STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on September 29, 2014 and completed on October 2, 2014, the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 2 of 17 sampled residents (Resident #1 and #13) in a manner and environment that maintained or enhanced each resident's dignity. Failure to ensure dignity during meals (Resident #1) and privacy during toileting cares (Resident #13) does not promote resident dignity or enhance quality of life. Findings include: Review of the facility policy titled "Resident Services Dignity Philosophy" occurred on 10/02/14. This policy, dated September 2013, stated, ". . . services are flexible to fit the needs of each individual . . . by instilling in all Resident Services personnel a desire to give considerate, respectful, and compassionate care, always	F 241	**F 241 Dignity and Respect of Individuality** 1. For resident #1, staff has been educated to wipe a resident's face or mouth from food spillage and to allow the resident ample time to eat and chew food and/or drink liquids. For the issue regarding resident #13, staff has been educated to gather supplies beforehand and assure all doors are closed when cares are being provided. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/2014 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents who require assistance with eating or drinking and/or are dependent upon staff for cares have the potential to be affected.	11-14-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia N. Buechler	President / CEO	11/3/14

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

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F 241	Continued From page 1 maintaining the highest regard for each resident's individuality, privacy, dignity, and ability to function at his/her highest physical and psychosocial levels. . . ." Review of the facility policy titled "Assisting the Resident to eat" occurred on 10/02/14. This policy, revised November 2013, stated, ". . . Use a napkin . . . to wipe a resident's face or mouth of food spillage. . . . Allow the resident plenty of time to eat and chew foods. Provide small bites and sips of liquids. . . . Ensure the resident's mouth and hands are clean after completing the meal. . . ." - Observations showed the following: * On 09/30/14 at 10:20 a.m., a CNA (#11) gave Resident #1 a glass of water as she lay in bed. Drool ran down the left side of Resident #1's face and neck. The CNA failed to wipe the drool from Resident #1's face/neck. * On 09/30/14 at 12:45 p.m., a CNA (#20) assisted Resident #1 during the noon meal. The CNA (#20) held a heaping spoonful of food three inches from Resident #1's mouth and repetitively prompted her to take another bite of food, as Resident #1 continued to chew the previous bite of food in her mouth. Resident #1 drooled, coughed twice, and began to hiccup. The CNA (#20) failed to allow the resident adequate time to eat and chew her food before holding the spoon to her mouth and failed to wipe the drool from Resident #1's face. * On 10/01/14 at 9:10 a.m., a CNA (#21) assisted Resident #1 during the breakfast meal. The CNA (#21) held a spoonful of food three inches from Resident #1's mouth and repetitively prompted her to take another bite of food, as Resident #1 continued to chew the previous bite of food in her	F 241	3. All staff have been educated at nursing meetings, C.N.A. meetings, and will be educated at All Staff Meeting on Nov. 6, 2014. 4. A QA tool has been developed and will be completed by assigned nurse manager or staff RN/LPN weekly x 1 month, monthly x 3 months and quarterly thereafter. The Quality Assurance / Performance Improvement Manager (QAPI Manager) will review the findings and report to the Quality Assurance and Performance Improvement Committee (QAPI Committee) for review and potential further action.	

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F 241	Continued From page 2 mouth. Resident #1 drooled. The CNA (#20) failed to allow the resident adequate time to eat and chew her food and failed to wipe the drool from Resident #1's face. * On 10/01/14 at 1:00 p.m., a CNA (#19) assisted Resident #1 during the noon meal. Within a ten minute time period the CNA (#19) asked Resident #1, "Are you ready to go then? Ok, I have to sit here until you're done. Are you ready? Are you all ready [Resident #1]? No? Not yet? Are you all done? Can we go back to your room? Are you ready [Resident #1]? Can we head back? No? Can you put your napkin up here, so we can head out?" During that same time period, Resident #1 repetitively shook her head "No" and demonstrated an immediate and/or delayed cough. The CNA (#19) failed to allow the resident plenty of time to drink her liquids. * On 10/02/14 at 9:10 a.m., a CNA (#22) watched as Resident #1 fed herself breakfast. Drool ran down Resident #1's chin (an indication Resident #1 did not swallow her secretions). The CNA (#22) failed to cue and/or wipe the drool from Resident #1's face. - Observation 10/02/14 at 9:35 a.m., showed two CNAs (#9 and #10) assisted Resident #13 with toileting cares. The CNAs (#9 and #10) failed to close the door to the bathroom prior to exiting the room for more supplies, allowing Resident #13 to be seen sitting on the toilet with her pants/incontinence brief pulled down to mid-shin. During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed staff are expected to allow residents adequate time to eat/chew their food before offering another bite of food and are expected to cue and/or wipe the drool from the residents' faces.	F 241		

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F 241	Continued From page 3 The managerial nursing staff member (#13) also confirmed staff are expected to ensure privacy during toileting cares.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 278	**F278 Assessment Accuracy/ Coordination / Certified** 11-14-14 1. For the identified resident, a new MDS is due and will be completed on November 13, 2014. Correction was completed on Section N-Antianxiety by nurse manager on 10/04/14 Correction of data entry error will not affect the resident's classification. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents residing in the facility have the potential to be affected. 3. All nurses who complete the MDS have been educated regarding attention to detail and accuracy of assessments. Date of Education: 10/02/14.	

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F 278	Continued From page 4 review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 1 of 3 sampled residents (Resident #11) coded on the MDS for an antianxiety medication. Failure to accurately assess and code the MDS may affect the level of care provided to residents and the accurate development of the comprehensive care plan. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, chapter 3 page N-5, states, ". . . Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period . . . " - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included anxiety and dementia. Resident #11's quarterly MDS dated 05/12/14, and an annual MDS dated 08/13/14, indicated she received an antianxiety medication seven days. Resident #11's current physician's orders stated the following: "Lorazepam [an antianxiety medication] 0.5 milligram [mg] on specific day of the week Friday one hour before bath/shower and the same dose Wednesday one hour before bath/shower." In May and August 2014, the resident's medication administration record showed lorazapam administered twice during the MDS look-back periods.	F 278	4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 278	Continued From page 5 During an interview on 10/02/14 at 11:45 a.m., an administrative nurse (#2) stated the MDS was incorrect. Resident #11 only received the medication on bath days.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of policies/procedures, and staff interview, the facility failed to review and revise the resident's plan of care for 2 of 17 sampled residents (Resident #2, and #11). Failure to review and revise the plan of care limited the facility's ability	F 280	**F280 Right to Participate in Planning Care-Revise Care Plan** 1. For residents #2 and #11, interventions were added to care plan and staff were educated to update care plans when new interventions are implemented. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents have the potential to be affected. 3. Nursing staff has been educated to review and revise care plans when any change in a resident's status occurs. Quality Indicator Meetings will be held semi-monthly to ensure care plans have been revised and updated with current interventions.	11-14-14

