with transfers. . . . [Resident #3] uses a FWW [front wheeled walker] to ambulate with to maintain [sic] balance. . . ." The care plan conflicts with the 07/09/17 MDS, which identified her as requiring "extensive assistance of two or more persons for transfers and locomotion." Observation on 07/22/17 at 6:15 p.m. showed a certified nursing assistant (CNA) (#38) provided toileting assistance, before transferring Resident #3 from the bathroom to her recliner using her front-wheeled walker. Resident #3 sat on the seat of the walker (facing the CNA), as the CNA (#38) pushed her (backwards) across the room. The CNA (#38) failed to transfer Resident #3 in a proper manner utilizing the front-wheeled walker.	{F 323}	assist of 1 Resident # 45: Walker and assist of 1. Care plans for the above residents have been revised to reflect assistance needed during toileting and with all transfers and ambulation. 2. All residents have the potential to be affected. 3. All residents will be assessed for adequate supervision and assistive devices to prevent accidents. Care plans for all other residents will be revised to reflect assistance needed. 9/3/17. Policy regarding transfers and adequate supervision will be updated. 9/3/17. Staff will be educated on lifts, walker use, gait belt use, swivel disc, and wheelchair brakes. 8/15/17, 8/22/17, and 8/29/17. 4. QA Manager/MDS Coordinator will check care plans after a fall, quarterly with MDS and with significant changes to determine if increased assistance is necessary. 10 staff members will be observed quarterly to determine if the care plan is being followed. Audit results will be reported to the QAPI committee monthly. 8/24/17. Audit results will be reported to the QA committee quarterly. 8/31/17 F323 CHEMICALS. 1. Chemicals were found on the cleaning carts unsecured. Chemicals were removed and secured.	

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{F 323}	Continued From page 69 - Review of the facility policy titled "Transfer Activities" occurred on 07/25/17. This policy, dated 05/12/09, stated, ". . . TRANSFER . . . TO WHEELCHAIR . . . Brakes on wheelchair should be locked. . . ." Review of Resident #11's medical record occurred on all days of survey. The quarterly MDS, dated 07/01/17, identified the resident is cognitively intact and requires extensive assistance of one person for transfers and locomotion on/off the unit. The current care plan stated, ". . . At Risk For Falls . . . Is able to self transfer. . . . Propells [sic] self in wheelchair throughout facility. . . . Staff are to use a gait belt when transfering [sic] [Resident #11] into a wheelchair . . ." The care plan conflicts with the 07/01/17 MDS, which identified her as requiring "extensive assistance of one staff member for transfers and locomotion." Observation on 07/24/17 at 8:15 a.m. showed a CNA (#37) provided Resident #11's toileting cares. The CNA (#37) assisted Resident #11 to stand-pivot from her wheelchair to the toilet, without locking the brakes on the wheelchair. The chair did roll backwards during the transfer. The CNA (#38) failed to transfer Resident #11 in a proper manner utilizing the brakes on her wheelchair. - Review of Operator's Instructions manual titled "EZ Way Smart Stand" occurred on 07/25/17. This manual, dated August 2009, stated ". . . The EZ Way Smart Stand was designed specifically for toileting and changing briefs of patients. The EZ Way Smart Stand can also be used for	{F 323}	2. All residents have the potential to be affected. 3. Cleaning carts were checked by Environmental Services to determine if locks are functional. Compliance noted. All areas that store chemicals were checked to assure that they were secure. Compliance noted. 7/26/17. Staff education was presented to housekeeping staff by manager. Policy regarding chemical storage was updated. 8/15/17. All chemicals that are not directly supervised will be locked at all times. 4. Random audits will be performed weekly x4, monthly x3, and quarterly x3 by Environmental Services or QA manager. 8/15/17. Audit results will be reported to the QAPI committee monthly. 8/24/17. Audit results will be reported to the QA committee quarterly. 8/31/17 F323 Bed Rails 1. All residents with ride rails will be assessed to determine if SRs are required for positioning or transfers, if there is a risk for elopement, and if dimensions are appropriate for resident size and weight. 08/14/2017 2. All residents with side rails will be identified to determine the above. 08/14/2017	

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{F 323}	Continued From page 70 transferring the patient from chair, wheelchair, toilet or bed, and can be used for ambulation. As patients do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding if the EZ Way Smart Stand is suitable for their needs. Patient should be able to bear some weight, have upper body strength and be able to follow simple commands. If patient does not meet each of these three criteria, an EZ Way total body lift must be used. . . . The EZ Way Smart Stand was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. . . ." During an interview on the morning of 07/25/17, a licensed nurse (#2) stated the facility lacked a sit-to-stand mechanical lift policy. - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated, ". . . [Resident #6] requires assist with adls [activities of daily living] r/t immobility, deformity in ankles, and Arthritis. . . . Two assist with transfers and toileting using sit to stand lift. . . ." The current "Care Sheet" (a guide CNAs use during their shift) identified Resident #6 required assistance of one staff member and no lift. Review of therapy's transfer status list showed Resident #6 required a sit-to-stand mechanical lift and assistance from one person for transfers. Observations during the survey showed the following:	{F 323}	3. Staff education at mandatory in-service. 08/29/2017 Staff that did not attend the mandatory in-service will need to sign policy acknowledging receipt and understanding by 09/03/2017 Prior to new SR, Physician orders will be obtained. All residents with side rails will have Physician orders obtained. 09/03/2017 A consent form will be obtained indicating the risks and benefits of side rails will be sent to Family/POA to sign. 09/03/2017 A copy of the unsigned consent will be kept in the resident□s chart as an indication that the consent was sent, until family/POA returns the signed copy. 09/03/2017 All residents with side rails will be care planned. 09/03/2017 4. Side rail assessment will be completed weekly x4, monthly x3, and quarterly x3 by MDS Coordinator. 09/03/2017	

