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 _____	10/20/2016

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 October 17, 2016 and completed on October 20, 2016, the sample included five (5) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		11/24/16

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

Electronically Signed | 11/11/2016

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately notify the resident's physician for 1 of 1 closed record resident (Resident #18) who experienced a significant decline in nutritional status. Failure to promptly notify the physician regarding Resident #18's poor meal and fluid intake may have contributed to his continued weight loss/dehydration. Findings include: Review of Resident #18's medical record occurred on October 19-20, 2016. Resident #18 was admitted to the facility on 02/25/16. Diagnoses included down syndrome with profound intellectual disabilities. The admission Minimum Data Set (MDS), dated 03/03/16, identified severely impaired cognition and extensive-to-total assistance of one or more persons for all activities of daily living (ADLs). The care plan, dated 02/26/16, identified, ". . . Self Care deficit r/t [related to] Down Syndrome . . . Eating: Extensive . . . Potential alteration in nutrition r/t weakness, lethargy . . . Dietary evaluation, Eats in Dining room, Monitor and record meal intakes, Not approved for a PFA [paid feeding assistant], Weight on admission two times per week for 2 weeks. . . ."	F 157	1. Resident #18 has since discharged so no correction possible. 2. Any resident that experiences a change in condition has the potential to be affected. 3. An inservice by the Director of Nursing, addressing circumstances that require notification to the resident's physician, legal representative or family member will be conducted at a mandatory nurses meeting, which will be held on 11-17-16. 4. The QA director or designee will conduct a random audit of ten (10) residents weekly for ten (10) weeks, then monthly thereafter, starting 10-31-16. The results will be discussed at the monthly Quality Assurance meetings with action and follow-up as necessary. These residents will be assessed to ensure that the notification of changes was made to the appropriate party in a timely manner.	

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F 157	Continued From page 2	F 157		

Resident #18's hospitalization record identified the following:
* Admission report, dated 01/28/16, ". . . This gentleman was transferred here from [local hospital] in regard to a small-bowel obstruction. . . ."
* Progress note, dated 02/22/16, ". . . He appears well-developed and well-nourished. No distress. . . . Small Bowel Obstruction - Resolved. . . ."

The physician's progress note, dated 02/26/16, identified, "[Resident #18] is admitted to the nursing home. . . . He actually has done pretty well here. . . . The staff really does not have any concerns as to how he is getting along. . . ."

The interdisciplinary progress note, dated 03/07/16, identified, ". . . [Resident #18's] . . . . care providers wanted to ensure that [name of provider] would continue to be his primary care physician. . . ."

Resident #18's weight report identified the following:
* 02/25/16, 110 pounds (weight upon admission to the facility)
* 03/10/16, 108 pounds
* 03/18/16, 102 pounds (-8.0 pounds = -7.2% severe weight loss in 23 days) The record failed to show staff notified Resident #18's physician regarding his -8.0 pounds = -7.2% severe weight loss 03/18/16.

The "Fax Tracking Log" identified a fax had been sent to Resident #18's physician on 03/22/16. The "issue/concern" read, "FYI [not] eating drinking . . ." The log failed to identify when [what time of day] the fax was sent and/or the

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F 157	Continued From page 3 physician's response. Resident #18's weight report also identified the following: * 03/23/16, 99 pounds (-11.6 pounds = -10.5% severe weight loss in 28 days) * 03/24/16, 94 pounds (-16.6 pounds = -15% severe weight loss in 29 days) The interdisciplinary progress note, dated 03/23/16, identified, "Continues to eat and drink poorly. Today's weight was 99.0 lbs [pounds]. Will do a reweight tomorrow and update MD [medical doctor] of weight loss if weight is accurate." The record failed to show staff notified Resident #18's physician regarding his -16.6 pounds = -15% severe weight loss on 03/24/16. Failure to notify the physician regarding Resident #18's poor meal and fluid intake may have contributed to his continued weight loss/dehydration.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and review of the facility's policy and procedure, the facility failed to provide care for 1 of 17 sampled residents (Resident #3) and 3 supplemental residents (Resident #14, #21, and #22) in a manner and environment that	F 241	1. Resident #22 has discharged from the facility. For Resident #3, #14, and #21, Lane nursing and housekeeping staff were immediately educated on the importance of dignity and respect of	11/24/16