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F 280	Continued From page 6 to communicate care needs and ensure continuity of care for each resident. Findings include: Review of facility policy titled "Care Plan" occurred on 10/02/14. This policy, dated May 2013, stated, ". . . 1. To identify needs and problems . . . 4. To evaluate resident responses to nursing interventions, psychosocial actions, and medical care . . . 7. To give a complete and accurate picture of the current status of the resident. . . ." Resident #2's medical record, reviewed September 29-October 2, 2014, identified diagnoses including senile dementia with behaviors. The quarterly Minimum Data Set (MDS), dated 07/24/14, identified severely impaired cognition and need for supervision with locomotion on/off the unit. The current care plan identified, ". . . Focus: [Resident #2] has potential for elopement due to dementia. . . Interventions: . . . Wanderguard placed on person. . . Door alarm. . . ." The progress notes, dated October 30-September 26, 2014, identified Resdient #2 eloped from the facility on eight occasions (five times to the Assisted Living Center and three times outside the facility). The incident reports identified the facility recommended the following interventions; an identification bracelet worn on the wrist, a name tag given to alert visitors that she was a resident, and a motion sensor placed on the door to her room.	F 280	4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 280	Continued From page 7 During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed staff failed to revise the resident's care plan if/when they initiated a new intervention (an identification bracelet, a name tag, and a motion sensor.) -Review of Resident #11's medical record occurred on all days of survey. Diagnoses included anxiety and dementia. Resident #11's current physician's orders stated the following: "Lorazepam [an antianxiety medication] 0.5 milligram [mg] on specific day of the week Friday one hour before bath/shower and the same dose Wednesday one hour before bath/shower" Review of Resident #11's current care plan stated, ". . . Decreased ADL [activities of daily living] function U/E [upper extremities] r/t [related to] dementia . . . Interventions . . . Extensive assist needed to tub bath/shower . . . " The care plan lacked the intervention of administering an antianxiety medication before bathing. During an interview in the afternoon of 10/02/14, an administrative nurse (#7) agreed the care plan lacked this specific intervention for Resident #11.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	**F309 Provide Care/Services for Highest Well Being** 1. Regarding resident #1, resident's fracture has healed and she is no longer in pain. However, licensed nursing staff was educated to notify the physician within 24 hours or less when the resident continues to complain of pain and/or reports/exhibits pain	11-14-14

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F 309	Continued From page 8 and plan of care. This REQUIREMENT is not met as evidenced by: PAIN 1. Based on medical record review, review of professional literature, review of facility policy, family interview, and staff interview, the facility failed to provide the necessary care and services to promote the optimal well-being for 1 of 1 sampled resident (Resident #1) who experienced continued uncontrolled pain secondary to a femur fracture. Failure to inform the attending physician of the resident's continued uncontrolled pain did not allow the physician the opportunity to ascertain the cause of and/or prescribe treatment for her pain and resulted in Resident #1 experiencing avoidable pain. Findings include: Review of the American Academy of Orthopaedic Surgeons "OrthoInfo - Distal Femur (Thighbone) Fractures of the Knee," orthoinfo.aaos.org, copyright 2011, stated, ". . . Distal femur fractures vary. The bone can break . . . into many pieces (comminuted fracture). Sometimes these fractures extend into the knee joint and separate the surface of the bone into a few (or many) parts. . . . The most common symptoms of distal femur fracture include: Pain with weightbearing, Swelling and bruising, Tenderness to touch . . . In most cases, these symptoms occur around the knee . . ." Review of the facility policy titled "Pain	F 309	in a different location after an injury. Date of Education: Professional Nurses Meeting 10/16/14 and All Staff Meeting 11/06/14. 2. Any resident who suffers an injury has the potential to be affected. 3. Licensed nursing staff will be educated to complete a detailed assessment and investigation, then update the physician immediately with all injuries, and/or within 24 hours or less when the resident continues to complain of pain, and/or reports/exhibits pain in a different location after an injury. If a response from the physician has not been received by the close of business day and resident continues to complain of pain, the on-call physician will be contacted. The facility pain policy was revised to reflect changes, and a Hospital ER Visits/OfficeVisits/Lab/Procedure and FAX Tracking Log was developed to ensure that the new policy/procedure is followed through on by professional nursing staff.	

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F 309	Continued From page 9 Management" occurred on 10/02/14. This policy, revised May 2013, stated, ". . . Pain will be treated promptly to assure that the resident may obtain the highest level of pain relief possible. . . . Have the resident rate his pain using the pain log until the resident has had 48 hours of pain rated at an acceptable level or less . . . If the resident's pain is not relieved by current interventions, the nurse will contact the physician to discuss other options and interventions. . . ." During an interview on 09/29/14 at 4:20 p.m., a family member (#1) reported the facility had "dropped" Resident #1 "in the beauty salon." The family member (#1) stated, "I think they dropped her. The force of falling on her knee, pushed it [the bone] up and cracked it. Her knee was swollen. It was huge. She kept complaining of pain. She had alot of pain. [They] xrayed her shoulder and hip [immediately after the fall and her] knee the next week. She wore a brace for six months." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a fall with injury/fracture. The annual Minimum Data Set (MDS), dated 08/16/14, identified intact cognitive skills. Resident #1's current care plan identified, ". . . Interventions: . . . Give analgesics PRN [as needed] for pain. . . ." The progress note, dated 01/10/14 at 2:21 p.m., identified, ". . . resident had fallen out of her wheelchair. Resident was laying on right side . . . unable to move left leg due to increased pain. . . . Rates pain 10/10 to the left leg. . . . [Physician] notified and gave order to transport to	F 309	Date of Education: Professional Nurses Meeting 10/16/14 and All Staff Meeting 11/06/14. 4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action. **F309 Swallowing** 1. Regarding resident #1 and #3, staff were educated to have residents as close to 90 degrees as possible prior to offering /giving liquids or food. Staff was educated to offer no larger than a teaspoon-sized bite of food to any resident with swallowing difficulties and to allow residents ample time to eat. Staff was educated to recognize signs and symptoms of dysphagia/aspiration such as drooling, coughing, and delayed coughing.	

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F 309	Continued From page 10 [emergency room] for evaluation via ambulance. . . ." The emergency room evaluation, dated 01/10/14 at 3:20 p.m., identified, ". . . staff found her lying on her side . . . [Resident #1] was complaining of most of the pain in her hip but also pain through her anterior left shoulder. . . . No swelling, bruising or injury to the knee is noted. . . . She was given a prescription for Hydrocodone/APAP (Acetaminophen) [an analgesic] . . . every 4-6 hours for severe pain . . ." The medication administration record (MAR) identified, "Hydrocodone-Acetaminophen 5-325 milligrams as needed every 4-6 hours for pain." The MAR showed Resident #1 requested the analgesic one to four times per day from January 10-30, 2014. In all instances but one, staff charted the medication was effective. The progress notes identified the following: * 01/10/14 at 5:02 p.m., "Resident came back from [hospital] with orders. . . . Resident has a bruise to her left knee and it is swollen which happened at facility." * 01/10/14 at 8:46 p.m., "Hydrocodone-Acetaminophen . . . Resident c/o [complains of] pain 9 out of 10 to her left knee. Ice pack is applied and was used to try to help pain." * 01/10/14 at 10:15 p.m., ". . . Resident is still c/o pain 8 out of 10 and facila [sic] expressions." * 01/11/14 at 2:57 a.m., "Hydrocodone-Acetaminophen . . . per resident request for c/o 9/10 left knee pain." * 01/11/14 at 3:24 a.m., ". . . No complaints of pain other than to left knee. Left knee continues to be swollen. . . ."	F 309	Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents who have swallowing difficulties have the potential to be affected. 3. All nursing staff will be educated to have residents as close to 90 degrees as possible prior to offering /giving liquids or food. All nursing staff will be educated to offer no larger than a teaspoon-sized bite of food to any resident with swallowing difficulties and to allow residents ample time to eat. All nursing staff will be educated to recognize signs and symptoms of dysphagia/aspiration such as drooling, coughing, and delayed coughing. Date of Education: All Staff Meeting 11/06/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