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{F 323}	Continued From page 71 * 07/22/17 at 4:50 p.m., one CNA (#12) toileted Resident #6 utilizing a sit-to-stand mechanical lift. * 07/23/17 at 9:49 a.m., two CNAs (#43 and #37) toileted Resident #6 utilizing a sit-to-stand mechanical lift. * 07/23/17 at 12:58 p.m., one CNA (#12) transferred Resident #6 from her wheelchair to the toilet with a sit-to-stand mechanical lift. A second CNA (#4) provided assistance midway through the observation. Both CNAs (#43 and #12) transferred Resident #6 with a sit-to-stand mechanical lift from the toilet to the wheelchair. * 07/24/17 at 8:30 a.m., one CNA (#44) toileted Resident #6 utilizing a sit-to-stand mechanical lift. The failure to clarify Resident #6's transfer status resulted in CNAs determining how much assistance Resident #6 required and placed her at risk for falls. - Review of Resident #12's medical record occurred on all days of survey. The quarterly MDS, dated 07/20/17, identified the resident had severely impaired reasoning skills and requires extensive assistance of two or more persons for transfers and of one person for locomotion on/off the unit. The current care plan stated, ". . . [Resident #12] requires assist with adls . . . At Risk For Falls . . . r/t Alzheimer's Disease. . . . Uses sit to stand lift at this time with assist of two . . . other times 1 or 2 staff [with] gait belt . . ." The two entries on the care plan (stand lift and 1 or 2 staff with gait belt) conflict with each other. Observation on 07/24/17 showed the following: * At 8:45 a.m., a CNA (#41) transferred Resident #12 from his wheelchair to the toilet utilizing a sit-to-stand lift. The CNA (#41) failed to lock the	{F 323}		

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{F 323}	Continued From page 72	{F 323}		

brakes on Resident #12's wheelchair prior to applying the sling, attaching the sling to the lift, and raising him in the lift. Resident #12 was in a semi-seated position with the harness straps pulling upward into his axillae raising his shoulders. He remained in this position and moaned throughout the transfer.
* At 8:55 a.m., after providing Resident #12's toileting cares, the CNA (#41) transferred him from the toilet to his wheelchair utilizing the sit-to-stand lift. Resident #12 was in a seated position with the harness straps pulling upward into his axillae (armpits) raising his shoulders. He remained in this position and moaned throughout the transfer. The CNA (#41) failed to transfer Resident #12 in a proper manner utilizing the sit-to-stand lift.

- Review of Resident #44's medical record occurred on all days of survey. The significant change MDS, dated 05/17/17, identified the resident had difficulty reasoning in new situations, and requires extensive assistance of one person for transfers. The current care plan stated, ". . . At Risk For Falls R/T CVA [cerebrovascular accident] R [right] hemiparesis . . . Two staff extensively assist with toileting using the sit to stand lift. . . ."

Observations on 07/23/17 at 12:54 p.m. and 2:27 p.m. showed two CNAs (#37 and #41) transferred Resident #44 from his wheelchair to the toilet and back from the toilet to his wheelchair utilizing a sit-to-stand lift. Although Resident #44 was able to bear his weight during the transfer, his paralyzed right arm hung at his side, slightly swaying. The two CNAs (#37 and #41) failed to support Resident #44's arm during

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{F 323}	Continued From page 73 the transfer. SELF TRANSFERS/FALLS 2. Based on observation and record review, the facility failed to provide adequate supervision/assistance for 2 of 3 residents (Resident #38 and #45) identified as experiencing falls while attempting to self transfer to the toilet/bathroom. Findings include: - Observation of Resident #38 being assisted to the toilet occurred at 11:05 a.m. on 07/24/17. During this observation, the CNA (Certified Nursing Assistant) (#41) placed a gait belt on Resident #38 and assisted her to stand and ambulate with her walker to the bathroom. After the resident had finished voiding, the resident wiped herself and the CNA assisted her to stand, pulled up her pull-up and pants and assisted the resident to stand and ambulate to the sink to wash her hands. Review of Resident #38's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 06/05/2017, identified the resident is severely impaired in daily decision making, always continent and required extensive assistance of one staff for toileting. The current care plan failed to address the resident required assistance with toileting. The care plan stated: ". . . Problem: At Risk For Falls R/T. . . Interventions: . . . Respond promptly to calls for assist to the toilet . . ." Record review identified Resident #38 experienced a fall on 06/09/17 and 06/13/17 while attempting to self	{F 323}		

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{F 323}	Continued From page 74 transfer to the toilet. Review of Interdisciplinary Notes identified the following: * 06/09/17 - "(1130) Aide found resident on floor in her bathroom. C/O [complained of] hitting her head. Neuro [checks] initiated per facility policy. Neuro [checks] - WNL [Within Normal Limits]. ROM [Range of Motion] WNL. Resident c/o pain to right foot. Discoloration to top of foot by toes. Resident assisted up [with] gait belt [and two] staff . . . Resident stated, 'I was pulling my pants up [after] going to the bathroom [and] fell.' This nurse noted pants are too tight. (1150) Son, [name] notified of fall [and] the fact that pants were too tight. . ." * 06/12/2017 - "(1030) Resident sent to the clinic to see [physician]. Fx [fracture] to 2nd, 3rd, [and] 4th metatarsul (sic). Fx aligned. Resident N.O. [New Order] received [and] observed. NWB [Non Weight Bearing]. PT [Physical Therapy] to work [with] resident. Boot on except when in bed [and] in shower. W/C Wheelchair for at least 4 weeks. Son [name] took walker home [with] him." * 06/13/17 - "0410 T [Temperature] 97.9 P [Pulse] 80 R [Respiration] B/P [Blood Pressure 113/94 Pulse ox [oxygenation] 97% on room air found laying on the floor before her bed, stated that she took self to the bathroom and was going back to bed Denies hitting head did c/o [complained] of mild discomfort to left lower butt, ROM WNL for lower extremities Boot intact to left foot Has a 1.2 cm [centimeter] bruise below left arm, also has a 3 cm bruise to outer aspect of left upper arm ROM WNL to upper extremities denies pain or discomfort." * 06/13/17 - ". . . (1315) Res [Resident] transport via NH [Nursing Home] van to clinic appt.	{F 323}		