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F 241	Continued From page 4 maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors or wait for a reply before entering a resident's room (Resident #3, #14, #21, and #22) and failure to feed a resident in a dignified manner (Resident #3) does not promote residents' dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Standards of Care" occurred on 10/20/16. This policy, revised 02/05/15, stated, " . . . EACH RESIDENT IS ALWAYS TREATED WITH DIGNITY AND RESPECT. . . . Knock and identify yourself upon entering the room. Give resident time to respond. . . ." - During the initial tour on 10/17/16 at 10:50 a.m., an unidentified housekeeping staff member entered two resident rooms on the B wing without knocking/announcing herself and waiting for a response from the residents (Resident #14, #21, and #22) who resided in those rooms. - Observations showed the following: * 10/17/16 at 5:50 p.m., a certified nursing assistant (CNA) (#8) stood over Resident #3 as she attempted to feed her supper in her room. * 10/18/16 at 5:30 p.m., a CNA (#8) stood over Resident #3 as she attempted to feed her supper in her room. * 10/19/16 at 8:29 a.m., showed two CNAs (#4 and #9) provided personal cares for Resident #3. During the cares, an unidentified CNA knocked on the resident's door and, without waiting for permission, entered Resident #3's room.	F 241	individuality with regards to knocking on residents' doors following the survey. For Resident #3, Acorn Lane staff was educated on the importance of sitting while assisting those residents that require assistance with eating. 2. All residents have the potential to be affected by staffs' failure to respect their privacy by knocking on doors. Any resident requiring assistance at meal time has the potential to be affected by the above mentioned incorrect feeding position. 3. An in-service will be conducted at the mandatory all-staff meeting on 11-10-16, mandatory nurses meeting 11-17-16, mandatory CNA meeting 11-23-16 and mandatory housekeeping meeting on 11-15-16; in regards to respecting resident privacy and dignity, focusing on the above issues. 4. The QA director or designee will make random observations of 20 staff weekly, across all shifts and departments, monitoring knocking on doors appropriately, for ten (10) weeks, then monthly thereafter, beginning 10-31-16. QA director or designee will make random observations of ten (10) residents who receive assistance with feeding, weekly for ten (weeks), and monthly thereafter, beginning 11-18-16. The results will be discussed at the monthly quality assurance meeting and appropriate action will be taken if indicated.	

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F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) in a timely manner for 1 of 7 sampled resident (Resident #12). Failure to complete a SCSA in a timely manner, delays the facility in obtaining the assessment information necessary to develop a care plan and to provide the appropriate care and services for the residents. Findings include: The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 2, pages 20 and 22, stated, "Significant Change in Status Assessment	F 274	1. This is a one-time occurrence. For identified Resident #12, the assessment was signed late, so no correction is possible. 2. Any resident requiring a significant change in status assessment has the potential to be affected. 3. All MDS coordinators were educated on 10-18-16 regarding the required time frames for signing off on significant change assessments. 4. The QA director or designee will conduct a random audit of ten (10) residents weekly for ten (10) weeks, then monthly for three months and quarterly	11/24/16

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F 274	Continued From page 6 (SCSA) (A0310A=04): The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary team] has determined that a resident meets the significant change guidelines for either improvement or decline. . . . The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD [Assessment Reference Date] (ARD + 14 calendar days) and no later that 14 days after the determination that the criteria for a SCSA were met. . . ." Review of Resident #12's SCSA MDS showed an ARD of 08/15/16. The MDS completion date at Z0500B was 9/13/16 (ARD + 29 days). During an interview on the morning of 10/20/16, an administrative nurse (#13) confirmed the late completion of Resident #12's Significant Change in Status MDS.	F 274	thereafter, starting 10-31-16. The results will be discussed at the monthly quality assurance meeting and monthly at the quality indicators meeting, and appropriate action will be taken if indicated.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		11/24/16