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F 309	Continued From page 11 * 01/11/14 at 8:11 a.m., "Hydrocodone-Acetaminophen . . . c/o left knee pain." * 01/11/14 at 12:28 p.m., ". . . helped some." * 01/11/14 at 2:10 p.m., ". . . C/O pain to left knee 9/10 area is swollen and bruised. Resident did not want to get out of bed as knee really hurting. . . . Gave PRN [as needed] hydro [hydrocodone]/APAP and ice to knee for pain . . ." * 01/11/14 at 4:06 p.m., ". . . 10/10 left knee pain." * 01/11/14 at 9:18 p.m., "Hydrocodone-Acetaminophen . . . c/o 8/10 left knee pain." * 01/11/14 at 10:05 p.m., ". . . C/O pain to left knee 8/10 area is swollen and bruised. Resident remained in bed this shift and sat up in bed for some of shift and for supper. Gave PRN hydro/APAP and ice to knee for pain with some relief . . ." The MAR showed Resident #1 received four doses of Hydrocodone on 01/11/14. Staff charted all four doses were effective which conflicts with the information documented above. * 01/12/14 at 1:59 p.m., "REsident complains of some soreness in (L) [left] knee. Continues with bruising to area. She is asking why it is sore . . ." * 01/12/14 at 8:55 p.m., "Hydrocodone-Acetaminophen . . . Resident rated her pain an [sic] 7/10. . . . she was helped into bed and HS [hour of sleep] cares were performed and it aggravated her left leg." * 01/13/14 at 11:27 a.m., "Hydrocodone-Acetaminophen . . . Given per request for pain in (L) leg level 8 of 10." * 01/13/14 at 1:09 p.m., "Resident continues with some pain and swelling of (L) knee. Resident transferred with standing lift. She beared weight most of the time with transfers. FAX to MD [medical doctor] [three days post fall and after	F 309	**F309 Urinary Tract Infections** 4. A QA tool has been developed and will be completed by nurse manager or staff RN/LPN weekly x 1 month, monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action. 1. Regarding resident #3, education was provided to licensed nursing staff that when a physician has not responded to a fax or a phone call by the end of the business day, the on-call physician must be contacted. Licensed nursing staff were also educated on updating resident or responsible party of lab results. Date of Education: Professional Nurses Meeting 10/16/14. 2. All residents with questionable infections have the potential to be affected by this.	

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F 309	Continued From page 12 Resident #1 complained of severe pain on nine occasions] regarding leg and swelling and possible xray of knee." * 01/13/14 at 1:59 p.m., ". . . Resident states knee is better now that [she] is laying down." * 01/13/14 at 7:34 p.m., "Hydrocodone-Acetaminophen . . . Resident requested for pain of 7/10, currently resting in bed rubbing area where it hurts. Room darken . . ." The MAR showed Resident #1 received two doses of Hydrocodone on 01/13/14. Staff had charted both doses were effective which conflicts with the information documented above. * 01/14/14 at 11:28 a.m., "Hydrocodone-Acetaminophen . . . c/o 7/10 left knee pain." * 01/14/14 at 3:20 p.m., ". . . yes it helped." * 01/14/14 at 9:23 p.m., "Hydrocodone-Acetaminophen . . ." * 01/14/14 at 10:26 p.m., "Gave PRN pain medication which was effective. [Resident #1] voiced her left knee is feeling a little better." * 01/15/14 at 9:41 p.m., "Hydrocodone-Acetaminophen . . . Resting quietly in bed." * 01/15/14 at 10:12 p.m., "Appt [appointment] made to see [physician] 1-16-14 . . . Left knee pain from post fall 1-10-14 . . ." * 01/16/14 at 1:36 p.m., "Resident returned to facility [six days post fall and after Resident #1 complained of severe pain on eleven occasions] . . . received call from [physician] that resident has a bad distal fx [fracture], keep immobilizer on at all times . . ." During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed Resident #1's physician was contacted three days post fall regarding her continued uncontrolled	F 309	3. All professional nursing staff will be educated on monitoring timeline for return of fax or phone calls related to positive culture results and implement treatment. Nursing staff will also be educated on informing resident or responsible party of lab results. A new Hospital ER Visits/Office Visits/Lab/Procedure/FAX Tracking form was developed to assure follow-through by professional staff. Date of Education: All Staff Meeting 11/06/14. 4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager weekly x 1 month, monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 309	Continued From page 13 pain and staff failed to follow-up until the sixth day post fall. The facility failed to inform Resident #1's attending physician of her continued uncontrolled left knee pain as evidenced by: * her left knee being bruised and swollen * her demonstrating pain through facial expressions and/or verbalizing being in pain * her requests for medication/ice to relieve the knee pain/swelling * her refusal to get out of bed due to her "knee really hurting" and reports of her knee "feeling better when she was laying down" * staff reports of her refusing to consistently bear weight and her reports of her knee being "aggravated" during transfers. The facility's failure to inform the attending physician of Resident #1's continued uncontrolled pain which did not allow him/her the opportunity to ascertain the cause of and/or prescribe treatment for her pain, and resulted in Resident #1 experiencing avoidable pain. Resident #1 expressed discomfort/pain in her left leg beginning on 01/10/14, and her femur fracture was not diagnosed until 01/16/14 (6 days post fall). SWALLOWING 2. Based on observation, record review, review of facility policy and procedure, resident/family interview, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #1) with a history of aspiration pneumonia and 1 of 1 sampled resident (Resident #13) at risk of aspirating received the care and services necessary to attain the highest degree of safety	F 309		

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F 309	Continued From page 14 possible while being fed. Failure to ensure residents were positioned properly prior to offering/giving liquids, control the size of the bolus (bite), allow adequate time for residents to eat/chew their food, and recognize the signs/symptoms of dysphagia/aspiration resulted in Resident #1 aspirating during meals and placed Resident #13 at risk of aspirating. Findings include: Review of the facility policy titled "Assisting the Resident to eat" occurred on 10/02/14. This policy, revised November 2013, stated, "Be sure the resident is (as much as possible) in proper positioning for eating. . . . If a resident remains in bed, the resident should be resting on his/her back, head of bed elevated at a 90 degree angle. . . . Allow the resident plenty of time to eat and chew foods. Provide small bites and sips of liquids. . . . Be observant of the resident during the feeding process. Watch for signs of choking. . . ." - During an interview on 09/29/14 at 4:20 p.m., a family member (#1) reported and Resident #1 confirmed she felt "rushed during meals." They reported feeling staff "push her to be done," even though she wished to continue eating. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, dysphagia, and recent history of aspiration pneumonia. The annual Minimum Data Set (MDS), dated 08/16/14, identified intact cognitive skills, the need for extensive assistance of one person at meals, and a mechanically altered diet. The current physician's orders further identified, ". . .	F 309		

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F 309	Continued From page 15 Mechanical soft with ground meat and thin liquids. . . ." Resident #1's current care plan identified, ". . . Focus: . . . nutritional problems . . . Parkinson's disease . . . dementia . . . dysphagia . . . slow eater . . . gradual unplanned weight loss . . . Interventions: Allow time to eat and finish meal to the extent that res [resident] wishes . . . Provide liberal geriatric [diet] - mech [mechanical] soft - pureed per MD [medical doctor] . . ." Observation showed the following: * On 09/30/14 at 10:20 a.m., a CNA (#11) gave Resident #1 a drink of water as she lay in bed (with the head of the bed raised to an approximate 25 degree angle - placing Resident #1 at an increased risk of premature loss of food/liquid over the back of her tongue). Drool ran down the left side of Resident #1's face and neck (an indication Resident #1 did not swallow her secretions). The CNA failed to raise Resident #1's bed to 90 degrees prior to offering her water. * On 09/30/14 at 12:45 p.m., a CNA (#20) assisted Resident #1 during the noon meal. The CNA (#20) held a heaping spoonful of food three inches from Resident #1's mouth and repetitively prompted her to take another bite of food, as Resident #1 continued to chew the previous bite of food in her mouth (placing Resident #1 at an increased risk of aspirating during a delayed swallowing response). Resident #1 drooled (an indication Resident #1 did not swallow her secretions), coughed twice (an indication Resident #1 had poor vocal fold closure and secretions had entered her airway), and began to hiccup. The CNA (#20) failed to provide small bites of food/small sips of liquids, allow the resident adequate time to eat/chew her food, and	F 309		