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{F 323}	Continued From page 75 [appointment]. [Son] will meet her there. (1515) Resident returned from clinic [with] new orders - Tylenol 650 mg [milligram] TID [three times a day] X [times] 2 weeks then PRN [as needed]. May apply heat or ice as needed . . ." * 06/13/17 - "2115 Boot intact to right foot . . . no c/o buttock pain, Re-educated to use call light when needing to get up or go to the bathroom." * 07/03/17 - "(0100) [Resident #38's] call light went off in her room. She managed to ambulate herself to Bathroom with a folding chair . . " * 07/06/17 - "1105 Res observed sitting on toilet after a self transferred. 1415: Res self transferred to toilet from w/c. 1600 Res self transferred from w/c to toilet . . . hearing impairment, mild cognitive impairment, memory loss, peripheral vision, left eye, unsteadiness and weakness in extremities. Res has been advised multiple [times] on the likely result of a self transfer. Res has been advice (sic) on the use and the importance of a call bell or call light. Res verbalized and demonstrated understanding but continues to self transfer [with] out asking or using her call light for help/assistance. MD notified. family aware." * 07/15/17 - "(0230) CNA discovered resident in bathroom resident removed straps from boot and apparently transferred herself to the bathroom. Resident only used call light from bathroom after she had already toileted self. Assisted resident back to bed, advised not to ambulate alone. Call light placed within reach and given verbal instruction on how to use , will continue to monitor." Even though Resident #38 had experienced falls with injury, had exhibited unsafe toileting practices, and could not be depended upon to	{F 323}		

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{F 323}	Continued From page 76 utilize the call light, staff failed to provide the necessary supervision and assistance to prevent future falls. - Observation on 07/24/17 at 9:00 a.m. showed staff were alerted to Resident #45's room by her chair alarm. She had already transferred herself from her w/c to the toilet. Review of Resident #45's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/11/17, identified the resident is cognitively intact, always continent, required extensive assistance of one staff for toileting and one fall with no injury and one fall with injury. The current care plan stated: ". . . Problem: Resident requires extensive assist of one for adls r/t impaired balance, contracture, and fall risk . . . Interventions: . . . assist with toileting . . . Problem: [Resident #45] will self transfer to the restroom @ [at] times. . . Interventions: A voice/alarm for [Resident #45] wheelchair has been placed to alert [Resident #45] . . ." An Accident/Incident Report, dated 07/22/17, at 2200 identified the following: "Fall, unobserved, one of the staff found her to be sitting on the floor beside her bed, resident stated that she was trying to go to the bathroom and transferred without assistance, without use of the call light button, [no] injuries, denies pain." Review of the July 2017 toileting continence documentation showed Resident #45 usually incontinent (This conflicts with the MDS which identified her as always continent). The facility failed to assess Resident #45's urinary	{F 323}		

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{F 323}	Continued From page 77 continence to determine the need for an individualized toileting plan to reduce her incontinence and reduce her risks for falls when attempting to self-transfer to the toilet. Even though Resident #45 had experienced falls with injury, had exhibited unsafe toileting practices, and could not be depended upon to utilize the call light, staff failed to provide the necessary supervision and assistance to prevent future falls. CHEMICAL STORAGE 3. Based on observation, review of facility policy, review of product labels, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 1 of 4 days of survey (07/23/17). This practice placed residents with dementia/wandering behaviors at risk of exposure to hazardous chemicals. Findings include: Review of the facility's policy titled "Chemical Storage" occurred on 07/25/17. The policy, undated, stated, "No resident shall have access to . . . chemicals of a hazardous nature. . . . Chemicals shall be stored in a locked or not readily accessible manner. . . . Housekeeping chemicals are keep [sic] in . . . lockable cleaning carts . . . Any chemicals found outside these locations need to be secured at once . . ." Observation on 07/23/17 showed the following: * At 8:33 a.m., a housekeeping staff member (#48) stepped into a resident's room and shut the door. The cleaning cart remained in the hallway,	{F 323}		

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{F 323}	Continued From page 78	{F 323}		

unattended for ten minutes. Four cleaning agents and a plastic pail containing a liquid solution sat on top of the cart, easily accessible to the residents. The cleaning agents included:
* Champion Instant Action Foaming Cleaner
* Champion Spray Disinfectant
* Insight Foaming Glass Cleaner
* Virex 11256

The housekeeping staff member (#48), during an interview after returning to her cart, reported the liquid solution in the plastic pail was "Virex and water."

* Between 9:13 a.m. and 9:35 a.m., the housekeeping staff member (#48) stepped into two resident rooms located down a second hallway. The cleaning cart remained in the hallway, unattended. The same four cleaning agents and the plastic pail containing Virex 11256 remained on top of the cart, easily accessible to the residents. Observation of an unidentified resident showed him walking past the unattended cart.

* At 9:50 a.m., the housekeeping staff member (#48) stepped into a third room located down a second hallway. The cleaning cart remained in the hallway, unattended. Five cleaning agents and the plastic pail containing Virex 11256 remained on top of the cart, easily accessible to the residents. The cleaning agents also included:
* Champion Instant Action Foaming Cleaner
* Champion Spray Disinfectant
* Crew Super Blue Mild Acid Bowl Cleaner
* Insight Foaming Glass Cleaner
* Virex 11256

The housekeeping staff member (#48), during an interview after returning to her cart, described the liquid solution in the plastic pail as "pretty potent." When asked how she mixed the solution, she

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{F 323}	Continued From page 79 stated, "[I mix] a half spout into a half gallon of water." When the surveyor read the directions on the product label (mix a half spout with a gallon of water), she stated "Oh-oh, I might be mixing it a little too strong." * At 10:20 a.m., the survey team notified two administrative staff members (#25 and #42) of the readily accessible chemicals on the cleaning cart. The product labels stated the following: * Virex 11256: ". . . Corrosive, causes irreversible eye damage and skin burns. . . . Harmful if swallowed, inhaled, or absorbed through the skin. . . ." * Crew Super Blue Mild Acid Bowl Cleaner: ". . . Causes burns, serious damage to the mouth, throat, and stomach. . . ." * Champion Spray Disinfectant: ". . . May cause eye irritation. . . ." * Champion Instant Action Foaming Cleaner: ". . . Keep out of the reach of children. . . ." * Insight Foaming Glass Cleaner: ". . . Keep out of the reach of children. . . ."	{F 323}		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,	F 325		9/11/17