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F 279	Continued From page 7 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop nutritional care plans for 2 of 17 sampled residents (Resident #3 and #4) identified with significant weight loss. Failure to develop nutritional care plans limited the staff's ability to communicate changes in the residents' status and to ensure continuity in care. Findings include: Review of the facility policy titled "Care Plan: Interdisciplinary" occurred on 10/20/16. This policy, revised May 2015, stated, " . . . Every resident has an accurate and updated Plan of Care in the clinical record that is resident focused based on resident wishes, medical information and past history. . . . Each discipline is responsible to initiate . . . problems on the Care Plan as they arise . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, depression, and glaucoma. During an interview on 10/20/16 at 3:00 p.m., a licensed/registered dietitian (#1) reported staff discuss the residents' status, possible causes for their weight loss, and intervention needs on a	F 279	1. Dietary care plans for Resident #3 and Resident #4 were developed on 10-21-16. 2. The facility has determined that all residents have the potential to be affected. 3. Registered dietician and dietary manager were reeducated on the importance of developing nutritional care plans for each resident on a timely basis on 10-21-16. 4. The QA director or designee will conduct a random audit of 10 residents' dietary care plans, weekly for ten (10) weeks, then monthly thereafter, beginning 11-17-16 to assure compliance. The results will be discussed at the monthly quality assurance meeting, the monthly quality indicators meeting, and appropriate action and follow-up will be taken if indicated.	

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F 279	Continued From page 8 weekly basis. The dietary progress notes identified the following "WEIGHT WARNINGS": * 12/31/15, -6.8 pounds = -6.8% significant weight loss in one month * 10/19/16, -13.1 pounds = -12.2% significant weight loss in six months The facility failed to develop a nutritional care plan for Resident #3 which included the interventions implemented by the facility. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease and stage 4 kidney disease. The dietary progress notes identified the following "WEIGHT WARNINGS": * 01/07/16, -13.9 pounds = -10.2% significant weight loss in six months * 10/13/16, -12.9 pounds = -11.9% significant weight loss in three months The facility failed to develop a nutritional care plan for Resident #4 which included the interventions implemented by the facility.	F 279		
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	F 280		11/24/16

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F 280	Continued From page 9 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 facility policy, and staff interview, the facility failed to review and revise the careplans for 2 of 17 sampled residents (Resident #3 and #5) and 1 of 3 closed records (Resident #18). Failure to review and revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity in care. Findings include: Review of the facility policy titled "Care Plan: Interdisciplinary" occurred on 10/20/16. This policy, revised May 2015, stated, " . . . Every resident has an accurate and updated Plan of Care in the clinical record that is resident focused based on resident wishes, medical information and past history. An interdisciplinary Care Plan Team is in effect to review and update all resident Care Plans. . . . Each discipline is responsible to	F 280	1. For Resident #3, padded side rails were placed and added to the routine care sheet and to the care plan as an intervention. In regard to Resident #5 and Resident #18, both residents have been discharged from the facility so no corrective action could be taken. 2. The facility has determined that all residents have the potential to be affected. 3. All interdisciplinary team members and licensed nursing staff will be reeducated on the importance of writing/revising care plans as changes occur. All care giving staff will be educated on the importance of following the care plans and routine care sheets. This education was done at the mandatory all-staff meeting on 11-10-16 and will be covered again at the	

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F 280	Continued From page 10 initiate, change, or discontinue problems on the Care Plan as they arise . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, history of delusional depression, and glaucoma. A fall risk care plan, dated 01/11/16, identified, ". . . Place side rails up at night or when resident is in bed. . . ." A progress note, dated 07/13/16, identified a one by two centimeter (cm) bruise to Resident #3's face. An "Injury of Unknown Origin" report, dated 07/13/16, identified, ". . . Staff . . . said that [Resident #3] lays her face against the bed rail. Will pad bed rails." Observations on all days of survey showed staff failed to pad Resident #3's bed rails when she laid in bed. During an interview on 10/20/16 at 8:30 a.m., when asked if Resident #3 required padding on her bed rails, a unit manager (#2) stated, "She should have padded side-rails." Resident #3's care plan failed to include the addition of padding to her bed rails. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included hypernatremia and reflux. A nutritional care plan, dated 09/09/16, identified, ". . . Adaptive feeding equipment [sipper cup] . . ." Observations on all days of survey showed	F 280	mandatory licensed nurses' meeting on 11-17-16, mandatory dietary meetings on 11-17-16 and mandatory CNA meetings on 11-23-16. 4. The QA director of designee will conduct a random audit of ten (10) care plans weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16. The results will be discussed at the monthly quality assurance meeting and monthly at the quality indicators meeting and the appropriate action and follow up will be taken if indicated.	