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F 309	Continued From page 16 watch for signs/symptoms of dysphagia/aspiration. * On 10/01/14 at 9:10 a.m., a CNA (#21) assisted Resident #1 during the breakfast meal. The CNA (#21) held a spoonful of food three inches from Resident #1's mouth and repetitively prompted her to take another bite of food, as Resident #1 continued to chew the previous bite of food in her mouth (placing Resident #1 at an increased risk of aspirating during a delayed swallowing response). Resident #1 drooled (an indication Resident #1 did not swallow her secretions). The CNA (#21) failed to allow the resident adequate time to eat/chew her food and failed to watch for signs/symptoms of dysphagia/aspiration. * On 10/01/14 at 1:00 p.m., a CNA (#19) assisted Resident #1 during the noon meal. The CNA (#19) asked Resident #1, "Are you ready to go then?" Resident #1 shook her head "No" and coughed as she continued to drink cocoa from a straw (an indication Resident #1 had poor vocal fold closure and secretions had entered her airway). The CNA (#19) then stated, "Ok, I have to sit here until you're done. Are you ready?" Resident #1 again shook her head "No," continued to drink her cocoa, and demonstrated a delayed cough (an indication Resident #1 had poor vocal fold closure and secretions had entered her airway). During the next five minutes, the CNA (#19) asked Resident #1, "Are you all ready [Resident #1]? No? Not yet? Are you all done? Can we go back to your room?" Resident #1 shook her head and/or stated "No" three times and began coughing (an indication Resident #1 had poor vocal fold closure and secretions had entered her airway). She presented with a "wet" vocal quality (an indication Resident #1 did not swallow her secretion and secretions had entered her airway). The CNA (#19) asked Resident #1,	F 309		

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F 309	Continued From page 17 "Are you ready [Resident #1]? Can we head back? No?" Resident #1 did not respond to the questions and continued drinking her cocoa. The CNA (#19) then asked Resident #1, "Can you put your napkin up here, so we can head out?" Resident #1 shook her head "Yes." The CNA (#19) failed to allow the resident adequate time to drink her liquids and failed to watch for signs/symptoms of dysphagia/aspiration. * On 10/02/14 at 9:10 a.m., a CNA (#22) watched as Resident #1 fed herself breakfast. Drool ran down Resident #1's chin (an indication Resident #1 did not swallow her secretions). The CNA (#22) failed to watch for signs/symptoms of dysphagia/aspiration. - Resident #3's medical record, reviewed September 29-October 2, 2014, identified diagnoses including weakness. The admission MDS, dated 08/01/14, identified intact cognition and need for assistance of one person for eating. Observation on 09/30/14 at 10:35 a.m., showed a CNA (#14) gave Resident #3 a drink of water as he lay in bed (with the head of the bed raised to an approximate 45 degree angle - placing Resident #3 at an increased risk of premature loss of food/liquid over the back of his tongue). The CNA failed to raise Resident #3 bed to 90 degrees prior to offering him water. During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed staff are expected to position residents as close to 90 degrees as possible prior to offering a drink, provide small bites of food/small sips of liquids, allow the residents adequate to eat/chew their food, and watch for signs/symptoms of dysphagia/aspiration.	F 309		

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F 309	Continued From page 18 The facility failed to 1) position Resident #1 (with a recent history of aspiration pneumonia) and Resident #3 as close to 90 degrees as possible prior to offering/giving them liquids, 2) control the size of the bolus; offering teaspoon sized bites of food, 3) allow Resident #1 plenty of time to eat/chew her food (especially considering her diagnoses), and 4) recognize Resident #1's signs/symptoms of dysphagia/aspiration (drooling, coughing/delayed coughing, etc.) Failure to implement the above interventions resulted in Resident #1 aspirating during meals and placed Resident #13 at risk of aspirating. URINARY TRACT INFECTIONS 3. Based on record review and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #3) received the care and services necessary to attain the highest practicable physical well-being possible after being diagnosed with a urinary tract infection (UTI). Failure to ensure a resident with a known UTI received appropriate treatment following a laboratory culture resulted in Resident #3 experiencing increased urinary frequency/discomfort. Findings include: The facility failed to provide a copy of their policy regarding urinary tract infections upon request. - Resident #3's medical record, reviewed September 29-October 2, 2014, identified diagnoses including a history of UTIs. The admission Minimum Data Set (MDS), dated 08/01/14, identified intact cognition and need for	F 309		

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F 309	Continued From page 19 extensive assistance of two or more persons for toileting. The progress note, dated 04/28/14 at 6:03 a.m., identified, "Straight cath [catheter] done at 5:55 a.m. for UA/UC [urinary analysis/urinary culture]. Obtained slightly cloudy yellow urine. No odor or sediment noted. Will send to [Hospital] for analysis. Resident did c/o [complain of] some discomfort with catheter insertion, otherwise no complaints." The laboratory report, dated 04/28/14 at 10:15 a.m., identified, ". . . Criteria has been met for ordering the urine culture test. . . ." The progress notes identified the following: * 04/28/14 at 2:40 p.m., ". . . received UA results and UC has been set up. resident complaints [sic] of frequency but is willing to wait until the culture returns before the MD [medical doctor] decides if treatment is warranted. . . ." * 04/29/14 at 10:19 a.m., ". . . contact isolation pending UC results. . . ." * 04/29/14 at 8:15 p.m., "[Physician] updated on recent UC, waiting to here [sic] back results." The laboratory report, dated 04/30/14 at 3:15 p.m., identified, ". . . Organism: Enterobacter aerogenes [a bacteria] . . . Interpretation: Sensitive . . . Antibiotic: . . . Ceftriaxone . . . Ciprofloxacin . . . Gentamicin . . . Peperacillin/Tazobactam . . . Trimethoprim/Sulfamethoxazole . . ." The progress notes identified the following: * 04/30/14 at 6:36 p.m., ". . . Resident did complain of urinary frequency and asked if U/C was back yet. . . ." Staff failed to inform Residnet	F 309		

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F 309	Continued From page 20 #3 of the above lab results. * 05/01/14 at 4:39 a.m., "Received final UC results. [Approximately 13 hours prior to this entry.] Fax prepared to update MD on UC results, and copy of results placed in chart." * 05/02/14 at 2:44 p.m., ". . . complaints of frequency and requesting to be started on something [This was the second time Resident #3 approached staff.] call placed to clinic x [times] 2 and also refaxed the UA/UC. [No evidence was found in the resident's medical record showing a previous fax had been sent to the physician.] taking fluids well. . . ." The facility received a fax from Resident #3's physician, dated 05/02/14 at 4:46 p.m. [2 hours after receiving the phone calls/"second" fax], which identified, "Cipro 250 (2 po [orally] tonight then 1 po BID [twice daily] x (four more days)." The progress notes identified the following: * 05/02/14 at 9:12 p.m., "Cipro 250-2 pills tonight then 1 pill PO BID for four more days." * 05/02/14 at 10:23 p.m., ". . . Antibiotics started for UTI [5 days after the UA was obtained.]" During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed staff are expected to notify a physician of the resident's continued symptoms/complaints and of the results of a culture.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		

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F 315	Continued From page 21 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide appropriate treatment and services to prevent urinary tract infections for 2 of 3 residents (Resident #8 and #15) observed during catheter care. Failure to cleanse the end of the drain tube may result in urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Catheter: Urinary Collection Bags, Emptying, Changing, Cleaning & Sanitizing" occurred on 10/02/14. This policy, dated September 2013, stated, "... Procedure: ... Emptying Urinary Collection Bag ... 5. Put on gloves. 6. Position the measuring container under the drainage bag. 7. Remove the drain tube from its holder. 8. Open the drain tube, empty bag and close drain. 9. Wipe the drain with an alcohol swab...." - Review of Resident #8's medical record occurred on September 29-30, 2014 and diagnoses included multiple sclerosis and history of UTIs. The current care plan stated, "Focus: ... Urinary incontinence r/t [related to] multiple	F 315	**F315 No Catheter, Prevent UTI, Restore Bladder Function** 1. Regarding residents #8 and #15, education has been provided to all nursing staff to cleanse the end of the catheter drain tube. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents with an indwelling catheter have the potential to be affected. 3. Education will be provided to all nursing staff on cleansing the end of the catheter drain tube with alcohol pad. Date of Education: All Staff Meeting 11/06/14. 4. A QA tool has been developed and will be completed by nurse manager or staff RN/LPN weekly x 1 month, monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	11-14-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