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F 325	Continued From page 80 unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to adequately assess the nutritional status, needs, and risk factors, and implement appropriate interventions to restore/maintain sufficient nutritional status for 1 of 1 sampled residents (Resident #3) who experienced severe weight loss. Failure to meet Resident #3's nutritional needs through diet, supplements, or other interventions may have contributed to her severe weight loss. Findings include: Review of the facility policy titled, "Weight Assessment and Intervention" occurred on 07/25/17. This policy, dated 05/18/17, stated, ". . . Negative trends will be evaluated by the treatment team whether or not the criteria for 'signigicant' [sic] weight change has been met. . . . Care Planning for weight loss . . . will be a multidisciplinary effort . . . Individualized care plans shall address . . . the identified causes of weight loss . . . Goals and benchmarks for improvement, and . . . Time frames and parameters for monitoring and reassessment. . . ." Review of Resident #3's medical record occurred	F 325	F325 Maintain Nutrition 1. Resident # 3 will receive set up help and cueing or supervision during meals. 8/15/17. Resident # 3's weight will be monitored weekly at Resident Review Committee meeting indefinitely. Dietician saw resident on 8/23/17. 2. All residents have the potential to be affected. 3. All resident weights will be reviewed weekly at Resident Review Committee meeting indefinitely. If weight loss is noted, Dietary Manager will complete a form regarding weight loss and give it to the Charge Nurse. Charge Nurse will report on the weight loss to Physician. Dietary Manager will contact Dietician for interventions. Staff will be educated on process. 08/29/2017. Staff will be educated to observe all residents at meal times to determine if a resident may require cueing, supervision or assistance. If this is noted, staff will report to Nurse. Nurse will report to DON or QA manager so interventions can be put in place. Dietary staff will also be educated	

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F 325	Continued From page 81 on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/09/17, identified the resident is moderately impaired in daily decision making, requires set-up assistance and supervision during meals, has experienced weight loss of 5% or more in the last month or 10% or more in the last 6 months, and receives a mechanically altered diet. The current care plan stated, ". . . [Resident #3] has a need for adequate nutrition r/t [related to] CHF [congested heart failure], poor appetite, and unplanned weight loss. . . . Offer a regular diet . . . Offer a mech [mechanical] soft diet with honey thickened liquids. . . . Monitor weight, Determine food likes and dislikes. Offer snacks betweeen [sic] meals. Supplement of choice 4 ozs [ounces] TID [three times daily]. . . . Assist with meals if needed. . . . 07/14/17 High calorie [and] high protein diet. . . ." The two entries regarding the residents current diet conflict with each other. The current physician's orders identified, ". . . Diet: Mechanical Soft. . . ." The physician's orders lacked orders for a "honey-thickened liquids" as care-planned. The dietary progress notes identified the following: * 01/05/17, "She eats per self in [sic] dining area or in her room. She is offered a regular diet. Her meal intake is fair to good. Wt [weight] 163.4. Will continue with present diet and monitoring weight. . . ." * 03/27/17, ". . . Weight is down = 12# [pounds]/2 months. In that time she has had [sic] back fracture with significant pain. She was in Bismarck for a procedure on 3/21. She has CHF and is treated w [with]/diuretics. Her baseline	F 325	regarding the above. 4. Weights will be audited weekly by QA manager, Dietary manager, and Resident Review team. 8/2/17. Audit results will be reported to the QAPI committee monthly. 8/24/17. Audit results will be reported to the QA committee quarterly. 8/31/17	

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weight is 158# ([increase] dose of diuretic if 4# over). Some of weight loss is intended (Her weight was the same . . . 150.6# 3/2016) Appetite has been down; may be r/t pain, side effects of pain medications. Nutrition supplements [sic]ordered TID. Recommend [sic] encourage, monitor acceptance, and adjust flavors/types if she doesn't accept well. . . ."

The physician's progress note, dated 05/13/17, identified, ". . . The patient is stable. Congestive heart failure at least clinically is okay. Her lungs are clear today. . . . She has no edema. . . ."

The dietary progress notes identified the following:
* 05/27/17, ". . . Weight is [down] 10#/2 months. She's been on [sic] antibiotic for bronchitis [and] has had episodes of nausea [and] emesis in past few weeks. 2+ [plus] edema documented [sic] 05/01/17 so likely [decreased] oral intake. Diet is regular per order. Nutrition supplements [sic] ordered TID between meals. Continue to monitor weight [and] intake. . . . Weight 1/17 was 163#. Some loss desireable [sic] diuresis; but need to monitor closely if continued loss d/t [due to] inadequate intake. . . ."
* [date unknown] [sic], "She eats per self in her room. Is offered a regular diet. Her meal intake is fair to poor. She refuses to eat a few meals at times. Wt 139.4. She continues to have slow weight loss. Hopefully her weight will stabilize. Will continue with present diet and monitoring weight. . . ."

The interdisciplinary notes, dated June 21-July 07, 2017, identified Resident #3 was hospitalized post fall for back pain, was readmitted with cough

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and some edema, requested to eat in her room, and refused an occasional meal. The notes also indicated Resident #3 required staff assistance to set-up her meal trays, consumed her meals when encouraged to do so, and consumed supplements on two occasions. The medical record failed to show staff identified Resident #3's weight loss trends, evaluated the interventions they had in place, and/or initiated any new interventions.

The dietary progress note, dated 07/13/17, identified, ". . . Weight [down] 40#/6 mo [months]. Severe loss. . . . She eats in her recliner in her room. Staff set-up meals. She states she's feeling better [and] eating better, but has no appetite and no energy. She did eat most of her meal today. . . . Calculated maintenance needs 1400-1600 [calories], 45-56 g [grams] protein, 1600 cc [cubic centimeter] fluids daily . . . Good nutrition important for . . . maintenance. Resident declined supplements or snacks - "ruins meals." Recommend DM [dietary manager] meet w [with]/her at least weekly to discuss food preferences [and] monitor intake [and] weights. . . ."