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F 280	Continued From page 11 Resident #5 drank liquids from a straw or directly from a regular glass/cup. Resident #5's care plan failed to include the addition of straws and regular glasses/cups. - Review of Resident #18's medical record occurred on October 19-20, 2016. Diagnoses included down syndrome with profound intellectual disabilities. A nutrition care plan, dated 02/26/16, identified, ". . . Dietary evaluation, Eats in Dining room, Monitor and record meal intakes, Not approved for a PFA [paid feeding assistant], Weight on admission two times per week for 2 weeks. . . ." During an interview on 10/20/16 at 3:00 p.m., a registered dietitian (#1) reported staff discuss the residents' status, possible causes for their weight loss, and intervention needs on a weekly basis. The progress notes identified the following: * 03/07/16 at 4:44 p.m., ". . . The team met today to review [Resident #18's] care plans. . . . He will have ensure 3 times per day . . ." * 03/23/16 at 9:55 a.m., ". . . Res [Resident] receives C/B [Carnation Instant Breakfast] with meals and snacks. . . ." Resident #18's care plan failed to include the addition of Ensure and Carnation Instant Breakfast during meals/snacks.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		11/24/16

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AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

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F 281	Continued From page 12 This REQUIREMENT is not met as evidenced by: INSULIN PEN PRIMING 1. Based on observation, review of facility policy, review of manufacturer's guidelines, and staff interview, the facility failed to appropriately prime 1 of 1 insulin pen. Failure to prime insulin pens according to facility policy/manufacturer's guidelines may result in an incorrect dose of insulin. Findings include: Manufacturer's instructions for NovoLog FlexPen stated, ". . . Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing upwards, press the push-button all the way. . . The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure. . . . Selecting your dose. Check and make sure that the dose selector is set at 0. Turn the dose selector to the number of units you need to inject. . . ." Review of the facility's policy titled "Insulin Pens" occurred on 10/19/16. This policy, dated November 2015, stated, ". . . Priming the insulin pen a) Dial 2 units by turning the dose selector	F 281	1. For Resident #11, directions were added to the eMAR covering the priming of insulin pens prior to injection per manufacturer's recommendations and professional standards The nurse who was witnessed not priming the insulin pen per protocol during survey was reeducated by the director of nursing on 11-2-16 regarding proper procedure. For the residents in the survey who did not receive timely follow-up after receiving PRN pain medications, no correction is possible due to these incidents being well in the past. 2. The facility has determined that any insulin-dependent diabetic resident receiving insulin via insulin pens has the potential to be affected. The facility has determined that any resident with a physician's order for prn pain medications has the potential to be affected. 3. Any resident receiving insulin by pen will have the directions regarding priming procedure placed on the eMAR. All licensed nursing staff will be educated on priming of insulin pens according to facility policy and procedure and manufacturer instructions, as well as timely follow-up of the prn pain medication effectiveness. This was done at the mandatory all-staff meeting on 11-10-16, and again at the mandatory nurses meeting on 11-17-16.	