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F 315	Continued From page 22 sclerosis At risk for UTI . . . Interventions: . . . Resident has supra Pubic cath [catheter] as resident is always incontinent of urine which was causing skin breakdown. . . ." An observation on 09/29/14 at 5:25 p.m. identified a certified nursing assistant (CNA) (#4) emptied the resident's urinary collection bag. After emptying the urine from the bag, the CNA (#4) failed to wipe the end of the drain tube with an alcohol swab. - Review of Resident #15's medical record occurred on October 01-02, 2014 and diagnoses included urinary retention. The current care plan stated, "Focus: [Resident #15] has a Suprapubic Catheter: r/t urinary retention. . . ." An observation on 10/02/14 at 11:25 a.m. identified a CNA (#5) emptied the resident's urinary collection bag. After emptying the urine from the bag, the CNA (#5) failed to wipe the end of the drain tube with an alcohol swab. During an interview on the morning of 10/02/14, an administrative nurse (#2) stated staff should follow the facility's catheter care policy and wipe the end of the drain tube with an alcohol swab after emptying the bag.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F323 Free of Accident Hazards/Supervision/Devices** 1. Regarding resident #1, verbal re-education was provided to beauticians on 1/10/14, and again on 10/02/14, regarding the use of the Wheelchair Recline unit (for shampooing hair).	11-14-14

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F 323	Continued From page 23 This REQUIREMENT is not met as evidenced by: FALLS 1. Based on observation, record review, review of a manufacturers pamphlet, review of professional literature, review of facility policy, family interview, and staff interview, the facility failed to ensure the environment remained free of accident hazards for 1 of 1 sampled resident (Resident #1) who experienced a fall with fracture in the beauty salon. Failure to ensure a safe environment resulted in Resident #1's comminuted femur fracture and failure to determine external causative factors for the injury has the potential to place her and other residents at risk of further injury. Findings included: Review of the "Wheelchair Recline unit (Platform Model)" www.WheelchairRecline.com, patent pending, stated, ". . . An innovative way for the wheelchair bound person to be reclined while staying in his or her own wheelchair. The versatile Wheelchair Recline unit can be used for shampooing hair in a beauty shop . . . The Wheelchair Recline platform elevates 5 inches! . . . Locking castors allow for easy maneuverability and are positioned to balance and support the weight of the occupant. . . ." The manual lacked specific instructions for the use of this product. Review of the American Academy of Orthopaedic Surgeons "OrthoInfo - Distal Femur (Thighbone) Fractures of the Knee," orthoinfo.aaos.org,	F 323	2. All residents who are wheelchair bound and use the beauty shop for shampooing hair have the potential to be affected. 3. An orientation checklist for proper use of the Wheelchair Recline unit has been developed and implemented. An instruction manual for the Wheelchair Recline unit has been obtained from the company and placed in the Beauty Shop as well as in our Safe Operating Procedures Manual. Dates of education: October 31, 2014 and All Staff Meeting 11/6/14. 4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager monthly x 1 month and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 323	Continued From page 24 copyright 2011, stated, ". . . Distal femur fractures vary. The bone can break . . . into many pieces (comminuted fracture). Sometimes these fractures extend into the knee joint and separate the surface of the bone into a few (or many) parts. . . . A lower-force event, such as a fall from standing, can cause a distal femur fracture in an older person . . ." Review of the facility policy titled "Fall Prevention/Safety Protocol" occurred on 10/02/14. This policy, revised December 2013, stated, ". . . Prevention . . . Environment will be assessed ongoing with any identified hazards removed or corrected. . . . Occurrence . . . If a Fall . . . should occur: . . . A licensed nurse will complete a Variance Report. It will include an . . . investigation of the incident and possible contributing factors . . . and action needed to prevent future falls. . . ." During interview on 09/29/14 at 4:20 p.m., a family member (#1) reported the facility had "dropped" Resident #1 "in the beauty salon." The family member (#1) stated, "I think they dropped her. They said she had slipped. The force of falling on her knee, pushed it [the bone] up and cracked it. One [staff] person, not two, transferred her. She [the staff person] was new." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, osteoporosis, and a fall with injury/fracture. The annual Minimum Data Set (MDS), dated 08/16/14, identified intact cognitive skills, the need for extensive assistance of two or more persons for transfers and locomotion on the unit, and impaired range of motion in the lower	F 323	**F323 Elopement** 1. Regarding resident #2, the resident was discharged to a locked dementia unit in another community on 10/02/14. This was a planned discharge, with contact made to the admitting facility on 9/25/14. 2. All residents who wander have the potential to be affected. 3. The Missing Resident/Elopement policy has been revised to include a detailed investigation as to how a resident was able to exit facility without staff knowledge and implement interventions to prevent a reoccurrence. Staff has been educated on the importance of accurate documentation on Close Observation logs (15 minute checks). A technician from R.F. Technologies, our Code Alert vendor, has placed	

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F 323	Continued From page 25 extremities. Resident #1's current care plan identified, ". . . Focus: . . . risk for falls r/t [related to] history of falls . . . Interventions: . . . Ensure a safe environment . . . Focus: . . . ADL [activities of daily living] Performance Deficit . . . Interventions: [Resident #1] requires a pivot transfer with 2 assist. . . . Hoyer for toileting. . . ." The current "routine care sheet" provided to staff further identified, ". . . [Resident #1] is non-ambulatory . . ." The progress note, dated 01/10/14 at 2:21 p.m., identified, "Type of Fall: . . . Observed, Time of Fall: 1:45 p.m., Location: Beauty shop, Description of Incident: Author was called into beuaty [sic] shop after resident had fallen out of her wheelchair. Resident was laying on right side when author arrived. Resident unable to move left leg due to increased pain. Resident did state that she bumped her head. Resident is alert able to verbalize needs. Rates pain 10/10 to the left leg. . . . Notification: [Physician] notified and gave order to transport to [emergency room] for evaluation via ambulance. . . ." The fall incident report, dated 01/10/14 at 1:45 p.m., further identified, ". . . No witnesses found. . . . Re-education to staff done." The incident report failed to identify environmental hazards that had been removed/corrected, a summary of the investigation including possible contributing factors, or the actions taken to prevent future falls. The emergency room evaluation, dated 01/10/14 at 3:20 p.m., identified, ". . . Apparently she was going to the salon today and was waiting to have her hair done. She generally requires assistance	F 323	additional sensors/alarms in the building, in the service wing and in the front entry on 10/29/14. This will provide a second layer of security to detect and prevent potential elopement from the building. All existing equipment was checked by company technician and found to be in good working order on 10/30/14. Maintenance staff will conduct a complete check of each alarm device on a daily basis. Nursing staff will be re-educated to complete a variance and detailed investigation after an elopement. Date of Education: All Staff Meeting 11/06/14. 4. A QA tool has been developed and will be completed by QAPI Manager or nurse manager monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 323	Continued From page 26 to transfer but staff found her lying on her side with her wheelchair. Apparently the chair was on its side. The fall was not witnessed and when she was found [Resident #1] was complaining of most of the pain in her hip but also pain through her anterior left shoulder. She does have a known history of osteoporosis with a total hip replacement on the right and open reduction, internal fixation of the left hip and a known rotator cuff tear on the right shoulder. . . . No swelling, bruising or injury to the knee is noted. . . . Assessment: Fall with contusion of left hip and shoulder . . ." The progress notes identified the following: * 01/10/14 at 5:02 p.m., "Resident came back from [hospital] with orders. . . . Resident has a bruise to her left knee and it is swollen which happened at facility [approximately one hour 30 minutes after returning to the facility]." * 01/15/14 at 10:12 p.m., "Appt [appointment] made to see [physician] 1-16-14 . . . Left knee pain from post fall 1-10-14 . . ." * 01/16/14 at 1:36 p.m., "Resident returned to facility without incident. [six days post fall and after Resident #1 complained of severe pain on ten occasions] . . . received call from [physician] that resident has a bad distal fx [fracture], keep immobilizer on at all times . . ." The radiology report, dated 01/16/14, identified, ". . . IMPRESSION: Comminuted angulated fracture in the distal femur potentially extending into a joint space although difficult to confirm. . . ." During an interview on 10/02/14 at 8:10 a.m., a managerial nursing staff member (#13) reported, "[Resident #1] was in the wheelchair lift [when she fell]. The lift reclines the wheelchair so they	F 323	3. Nursing staff have been/will be instructed to grasp the gait belt during transfers and avoid pulling on resident's arms. They have been/will be instructed to cue residents to stand and bear weight during transfer when a mechanical lift is being used, and if the resident is unable to do so, to notify the nurse to re-evaluate the method of transfer. Nursing	