During an interview on 07/25/17 at 9:15 a.m., when asked if staff were monitoring Resident #3's weight and if they had notified her physician regarding her severe/continued weight loss, a dietary supervisor (#10) reported weights could be found in "the [progress] notes or ADL [activity of daily living] book." She also indicated nursing staff would notify Resident #3's physician regarding her continued weight loss. When asked questions pertaining to Resident #3's dietary interventions, the dietary supervisor (#10)

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reported she had recently met with Resident #3 to determine her likes/dislikes, but had not documented in the resident's medical record that she had done so. When asked if the facility had offered Resident #3 a variety of supplements to try, the dietary supervisor (#10) stated, "No, we haven't. She's been accepting our house supplement." This contradicted the dietitian's 07/13/17 progress note, which indicated Resident #3 "declined supplements." She (#10) also indicated the dietary department "just started [offering Resident #3] high calorie/high protein foods."

The interdisciplinary note, dated 07/16/17, identified, ". . . 4# weight loss noted from 07/01/17 until 07/16/17. [Physician] notified by fax. Dietitian just here. Weight 129# on 07/01/17. Current weights on 07/16/17 125.4#. . . ." The record identified this was the first/only attempt facility staff made to contact Resident #3's physician regarding her severe/continued weight loss.

Observation on 07/22/17 at 5:55 p.m. and 07/23/17 at 8:00 a.m., showed Resident #3 seated in her recliner in her room, feeding herself following tray set-up. Staff failed to supervise Resident #3's meals and assist as needed.

During an interview on 07/25/17 at 9:20 a.m., when asked if/how the facility contacted Resident #3's physician regarding her continued weight loss, a managerial nurse (#2) stated, "We use a physician's communication form to update the doctor." After she was unable to locate any physician's communication forms in Resident #3's medical record, the managerial nurse (#2)

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F 325	Continued From page 85 added, "[The doctor] takes them [forms] with him and uses them to do his dictation." The medical record failed to show Resident #3's physician received and/or responded to any communication attempts by staff regarding her continued weight loss. Facility staff failed to: * Identify/evaluate Resident #3's weight loss trends. * Care plan the causes of Resident #3's weight loss, the goals/benchmarks for improvement, and time frames/parameters for monitoring and reassessing her weight loss. * Care plan Resident #3's current diet as ordered by her physician. * Determine Resident #3's likes/dislikes. * Offer Resident #3 a variety of supplements, monitoring her acceptance and adjusting the flavors/types according to her likes/dislikes. * Supervise Resident #3 during meals. * Notify Resident #3's physician regarding her lack of appetite/energy and severe, and continued, weight loss - prior to her losing 40 pounds in 6 months.	F 325		
{F 431} SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	{F 431}		9/11/17

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{F 431}	Continued From page 86 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	{F 431}		

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{F 431}	Continued From page 87 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner on 2 of 4 days of survey (July 22 and 24, 2017). Failure to store all medications securely may result in unauthorized access to medications. Findings include: The facility policy titled "STORAGE OF MEDICATIONS" occurred on 07/25/17. This policy, dated 09/01/07, stated, ". . . 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. . . ." The facility's plan of correction for F431 stated, ". . . All nursing staff that handle medication administration were educated on 07/05/17 regarding proper medication management storage of residents' medications. . . . " - During tour on 07/22/17 at 2:40 p.m., observation of Resident #3's room showed two tubes of "zinc oxide formula" laid on her	{F 431}	1. Medications were found in Resident #3 and #6 room. The above residents were not approved to self-administer medications. Resident #6 had a medication in their room with another residents name on it. These medications were removed from the room. 08/14/2017 2. All resident rooms were checked for medications. Medications that were found in any resident room that were not approved to self-administer were removed from the room. 08/14/2017 3. Staff education at mandatory meeting. Any staff members that did not attend, will read policy and sign acknowledging receipt and understanding of policy. 08/29/2017 and 09/04/2017. Staff will be educated to report to the nurse on duty if a medication is found in a resident's room so a self administration of medication assessment can be performed. The resident review team will also be involved to determine if the resident is safely able to self administer medications. If deemed so, a Physician's order will also be obtained. A letter will be sent to all families/POA requesting that if they bring a medication in for the resident, they will need to report to the Nurse on duty. Family will be informed that we will need a Physician's order and an assessment completed prior to the resident self	

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{F 431}	Continued From page 88 bathroom floor. - During an observation on 07/24/17 at 8:40 a.m., Resident #6 opened the bottom drawer of her nightstand and reached in to the back of the drawer and pulled out a tube of hemorrhoidal ointment. The pharmacy label showed a different resident's name (Resident #52) on it. Resident #6 could not recall the last time facility staff applied hemorrhoidal ointment. During an interview on 07/24/17 at 10:15 a.m., a licensed nurse (#22) stated staff kept all ointments in the medication room. Observation of the medication room showed both Resident #6 and #52 prescribed the same hemorrhoidal ointment.	{F 431}	administering medications. 4. Random audits will be performed quarterly x3 by QA/Designee, to ensure that only those residents approved to self-administer medications have medications in their rooms. Audits will be done weekly x4, monthly x3, and quarterly x3 to determine if a Physicians order has been obtained and an assessment has been completed. Results will be reported at the quarterly QA meeting.8/31/17	
{F 441} SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	{F 441}		9/11/17

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{F 441}	Continued From page 89 limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	{F 441}		

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{F 441}	Continued From page 90 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. HAND HYGIENE 1. Based on observation, record review, review of facility policy, and review of professional reference, facility staff failed to follow standard infection control practices for 4 of 16 residents (Resident #5, #6, #11, and #28) observed during personal cares. Failure to follow infection control practices while providing toileting/perineal cares has the potential to cause/spread infection to residents, visitors, and staff. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education Inc., New Jersey, page 620, stated, ". . . Gloves . . . The hands are cleansed each time gloves are removed for two primary reasons: (1) The gloves may have imperfections or be damaged during wearing so that they could allow microorganism entry and (2) the hands may become	{F 441}	F441 Isolation 1. Staff were unaware of the isolation status of resident #27. Resident was removed from isolation 07-23-2017. 2. All residents have the potential to be affected. No residents on isolation precautions at this time. 08/16/2017 3. Staff education on isolation policies will be provided 08/29/2017. Any staff member that does not attend the mandatory meeting will need to read the policy and acknowledge receipt and understanding by 09/03/2017. When a resident develops an infection that requires isolation, signage will be placed on the resident door. PPE for staff will be located outside of the room. Documentation in Residents record and on 24hr report form. 08/11/2017 4. Random audits will be performed weekly x4, monthly x3, and quarterly x3 to determine if the resident was placed on isolation appropriately, signage and PPE	