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F 281	Continued From page 13 clockwise b) With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. . . ." - Observation during medication pass on 10/18/16 at 8:38 a.m. showed a licensed nurse (#15) administered 8 units of NovoLog insulin to Resident #11. The nurse failed to prime the insulin pen prior to the administration. During an interview on the morning of 10/19/16, a licensed nurse (#17) stated the pens should be primed with 2 units of insulin before dialing the ordered dose. During an interview on 10/19/16 at 3:45 p.m. a nurse manager (#14) stated insulin pens should be primed with 2 units per facility policy. PRN MEDICATION FOLLOW-UP 2. Based on record review, review of facility policy and procedure, professional reference, and staff interview, the facility failed to ensure staff reassessed the response to as needed (PRN) pain medications for 7 of 14 residents (Resident #3, #5, #7, #11, #12, #13, and #16) identified with orders for PRN pain medications. Failure to timely reassess after administering a PRN pain medication limits staff's ability to assess the effectiveness of the pain medication and may result in the resident experiencing unrelieved pain. Findings include: Review of the facility policy titled "Medication -	F 281	4. The QA director or designee will conduct a random audit of twenty(20) residents receiving prn pain medications weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16. The QA director or designee will monitor licensed nursing staff for proper use of insulin pen weekly for four (4) weeks, then monthly for three months and quarterly thereafter, starting 10-31-16. The results will be discussed at the monthly quality assurance meeting and the appropriate action and follow-up will be taken if indicated.	

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PRN Administration" occurred on 10/20/16. This policy, dated February 2016, stated, ". . . Documentation should include: a. The time, drug, dose, route, reason for giving b. The time and the effect of the P.R.N. medication given -usually within 1 hour. . . ."

"Nursing 2015 Drug Handbook," 35th ed., Wolters and Kluwer, Pennsylvania, page 704, stated, "hydrocodone bitartrate-acetaminophen [Norco] . . . Pharmacologic class: Opioid. . . ." Administered oral hydrocodone has a "peak" [highest level of pain relief] at "1 1/3 hour."

Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1109, states, ". . . Opioids relieve moderate to severe pain . . . NURSING RESPONSIBILITIES * Assess pain prior to and 60 minutes after administration. . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included right hip fracture. Pain medications included Tramadol HCL 50 milligrams (mg) 1 tablet every 6 hours PRN and Ibuprofen 400 mg 1 tablet every 12 hours PRN for right acetabular fracture. Review of the eMAR (electronic medication administration record) and progress notes for September through October 10, 2016 showed Tramadol administered six times and Ibuprofen administered one time with no reassessment until 2-4 hours later.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included pelvic and perineal pain, lumbosacral

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spine and pelvis fractures. Pain medications included Morphine Sulfate 15 mg 1 tablet every 4 hours PRN for pain and Tramadol HCL 50 mg 1 tablet every 6 hours PRN. Review of the eMAR and progress notes for September through October 10, 2016 showed Morphine administered five times and Tramadol administered two times with no reassessment until 2-4 hours later.

-- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis and left proximal humerus fracture. Pain medications included Tramadol 50 mg every 6 hours PRN for left fracture proximal humerus pain. Review of the eMAR and progress notes for September 1-October 19, 2016 showed Tramadol administered 2 times with no reassessment until 4-8 hours later.

- Review of Resident #11's medical record occurred on all days of survey. Diagnoses included osteoarthritis, neuropathy, cellulitis and knee pain. Pain medications included Acetaminophen 325 mg 2 tablets every 4 hours as needed for pain and Hydrocodone-Acetaminophen 5-325 mg 1 to 2 tablets every 6 hours PRN times (x) 7 days. Review of the eMAR and progress notes for March through April 26, 2016 showed Acetaminophen administered 23 times with no reassessment until 2-6 hours later, and Hydrocodone-Acetaminophen administered 10 times with no reassessment until 2-5 hours later.

- Review of Resident #12's medical record occurred on all days of survey. Diagnoses included osteoarthritis, polymyalgia rheumatica

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and chronic pain. Pain medications included oxycodone-acetaminophen 5-325 mg 1 tablet PRN for pain, no more than 3 tablets given in a 24 hour period. Review of the eMAR and progress notes for October 1-19, 2016 showed oxycodone-acetaminophen administered 6 times with no reassessment until 2-4 hours later and twice with no follow up.

- Review of Resident #13's medical record occurred on October 19-20, 2016. Diagnoses included polyosteoarthritis. Pain medications included hydrocodone-acetaminophen 5-325 mg 1 tablet PRN for pain. No more than 3 tablets given in a 24 hour period to comply with 3000 mg maximum dose order. Review of the eMAR and progress notes for October 1-19, 2016, showed hydrocodone-acetaminophen administered 32 times with no reassessment until 2-4 hours later.