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F 323	Continued From page 27 [beauticians (#23 and #24)] can put their [the resident's] head in the sink. It's unclear if she [the beautician (#24)] didn't lock it or if she bumped the lock. The chair went sideways. Staff [the beauticians (#23 and #24)] were re-educated on the lift. Two beauticians (#23 and #24) were in the room [at the time of the fall]." The information obtained during the interview (regarding the resident having been in a lift and facility staff being present at the time of the the fall) directly conflicts with the incident report and the emergency room evaluation. During observation/interview on 10/02/14 at 8:30 a.m., an administrative staff member (#17), a managerial nursing staff member (#13), and beautician (#23) used straps to secure the front wheels and J-hooks to secure the back wheels of a wheelchair to the wheelchair recline unit (lift). The beautician (#23) reported, although present the day of the fall, she "didn't see [Resident #1] fall." She reported turning around and seeing the wheelchair to the left of the lift and Resident #1 lying on the floor to the right. She stated, "The [second beautician (#24) (who is no longer employed at the facility)] said she didn't strap the front two [wheels]." [At the time of this interview the administrative staff member (#17) was unaware of this fact.] The beautician (#23) unstrapped the front wheels of the wheelchair per request, and this surveyor attempted to dislodge the wheelchair from the lift with only the J-hooks in place. The administrative staff member (#17), the managerial nursing staff member (#13), and the beautician (#23) confirmed the wheelchair was secure. The information obtained during the observation/interview (regarding the resident having been partially secured in the lift and facility staff being present at the time of the the fall)	F 323	**F323 Gait Belt/Mechanical Lift (EZ stand) Transfers** 1. Regarding resident #9, staff has been instructed to grasp the gait belt during transfers and avoid pulling on resident's arms. Regarding resident #3, staff was instructed to cue resident to stand and bear weight during transfer, and if resident is unable to do so, to notify the nurse for re-evaluation of the method of transfer. Regarding resident #14, safety stoppers have been replaced on the EZ Stand lifts, with no adverse effect to the resident during cited transfer. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents requiring use of a gait belt or a mechanical lift for transfers have the potential to be affected.	

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F 323	Continued From page 28 directly conflicts with the incident report and the emergency room evaluation. During interview on 10/02/14 at 10:27 a.m., an administrative staff member (#17) and beautician (#23) confirmed they were unable to provide proof of staff education (prior to and/or following the 01/10/14 incident). During interview on 10/02/14 at 10:40 a.m., a beautician (#23) provided additional information regarding the 01/10/14 incident. She reported she was giving "a perm and didn't hear anything." When the [second beautician (#24)] called out to her, and she turned to see "[Resident #1] already on the floor." The beautician (#23) reported stating, "You didn't have her strapped," to which the [second beautician (#24)] responded, "Yes I did." (This statement directly conflicts with her earlier statement.) The beautician (#23) also stated, "It makes sense. She (#24) couldn't have strapped [Resident #1] in. She (#24) couldn't have undone the straps and moved the wheelchair before I turned around." The facility failed to: * thoroughly investigate and determine the external causative factor(s) of Resident #1's fall and resulting fracture, placing her and other residents at risk of further injury. The incident report failed to identify environmental hazards that had been removed/corrected, a summary of the investigation including possible contributing factors, or the actions taken to prevent future falls. In addition the information obtained from interviews directly conflicted with the incident report and the emergency room evaluation. * educate staff on the proper use of the "Wheelchair Recline" unit. The "Wheelchair	F 323	staff have been/will be educated that if equipment fails or needs repair they are to pull the equipment out of use, place a note stating "Disabled" prominently on the equipment, and notify maintenance by completing a work order as soon as possible. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting; All Staff Meeting 11/06/14. 4. A QA tool has been developed and will be completed by nurse manager or staff RN/LPN, weekly x 1 month, monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

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F 323	Continued From page 29 Recline" pamphlet lacked specific instruction on how to properly use the unit. ELOPEMENT 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the safety of 1 of 1 wandering resident (Resident #2) who exited the facility while wearing a wanderguard bracelet. Failure to provide adequate supervision and/or evaluate the effectiveness of the interventions the facility had put in place, allowed Resident #2 to elope from the facility on eight separate occasions, and on one of those occasions sustain a head injury. Findings include: Review of the facility policy titled "Missing Residents" occurred on 10/02/14. This policy, dated April 2014, stated, ". . . 3. Upon return of the resident to the facility, the Charge Nurse should . . . b. Examine the resident for injuries; c. Contact the primary physician and report findings and conditions of the resident; d. Notify the resident's legal representative; e. Complete and file an incident report; and f. Make appropriate entries into the resident's medical record." The policy failed to address the need for an investigation focusing on how the resident was able to exit the facility unsupervised, and failed to address any interventions required to prevent a reoccurance. During the initial tour of the facility on the morning of 09/29/14, an unidentified staff member reported Resident #2 wanders and had exited the facility on more than one occasion. Subsequent observations made throughout the survey	F 323		

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F 323	Continued From page 30 (September 29-October 2, 2014) showed Resident #2 wearing a name tag and wandering throughout the facility. Resident #2's medical record, reviewed September 29-October 2, 2014, identified diagnoses including senile dementia with behaviors. The quarterly Minimum Data Set (MDS), dated 07/24/14, identified severely impaired cognition and need for supervision with locomotion on/off the unit. The current physician's orders identified, ". . . Wanderguard on Check q [every] shift and change as needed. . . ." The current care plan identified, ". . . Focus: [Resident #2] has potential for elopement due to dementia. . . Interventions: . . . Wanderguard placed on person. . . Door alarm. . . ." The routine care sheet (provided to direct care staff) further identified, ". . . Res. [Resident] is high elopement risk. Has Code alert and also wears a name tag that identifies her as a Resident. Please monitor that she wears this when she is up and walking around. Will take it off frequently." The progress notes identified the following: * 10/30/13 at 3:59 p.m., "Code alert was alarming. Went to check to see who it was. Res. [Resident] [#2] was walking over with another resident from the [Assisted Living Center]. . . . * 12/27/13 at 12:03 p.m., "Resident walked over to [Assisted Living Center] x 2 this AM. She states she was just out walking and wanted to go back and see everyone. Wanderguard did not trip alarm. Wanderguard is checked and in working order. Changed wanderguard to (L) [left] wrist."	F 323		

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F 323	Continued From page 31 The wanderguard failed to alert staff Resident #2 had exited the facility. Nursing staff failed to complete an incident report for each of the incidents. * 03/03/14 at 5:00 p.m., "Resident was found in [room on A Lane] with door closed. Resident was taking her blouse off. Room was empty. . . ." * 03/02/14 at 10:20 p.m., "Resident went in [room on D Lane]. Sat in resident's chair and 'fiddled' with some of the occupant's things. Was taken back to her room . . ." * 03/06/14 at 1:36 p.m., "Resident found at [Assisted Living Center] by staff . . . over there and brought resident back to her room and reported to me. Door alarmed as she brought resident back into facility. Will continue to monitor on 15 min [minute] checks. Wanderguard on and working now." The wanderguard failed to alert staff Resident #2 had exited the facility. * 07/24/14 at 10:51 a.m., ". . . No episodes of leaving her designated area recently although she does follow people when they are walking towards the [Assisted Living Center] and needs cues to turn around when she gets to the door. . . . Resident continues to use a wanderguard bracelet to prevent elopement from the building. This is non purposeful when it does happen, and resident will turn around if the alarm sounds at the door. . . ." * 07/29/14 at 4:03 p.m., "Wanderguards all checked good in a.m., resident was found in tunnel going to the [Assisted Living Center] by [Assisted Living Center] staff. Tried and was able to also walk out the front door. New wanderguard placed on resident . . . this one did lock the door. . . ." The wanderguard failed to alert staff Resident #2 had exited the facility. The 07/29/14 Incident report was submitted at	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 323	Continued From page 32	F 323		

2:45 p.m. (approximately 1 hour 15 minutes prior to the progress note), and the "close record observation" log for that day showed staff made no entries from 2:00 p.m. to 2:45 p.m. "hall" was recorded at 2:45 p.m. The time the nurse documented on the incident report conflicts with the entries made by the CNAs on the "close record observation" log.