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{F 441}	Continued From page 91 contaminated during glove removal. . . ." Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 07/25/17. This policy, revised 09/09/15, stated, ". . . handwashing with antimicrobial or non-antimicrobial soap and water must be performed under the following conditions . . . After removing gloves . . . The use of gloves does not replace handwashing. . . . If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations . . . After contact with resident's intact skin . . . After removing gloves. . . ." Observations identified the following: * 07/22/17 at 2:55 p.m., A certified nursing assistant (CNA) (#38) toileted Resident #28, who was incontinent of urine and continent of bowel. The CNA (#38) removed Resident #28's shoes, soiled pants, and soiled brief, and then removed her gloves. Without performing hand hygiene, the CNA (#38) donned gloves and applied Resident #28's fresh brief and clean pants. The CNA (#38) failed to perform hand hygiene after removing her gloves and before applying a fresh brief/clean clothing. * 07/23/17 at 12:20 p.m., two CNAs (#12 and #44) toileted Resident #11, who was incontinent of urine and continent of bowel. One of the CNAs (#12) cleansed the resident's peri area and removed her gloves. Without performing hand hygiene, she donned new gloves, cleansed the resident's buttocks, removed those gloves, adjusted the resident's clothing, and assisted her to stand-pivot into her wheelchair. The CNA (#12) failed to perform hand hygiene after removing either set of gloves.	{F 441}	were put in place, and also that staff were notified. 08/11/2017 F441 Hand Hygiene 1. Staff will perform appropriate hand hygiene during resident cares. Observation of hand hygiene during cares completed for the above residents. Compliance noted. 08/14/2017 2. All residents have the potential to be affected. 3. Staff education will be provided on 8/29/17. Staff will be educated on proper hand hygiene which includes washing hands after glove removal per policy. Policy updated 08/16/2017 4. Random audits will be performed weekly x4, monthly x3, and quarterly x3 by QA manager/Designee. Audit results will be reported to the QAPI committee monthly. 8/24/17. Audit results will be reported to the QA committee quarterly. 8/31/17	

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{F 441}	Continued From page 92 * 07/23/17 at 12:58 p.m., two CNAs (#4 and #6) toileted Resident #6, who was incontinent of urine and continent of bowel. One CNA (#4) performed perineal cares and removed his gloves. Without performing hand hygiene, the CNA (#4) donned a new pair of gloves, and applied barrier ointment to Resident #6's buttocks. The CNA (#4) failed to perform hand hygiene after removing his gloves and prior to donning a new pair of gloves to apply a barrier ointment. * 07/23/17 at 1:00 p.m., two unidentified CNAs provided pericares in bed on Resident #5, who was incontinent of urine and continent of bowel. One of the CNAs cleansed Resident #5's rectal area, dipped her fingers into the container of barrier ointment, applied barrier ointment to rectal area, and removed her gloves. Without performing hand hygiene, the CNA donned a new pair of gloves, cleansed Resident #5's frontal peri area, adjusted the resident's clothing, and removed her gloves. Without performing hand hygiene, placed a pillow between her knees, covered her with a blanket, raised the head of her bed, raised the side rail, placed the call light within her reach, and exited the room. The CNA failed to remove her contaminated gloves prior to dipping her fingers into the container of ointment, failed to perform hand hygiene after removing her gloves and prior to cleansing Resident #5's frontal peri area/adjusting her clothing, and failed to perform hand hygiene after removing her gloves and continuing other cares and exiting the resident's room. * 07/24/17 at 9:30 a.m., a nurse (#46) and a CNA (#41) toileted Resident #5, who was incontinent of urine and continent of bowel. The CNA (#41) preformed frontal pericare, cleansed the rectal	{F 441}		

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{F 441}	Continued From page 93	{F 441}		

area, applied barrier ointment, and removed her gloves. Without performing hand hygiene, the CNA (#41) donned gloves, adjusted Resident 5's clothing, transferred Resident #5 into her wheelchair utilizing a Hoyer lift, removed their gloves, and exited the resident's room. The CNA (#41) failed to perform hand hygiene after removing her gloves, before adjusting the resident's clothing, and prior to transferring her into her wheelchair. Both the nurse (#46) and CNA (#41) failed to perform hand hygiene prior to exiting the resident's room.

ISOLATION PRECAUTIONS

2. Based on observation, review of facility procedure, and staff interviews, the facility failed to implement appropriate infection control practices for 1 of 1 sampled resident (Resident #27) observed with isolation precautions. Failure to accurately determine the source of the infection resulted in staff inappropriately implementing contact precautions for Resident #27.

Findings include:

Review of facility policy "Isolation Precautions" occurred on 07/25/17. This procedure, dated 07/05/17, stated, ". . . It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. . . .The isolation will be the least restrictive possible for the resident under the circumstances. a. Decisions regarding isolation will be individualized to the resident and the organism/condition. . . ."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 94 Observation on 07/22/17 at 2:50 p.m. showed an isolation cart outside Resident #27's room and a sign on the resident's door which stated, "Contact Isolation." During an interview on 07/22/17 at 3:54 p.m. a registered nurse (#47) stated Resident #27 is in contact precautions for a urinary tract infection caused by E. coli (Escherichia coli [bacteria found in the bowel]). Observation on the afternoon of 07/22/17 showed a sticker on the front of Resident #27's chart stating "VRE [vancomycin resistant enterococcus] UTI [urinary tract infection]" The resident's medical record, reviewed on all days of survey, failed to identify Resident #27 had a UTI. The record lacked evidence of a urine culture, but identified a blood culture drawn on 06/29/17. The final report, dated 07/06/17, identified "Enterococcus faecalis [bacteria found in the bowel]." An interview with an administrative nurse (#42) occurred on 07/23/17 at 4:45 p.m. The nurse confirmed Resident #47 did not have a UTI, but had sepsis (an infection in the blood stream) and stated staff would discontinue the contact isolation (not required for sepsis).	{F 441}		
{F 497} SS=E	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	{F 497}		9/11/17

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	355042	A. BUILDING _____ B. WING _____	R-C 07/25/2017