- Review of Resident #16's medical record occurred on October 19-20, 2016. Diagnoses included migraines and spasmodic torticollis (head/neck condition which can cause pain). Pain medications included Tramadol HCL 50 mg 1 tablet every 6 hours PRN for pain level of 1-5 and 2 tablets for pain level of 6-10. Review of the eMAR and progress notes for September through October 10, 2016 showed Tramadol administered eleven times with no reassessment until 2-4 hours later and one time with no follow-up completed.

During an interview on 10/17/16 at 4:40 p.m. a licensed nurse (#18) stated after giving a PRN pain medication the nurse should follow-up and document in the eMAR the effectiveness of the medication about one hour later.

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interviews, the facility failed to ensure 3 of 17 sampled residents (Resident #3, #6 and #12) received the necessary care and services. Failure to ensure Resident #3's proper positioning for fluid intake, Resident #3 and #6 had padded side rails, Resident #6 had right wheelchair arm tray table, and Resident #12 had TED (Thrombo-Embolic Deterrent) hose applied, may result in residents not achieving or maintaining their highest level of physical well-being. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 125, 128, and the educational handouts, identified, ". . . Signs of oral phase dysphagia include . . . losing . . . liquid out the front of the mouth . . . During the oral intake of . . . liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of	F 309	1. For Resident #3, the CNA involved was educated on 11-1-16 by the nurse manager regarding the potential seriousness of the complications due to improper technique when administering food and/or fluids. For Residents #3 and #6, the side rails were padded and for Resident #6 the wheelchair arm tray table was placed on the resident's wheelchair. The CNAs involved were re-educated on 10-19-16 on the importance of following through with interventions as care planned. Resident #12 had TED hose discontinued due to her regular refusal to wear them. 2. The facility has determined that all residents have the potential to be affected. 3. All staff were educated on the importance of proper positioning of residents when administering food and/or drink, and on ensuring specific resident interventions are implemented as care	11/24/16

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F 309	Continued From page 18 food over the back of the tongue . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, history of delusional depression, and glaucoma. The significant change Minimal Data Set (MDS), dated 10/05/16, identified severely impaired cognitive skills, supervision from one person required during meals, and extensive assistance of two or more persons required for bed mobility. The care plan, dated 01/11/16, identified, ". . . Decreased ADL [Activities of Daily Living] function . . . Supervision/cues needed for eating. . . . At risk for falls . . . Place side rails up at night or when resident is in bed. . . ." During an observation on 10/19/16 at 10:45 a.m., a Certified Nursing Assistant (CNA) (#4) raised Resident #3's bed to an approximate 20 degree angle before offering her a glass of water. Resident #3 drooled down the left side of her face as she drank from the glass. Staff failed to raise Resident #3's bed to an approximate 90 degree angle prior to offering her any liquids, placing her at risk of aspiration. The progress note, dated 07/13/16, identified a 1 by 2 centimeter (cm) bruise to Resident #3's face. The "Injury of Unknown Origin" report, dated 07/13/16, identified, ". . . Staff . . . said that [Resident #3] lays her face against the bed rail. Will pad bed rails."	F 309	planned during the mandatory all staff meeting on 11-10-16. Further education will take place at the mandatory nurses meeting scheduled for 11-17-16 and at the mandatory CNA meeting on 11-23-16. 4. The QA director or designee will conduct a random audit of ten (10) residents' care plans to ensure interventions are being implemented, weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16. The QA director or designee will conduct a random audit of ten (10) residents for ten (10) weeks, and monthly thereafter in regards to positioning of residents when administering food and/or drink, starting 11-18-16. The results will be discussed at the monthly quality assurance meeting and appropriate action and/or follow up will be taken if indicated.	