The progress notes identified the following:
* 08/11/14 at 8:00 p.m., "Resident was sitting on the curb at [Park] on 19th Street which is the street that runs in front of the nursing home. Someone driving by saw her there and stopped to help her. She couldn't get up off the curb, she had gross [sic] on the back of her shirt, and said, 'I smacked the back of my head pretty good.' The lady was unable to help her get up off the curb by herself so a couple of high school boys stopped and helped her get [Resident #2] into her car. [Resident #2] was able to tell her she lived at the [Assisted Living Center]. [Resident #2] has a 5 cm superficial abrasion to her scalp in the middle of the back of her head which is elevated. Resident did not want to hold a cold pack to the area. Resident did not want to sit in her recliner. She said, 'I've got to keep moving.' Resident stated she left the building with a bunch of people. Neuro checks were initiated per facility policy. Resident is on 15 minute safety checks/close observation. A prayer service was being held in the nursing home chapel and there was a large, noisy crowd of people and was a change to [Resident #2's] usual environment and routine. She talked about feeling really foolish and embarrassed about what happened. Reassurance was given numerous times -- she felt like she had done something wrong. We assured her that she had done nothing wrong."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

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F 323	Continued From page 33 The wanderguard failed to alert staff Resident #2 had exited the facility. The incident report, submitted 08/11/14 at 7:50 p.m., further identified, "At approximately 7:50 p.m., a young woman . . . brought resident [#2] into the nursing home. . . . [Resident #2] later said that she walked out of the nursing home with a bunch of people. . . . Resident [#2] is always on 15 minute checks. . . . At 7:00 p.m. there was a prayer service being held in the chapel and there was a large, noisy crowd of people. This change in routine or in her environment bothered her and she was sort of nervous. About 6:45 p.m. her wanderguard had set off the alarm to the [Assisted Living Center]. We went over and got her and returned her to her neighborhood. About 10 minutes later, her wanderguard set off the alarm at the front door where she was found in the large crowd of people in the chapel. She came back to the neighborhood again. When she left the building, her wanderguard did not set off the alarm and it did not come over the pagers. She said that she left with a bunch of people. The batteries on the wanderguards had already been checked on our shift. . . . 08/12/14 ID [identification] bracelt [sic] on wrist. . . . 08/12/14 Name tag given to resident to alert others that she is a resident at [Facility]. . . . 08/15/14 Placement to a more appropriate facility is being looked at." The 08/11/14 incident report was submitted at 7:50 p.m., and the "close record observation" log for that day showed Resident #2 was in the "hall by the kitchen" at 7:45 p.m. and "outside" at 8:00 p.m. The time the nurse documented on the incident report conflicts with the entries made by the CNAs on the "close record observation" log.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

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F 323	Continued From page 34 The progress notes identified the following: * 09/25/14 at 3:25 p.m., "[Family] updated on Elopment [sic] episode on 09/24/14 [at] 11 p.m. . . . Spoke with [Family] regarding recent elopement. She approved sending information to [another nursing home] for potential placement in their Memory Care unit. . . ." * 09/26/14 at 11:00 p.m., "Door alarm placed this shift for NOC [night]'s and per shift at nurse discretion. . ." * 09/26/14 at 11:26 p.m., ". . . Resident followed staff outside, evening of the 24th. She was assisted back into the building without further attempts." The wanderguard failed to alert staff Resident #2 had exited the facility. The incident report, dated 09/24/14, further identified, "[CNA] called to inform nurse that [Resident #2] went out the back door and [another CNA] brought her back into the building. . . . Wanderguard was checked earlier this shift and in working order. Checked again and is still in working order. . . . 09/25/14 Upon further investigation it was noted that [Resident #2] walked out after pm staff were leaving [The incident report indicated this occurred at 11:00 p.m.], using the employee exit. When [CNA] was backing out her car she noticed [Resident #2] heading towards the maintenance shop. [Another CNA] escorted Resident [#2] back into building. Alarm didn't sound related to staff exiting building and using code to exit. Continue with code alert and need for placement in a secured facility related to high risk of elopement. . . . 09/26/14 Door alarm placed during NOC shift and all other shifts per nursing discretion. . . . 09/30/14 Clarification . . . door alarm motion sensor placed to her room. . . . 09/30/14 Moving to [another	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 35 facility]." The 09/24/14 incident report was submitted at 11:00 p.m., and the "close record observation" log for that day showed Resident #2 was in the "hallway" at 10:45 p.m. and "outside" at 11:00 p.m. The time the nurse documented on the incident report conflicts with the entries made by the CNAs on the "close record observation" log. During an interview on 09/30/14 at 5:00 p.m., a nurse (#16) reported, "The only way to get to [Assisted Living Center] is through the tunnel." She explained, "It requires a key or phone [to be] beeped in [if you try to enter the building from the outside.]" She also indicated the wanderguard should sound when exiting the facility, but would not sound when entering the facility from the Assisted Living Center. During an interview on 09/30/14 at 5:15 p.m., an administrative nurse (#1) walked the surveyor through the tunnel and explained where each of the nine doors in the tunnel led. One door led to the Assisted Living Center, one led to a flight of stairs, three led to adjoined garages, and one led outdoors, and once closed would not allow re-entry. During an interview on 10/01/14 at 2:40 p.m., two administrative staff members (#1 and #17) and three managerial staff members (#7, #13, and #18) reported "up until this summer [Resident #2] always went to the [(Assisted Living) Center] which is staffed 24 hours a day." They stated, "We got serious about a locked unit after she got outside. After she followed three staff members out into the parking lot, we had to do something. Her family wasn't happy. They wanted her to stay,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 36 but she's not safe here." They also explained "[Resident #2] doesn't look like a resident. [She] followed the crowd out the front door after attending the service in the chapel. Once the front door is opened it doesn't alarm." They described 19th street as a "high traffic" area, and reported the resident was returned to the facility "[with]in 15 minutes." The facility's "elopement" policy failed to address the need for an investigation focusing on how the resident was able to exit the facility unsupervised, and failed to address any interventions required to prevent a reoccurance. The facility failed to revise the resident's care plan if/when they initiated a new intervention (an identification bracelet, a name tag, and/or motion sensor.) The nursing staff failed to complete incident reports for two of Resident #2's elopements on 12/27/13. The CNA staff failed to monitor Resident #2's whereabouts every 15 minutes. The nursing documentation on the incident report conflicts with the entries made by the CNAs on the "close record observation" logs. The wanderguard failed to alert staff Resident #2 had exited the facility on eight separate occasions, and was outdoors on three of the eight occasions. The facility failed to provide adequate supervision and/or evaluate the effectiveness of the interventions they had put in place, which allowed Resident #2 to elope from the facility, and on one of those occasions sustained a head injury. GAIT BELT/MECHANICAL (EZ STAND) LIFT TRANSFERS 3. Based on observation, record review, review of operating instructions, review of facility policy, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 37	F 323		

accidents for 2 of 8 residents (Resident #3 and #9) who required extensive staff assistance for transfers. Failure to properly use a sit-to-stand (E-Z Stand) lift (Resident #3) and gait belt (Resident #9) increased the risk for falls, pain, and injury to residents.