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{F 497}	Continued From page 95 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on review of facility staff employment records and staff interview, the facility failed to complete annual performance reviews for 2 of 16 certified nursing assistants (CNA) (#36 and #39) and failed to provide in-service education based on the outcome of the reviews for 3 of 16 CNA (#31, #34, and #35) records reviewed. Failure to ensure CNA staff receive annual competency training regarding the facility's policies and procedures, new and expanding programs, techniques, equipment, and concepts of quality care placed all residents at risk for neglect, harm and/or injury. Findings include: The facility's plan of correction for F497 stated, ". . . CNAs #3, #4, #5, #12, #26, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, and #41 had annual performance reviews completed with in-service training . . . Employee performance evaluations were completed and housed in the HR [Human Resources] department at the hospital . . . completion date 07/21/17. . . . " Review of CNA employment records occurred on 07/25/17. The facility failed to provide annual performance reviews for two CNAs (#36 and	{F 497}	1. Annual performance review were not completed for CNA #36 & 39. #36 completed by 09/03/2017 CNA #39 is no longer employed. For competency training was not completed for CNA #31, #34, #35 CNA #31 completed on 08/01/2017 CNA #34 no longer employed CNA #35 completed on 08/15/2017 2. This has the potential to affect all CNA□s. 3. Annual performance reviews for Certified Nursing Assistants will be completed by DON/Designee. 4. Audits will be performed by the DON/Designee quarterly to check compliance. Audit results will be reported to the QA committee quarterly. 8/31/17. Audit results will be reported to the monthly QAPI committee. 8/24/17	

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{F 497}	Continued From page 96 #39). During an interview on the afternoon of 07/24/17, the managerial nurse (#2) confirmed the facility failed to ensure three CNAs (#31, #34, and #35) received annual competency training.	{F 497}		
{F 498} SS=F	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT.	{F 498}	1. Certified Nurse Assistants # 3, 4, 5, 12, 26, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, & 41; did not completed training that included : resident rights, advanced	9/11/17

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{F 498}	Continued From page 97 Refer to 06/07/17 CMS-2567. Based on review of the staff education calendar outlining future inservices, the facility failed to ensure each certified nursing assistant (CNA) for 16 of 16 CNAs (#3, #4, #5, #12, #26, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, and #41) completed the inservice training provided between July 2016-June 2017. Failure to ensure each CNA received/reviewed the inservice materials addressing resident rights, advanced directives, dementia, communication, nutrition, and emergency situations (Code Black, Code Blue, and Code Red), placed all residents at risk for neglect, harm, and/or injury. Findings include: On the afternoon of 07/24/17, a managerial nurse (#2) provided the staff education calendar that identified future inservice topics/presenters tentatively scheduled between 07/18/17-12/26/17. The managerial nurse (#2) confirmed the facility failed to ensure each CNA received/reviewed the July 2016-June 2017 inservice materials addressing resident rights, advanced directives, dementia, communication, nutrition, and emergency situations (Code Black, Code Blue, and Code Red).	{F 498}	directives, dementia, communication, nutrition, and emergency situations. #3 □ no longer employed #4 □ no longer employed #5 □ completed training #12 □ completed training #26 - completed training #31 - completed training #32 - completed training #33 - completed training #34 □ no longer employed #35 □ complete by 09/03/2017 #36 □ complete by 09/03/2017 #37 - completed training #38 - completed training #39 □ no longer working at LTC #40 no longer employed #41 - Completed Training 2. All Certified Nursing Assistants have the potential to be affected. 3. 12 hours of in-service training will be provided to all CNA□s each year. A roster of each CNA that attends each in-service will be kept. If a CNA does not attend the in-service provided, minutes of the in-service and education provided will be available. Those CNAs that did not attend will need to read and sign off understanding of the materials. QA manager will be responsible for arranging in-services that are pertinent to LTC. QA manager will update staff in-service roster after each in-service to assure that all required staff member have received the education.	

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{F 498}	Continued From page 98	{F 498}	4. QA manager will update staff in-service roster after each in-service to assure that all required staff members have received the education. QA manager will perform an audit quarterly. Audit results will be reported to the QA committee quarterly. 8/24/17 Audit results will be reported at the monthly QAPI meetings. 8/24/17	
{F 514} SS=F	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	{F 514}		9/11/17

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{F 514}	Continued From page 99 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a complete and readily accessible medical record for 22 of 33 records reviewed (Resident #2, #3, #4, #5, #6, #9, #11, #15, #16, #17, #18, #24, #25, #27, #32, #33, #34, #35, #38, #43, #45, and #49) during the onsite revisit. Failure to have a complete and readily accessible medical record limited staff's access to the most recent medical information regarding the residents. Findings include: - Review of the facility's fall tracking form occurred on 07/23/17 and identified Resident #34 experienced a fall in the facility van on 06/22/17. An Accident/Incident Report, dated 06/22/17, identified on 06/22/17 at 9:30 a.m. the resident "slipped out of wheelchair onto floor of van." During an interview on 07/24/17 at 8:00 a.m. a staff member present during the incident stated the fall occurred when staff transported the resident to an appointment in Bismarck. The resident's medical record identified Resident #34 left the facility at 6:00 a.m. on 06/22/17 and returned at 3:30 p.m. The record lacked documentation regarding the fall and failed to	{F 514}	1. Resident Records were not complete and accessible for the following residents: #2, 3, 4, 5, 6, 9, 11, 15, 16, 17, 18, 24, 25, 27, 32, 33, 34, 35, 38, 43, 45, and 49. A late entry progress note was added to resident # 34□s record on the 6/22/17 fall. Resident # 2□s MDS was placed in the right file. All 27 residents most recent MDSs were filed in their files. The MDS notes were filed in all resident□s records. The forms for continence/incontinence were reviewed and updated. 2. All Residents have the potential to be affected. 3. Each Resident record will be complete and readily accessible and be systematically organized. The records will include information to identify the resident, record of assessments, care plan, results of preadmission screening, physician, nurses, and other licensed professionals progress notes, lab, radiology, and other diagnostic service reports. 09/03/2017. Education will be provided to staff regarding resident	