Findings include:

Review of the facility policy titled "Mandatory Lift" occurred on 10/02/14. This policy, dated April 2014, stated, "POLICY: Gait Belts or mechanical lifts will be used for all residents requiring assistance with transfers . . . PROCEDURE: The nursing or therapy staff will evaluate individual resident's ability to assist with transfer . . . Gait belts should be used with all assisted transfers unless contraindicated or resident refusal. . . ."

- Review of Resident #9's medical record occurred on September 29-30, 2014 and diagnoses included dementia and chronic pain. The current care plan stated, "Focus: Decreased ADL [Activities of Daily Living] function . . . Intervention: . . . extensive to total assist with bed mobility, transfers and ambulation depending on her day. . . ."

Observation on 09/30/14 at 3:55 p.m. identified two certified nursing assistants (CNAs) (#5 and #6) transferred Resident #9 from her wheelchair to the toilet using a gait belt. Both CNAs (#5 and #6) held the gait belt with one hand and lifted under Resident #9's arms with their other hand.

Observation on 09/30/14 at 4:05 p.m. identified two CNAs (#5 and #6) assisted Resident #9 from the toilet to her wheelchair using a gait belt. One CNA (#6) lifted under Resident #9's arm to assist

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F 323	Continued From page 38	F 323		

her to a standing position from the toilet. As Resident #9 ambulated to her wheelchair, observation showed the gait belt was loose and bunched up in the CNA's hand.

During an interview on the afternoon of 10/02/14, an administrative nurse (#2) stated staff should grasp the gait belt during transfers and avoid pulling on the resident's arms.

Review of the manufacturer's guideline "EZ Stand Operating Instructions" occurred on 10/02/14. The instructions, revised January 2001, stated, ". . . The EZ Stand was designed specifically for toileting and changing briefs of patients. The EZ Stand can also be used for transferring the patient from chair, wheelchair or bed. . . . Patients should be able to bear some weight."

- Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included chronic airway obstruction and osteoarthrosis. The admission Minimum Data Set (MDS), dated 08/01/14, identified intact cognition and need for extensive assistance of two or more persons for transfers.

The current care plan addressing Resident #3's transfer needs identified, ". . . Interventions: . . . [Resident #3] requires extensive assistance for transfers with use of standing lift. . . . Stand lift at all times. . . ."

Observations showed the following:
* 09/30/14 at 12:35 p.m., a CNA (#11) transferred Resident #3 from the toilet to his wheelchair using the EZ Stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward

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F 323	Continued From page 39 into Resident #3's axillae (armpits), his shoulders raised to ear level. * 09/30/14 at 3:30 p.m., a CNA (#12) transferred Resident #3 from his wheelchair to the bed using the EZ Stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #3's axillae, his shoulders raised to ear level. Staff failed to cue Resident #3 to stand, ensure he was able to bear weight throughout the stand lift transfer, and report his inability to bear weight to the nurse. - Observation on 10/02/14 at 11:05 a.m. showed a CNA (#9) assisting Resident #14 from her wheelchair to the toilet utilizing a stand lift. While securing the harness hook to the end of the EZ Stand arm, she discovered a missing "safety stopper" on the right side. Using her pager, the CNA (#9) requested assistance and an unidentified CNA came to the resident's room to give her (#9) the safety stopper she had removed from another EZ Stand located at the nurses station. Per request, following cares, the CNA (#9) showed this surveyor the EZ Stand with the missing "safety stopper." The unidentified CNA had failed to label the machine "disabled" after removing the "safety stopper," and the EZ Stand remained available for use. Upon inspection, it was discovered that both "safety stoppers" were missing from the machine. During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed a resident should be able to bear his/her own weight if a sit-to-stand lift is used. She also confirmed equipment should be labeled "disabled" if parts are missing.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441 Infection Control, Prevent Spread, Linens** 1. Regarding residents #1, #2, #7 and #9, staff have been educated as follows: Hand hygiene is to be completed before and after caring for each resident, before serving fluids and after using the toilet. Hand hygiene is also to be completed after removal of gloves. Dates of Education: 10/06/14 Acorn Lane Meeting; 10/13/14 Bison Lane Meeting; 10/16/14 Professional Nurses Meeting; 10/20/14 Cottonwood Lane Meeting; 10/23/14 C.N.A. Meeting; 10/27/14 Dakota Lane Meeting. 2. All residents in the facility have the potential to be affected. 3. All staff will be educated on proper hand hygiene during All Staff Meeting 11/06/14.	11-14-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 4 of 14 sampled residents (Resident #1, #2, #7, and #9) observed during perineal cares. Failure to perform hand hygiene after assisting with perineal care may result in the spread of infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Perineal Care With or Without a Catheter" occurred on 10/02/14. This policy, revised April 2013, stated, ". . . Procedure: . . . 7. Wash your hands . . . 9 . . . a. Put on gloves . . . d. Separate labia, washing front to back . . . h. Remove gloves and put in plastic bag. i. Wash your hands. . . ." - Observation on 09/30/14 at 4:00 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) checked and changed Resident #7's brief as she lie in bed. Observation showed the resident was incontinent of urine and stool, and a CNA (#6) provided perineal cares. The CNA (#6) then removed the gloves, placed a clean brief on the resident, pulled up the resident's pants, and placed a mechanical lift sling under the resident. As Resident #7 remained in bed, the CNA (#6) donned gloves and entered the bathroom to assist the resident's roommate (Resident #9) with toileting. The CNA (#6) provided perineal cares, placed a new brief, removed her gloves, pulled Resident #9's pants up, and then washed her hands. The CNA (#6) failed to perform hand hygiene after providing perineal cares to Resident #7 and prior to assisting Resident #9.	F 441	4. A QA tool has been developed and will be completed by nurse manager or staff RN/LPN, weekly x 1 month, monthly x 3 months and quarterly thereafter. The QAPI Manager will review the findings and report to the QAPI Committee for review and potential further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	10/02/2014

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F 441	Continued From page 42 Review of the facility policy titled "Hand Hygiene" occurred on 10/02/14. This policy, revised March 2013, stated, ". . . HAND HYGIENE SHOULD BE PRACTICED: . . . Before and after caring for each resident. . . . before serving fluids. . . . After using the toilet . . ." - Observation on 09/30/14 at 10:20 a.m., showed a CNA (#11) assisting Resident #1 to stand-pivot into bed. The CNA (#11) gloved, lowered the resident's clothing, provided pericares, removed her gloves, rubbed her hands with hand sanitizer, placed a new brief, adjusted the resident's clothing, gave her a drink of water, and exited the room. The CNA failed to wash her hands before serving fluids and prior to exiting the resident's room. - Observation on 09/30/14 at 11:40 a.m., showed a gloved CNA (#11) lowered Resident #1's clothing, checked the inside of the resident's brief with her gloved hand, and removed her gloves. The two CNAs (#11 and #19) placed a gaitbelt around the resident's waist before stand-pivoting her from the bed into her wheelchair. The two CNAs (#11 and #19) then combed her hair and offered her a drink of water. The CNA (#11) failed to wash her hands before serving fluids and prior to exiting the resident's room. - Observation on 10/01/14 at 11:00 a.m., showed a CNA (#15) assisting Resident #2 in the bathroom. Resident #2 provided her own pericares after voiding in the toilet. The CNA (#15) helped her to adjust her clothing, removed his gloves, washed his hands, and exited the bathroom with the resident. The CNA failed to ensure Resident #2 also washed her hands prior	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 43 to exiting the bathroom. During an interview on the morning of 10/02/14, a managerial nursing staff member (#13) confirmed staff are expected to wash and/or assist the resident to wash their hands after pericares/removing their gloves, before serving fluids, and prior to exiting the resident's room.	F 441		