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{F 514}	Continued From page 100 identify if the resident sustained an injury during the fall. - Observation of the Minimum Data Set (MDS) filing cabinet (where staff maintain residents' MDSs) on the morning of 07/23/17 showed three of Resident #2's MDSs in another resident's MDS folder. The MDS folder failed to include the most recent MDSs completed for 27 residents. The MDS Coordinator (#6) provided all 27 MDSs when asked. During an interview on 07/24/17 at 9:40 a.m., the MDS Coordinator (#1) stated the facility lacks a Health Information Management (HIM) staff member who would be responsible for filing the assessments. Facility staff failed to ensure readily accessible and systematically organized MDSs. - Record review occurred on all days of survey. Resident #2, #3, #4, #5, #6, #9, #11, #15, #16, #17, #18, #24, #25, #27, #32, #33, #34, #35, #38, #43, #45, and #49's medical records lacked physicians' progress notes. During an interview on 07/24/17 at 4:50 p.m., an administrative staff member (#3) stated the facility found a large pile of physician progress notes that staff had not filed. Facility staff failed file the following physicians' progress notes in the residents' medical records: * Resident #2: 05/13/17 (last note filed 02/28/17) * Resident #3: 04/27/17 and 05/13/17 (last note filed 03/31/17) * Resident #4: 04/07/17, 05/05/17, 05/18/17, and 06/13/17 (last note filed 02/28/17)	{F 514}	records and documentation on 8/31/17. HIM was hired. 8/21/17. All resident records will be reviewed for compliance by HIM. 9/3/17 4. HIM will audit 10 resident records monthly indefinitely to determine compliance. HIM will audit the resident□s record for completion which will include: assessments, care plan, results of preadmission screening, physician, nurses, and other licensed professionals progress notes, lab, radiology, MDS, and other diagnostic service reports. Audit results will be reported to the QA committee quarterly. 8/31/17. Audit results will be reported to the QAPI committee monthly. 8/24/17.	

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{F 514}	Continued From page 101 * Resident #6: 04/26/17 and 06/15/17 (last note filed 02/22/17) * Resident #9: 05/25/17 (last note filed 03/12/17) * Resident #11: 03/3017 and 06/12/17 (last note filed 03/03/17) * Resident #15: 04/04/17, 04/05/17, and 05/31/17 (last note filed 03/12/17) * Resident #16: 05/18/17 (last note filed 03/13/17) * Resident #17: 05/02/17 and 05/13/17 (last note filed 01/27/17) * Resident #18: 04/30/17 (last note filed 04/06/17) * Resident #24: 04/26/17 * Resident #25: 03/30/17 and 05/13/17 (last note filed 03/16/17) * Resident #27: last note filed 02/10/17 * Resident #32: 05/12/17 (last note filed 02/08/17) * Resident #33: 04/22/17 and 06/13/17 (Last note filed 02/19/17) * Resident #34: 04/26/17 (last note filed 02/22/17) * Resident #35: 05/14/17, 06/13/17 (last note filed 04/13/17) * Resident #38: 04/23/17, 05/19/17 and 06/27/17 (last note filed 02/18/17) * Resident #43: 04/23/17, 06/02/17, and 06/27/17 (last note filed 02/18/17) * Resident #45: 03/30/17 and 05/13/17 (last note filed 01/27/17) * Resident #49: 04/10/17 and 05/12/17 (last note filed 02/10/17) Facility staff failed to ensure readily accessible and systematically organized physician's progress notes. The lack of physician's progress notes in the medical record limits staff's ability to	{F 514}		

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{F 514}	Continued From page 102 ensure timely physician visits. - Record review occurred on all days of survey. Documentation for Resident #3, #5, #18, and #38 showed staff charted the residents' urinary continence/incontinence under the heading "snacks/supplements." During an interview on 07/25/17 at 8:40 a.m. a licensed practical nurse (#6) stated the charting found under the heading "Snack/Supplement" is actually incontinence charting. He stated "they just chart it under supplements." This practice does not ensure accurate information for staff to review the residents' continence/incontinence. When interviewed, on 07/25/27 at 8:56 a.m., an administrative staff member (#25) and an administrative nurse (#42) confirmed staff should use the correct form (with incontinence as the heading) when charting the residents' continence status.	{F 514}		
{F 520} SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	{F 520}		9/11/17

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{F 520}	Continued From page 103 administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 07/25/17, EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 06/07/17 CMS-2567. Based on record review and staff interview, the facility failed to complete Quality Assurance (QA) monitoring as identified the the Plan of Correction, and failed to develop and implement	{F 520}	1. QA monitoring will be completed for all citations. 2. All residents have the potential to be affected by incomplete QA. 3. Staff education will be provided for incomplete studies. 08/29/2017 4.Audits will be completed per schedule.	

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{F 520}	Continued From page 104 appropriate plans of action to correct deficient practice and ensure compliance with federal requirements for 20 of 36 defieciencies cited during the 06/07/17 complaint survey. Findings include: Review of the facility's QA monitoring for deficiencies cited during the 06/07/17 complaint survey occurred on 07/23/17 with a QA staff member (#2). The review identified staff failed to perform monitoring for the following citations: L1200: Staff education F250: Social Services F280: Care planning F284: Discharge planning F323: Accidents F353: Nursing staffing F431: Drug storage F441: Infection Control F490: Administration F497: Performance reviews F498: Nurse Aide competency F514: Accuracy of medical record The review also identified staff performed incomplete studies for the following citations: F157: Physician notification F164: Privacy F176: Self-administration of medication F241: Dignity F246: Accommodation of needs F281: Professional standards F312: Assistance with Activities of Daily Living F315: Incontinence/toileting The facility's Plan of Correction (POC) stated: "A monthly QAPI [Quality Assurance Performance	{F 520}	Audit results will be reported to the QA committee quarterly 8/31/17. Audits results will be reported to the QAPI committee monthly. 8/24/17	

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{F 520}	Continued From page 105 Improvement] meeting has been started on 07/13/17." When requested, the facility provided no evidence of a QAPI meeting on 07/13/17. During the review the staff member (#2) confirmed staff performed no QA monitoring or incomplete monitoring for the above listed citations. The staff member also confirmed the facility did not have a QA meeting on 07/13/17, as stated in the POC.	{F 520}		