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F 309	Continued From page 19 Observations on all days of survey showed staff failed to pad Resident #3's bed rails. During an interview on 10/20/16 at 8:30 a.m., when asked if Resident #3 required padding on her bed rails, a unit manager (#2) confirmed, "She should have padded side-rails." Staff failed to pad Resident #3's bed rails, allowing her to be at risk for further bruising. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included muscle weakness, vascular dementia with behavioral disturbance, major depression and cerebrovascular disease. The quarterly MDS, dated 07/27/16, identified extensive assistance of two persons for bed mobility, total dependence with support of two for transfers and total dependence with assist of one for locomotion. The current care plan stated, ". . . Focus: . . . potential for pressure ulcer development r/t [related to] immobility. Interventions: . . . Provide support for her (R) [right] arm during transfers and when she sits in a w/c [wheelchair] with use of w/c tray. . . . Padded side rails. . . . " Observations on October 17-20, 2016 identified no right arm tray providing support for her right arm while sitting in the w/c, and no padding on the side rails of the resident's bed: * 10/17/16 at 4:27 p.m.: Resident up in w/c. No right arm tray in place to w/c. * 10/17/16 at 4:35 p.m.: Resident transferred to bed. No padding noted to side rails. * 10/18/16 at 7:40 a.m.: Resident up in w/c. No	F 309		

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F 309	Continued From page 20 right arm tray in place to w/c. * 10/18/16 at 9:40 a.m.: Resident transferred from w/c to bed. No padding noted to side rails. * 10/18/16 at 11:35 a.m.: Resident sitting in w/c. No right arm tray in place to w/c. * 10/18/16 at 12:25 p.m.: Resident sitting in w/c in room. No right arm tray in place to w/c * 10/18/16 at 1:55 p.m.: Resident lying in bed. No padding noted to side rails. * 10/20/16 at 8:45 a.m.: Resident up in w/c. No right arm tray in place to w/c. No padding to side rails of bed. During an interview on 10/19/16 at 3:45 p.m., observations of no padded side rails and no right arm tray to w/c were identified to an administrative nurse (#2). The administrative nurse confirmed that Resident #6 was to have her side rails padded using sheep skin so Resident #6 does not get injured and that the CNA (certified nursing assistant) should be using the arm support as part of her the w/c. Observation with the administrative nurse showed no padding to the side rails and the w/c arm tray sitting on floor next to resident's bedside stand. Failure to implement the interventions care planned as above placed Resident #6 at increased risk for injury. -Review of Resident #12's medical record occurred on all days of survey. Diagnoses included hypertension. Current physician orders included the following, "09/13/2016 Compression Stockings to L [left] foot knee high on in AM off in PM every day and evening shift . . ."	F 309		

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F 309	Continued From page 21 During the following observations Resident #12 failed to have her TED stockings in place: 10/18/16, 9:20 a.m. and 4:13 p.m. 10/19/20, 8:45 a.m. and 1:20 p.m. 10/20/16 8:30 a.m. Resident #12's current care plan and "Routine Care Sheet" identified the resident needs assistance applying the TED hose. During an interview on the afternoon of 10/19/16, administrative nurse (#2) acknowledged Resident #12 has an order for TED stockings.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment, interventions, and services to promote the healing of pressure ulcers for 3 of 3 sampled residents (Resident #3, #5, and #10) with current pressure ulcers. Failure to ensure consistent implementation of interventions and treatment may have resulted in the deterioration of existing pressure ulcers for	F 314	1. For Resident #3, the Vaseline intervention for superficial pressure ulcer was placed on routine care sheet and care plan. Resident #5 discharged from the facility on 10-22-16, so no correction is possible. For the benefit and protection of Resident #10, the following actions were taken: a) The bath aide was reeducated regarding	11/24/16

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F 314	Continued From page 22 Resident #3, #5, and #10. Findings include: Review of the facility policy titled "Skin Care Protocol" occurred 10/20/16. This policy, revised September 2016, stated, " . . . efforts will be made to promote healing of the skin and tissue . . . Protocol for Pressure Area Prevention will be placed in bathroom folder . . . The Physician will be updated at the nurse's discretion if no improvement in the ulcer is Noted . . . To assure protocol follow through . . ." The facility failed to provide additional information regarding the "Protocol for Pressure Area Prevention." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included pressure ulcer to the sacrum. The significant change Minimum Data Set (MDS), dated 10/05/16, identified extensive assistance from one or more persons required for toileting and personal hygiene. The nursing progress notes identified the following: * 10/05/16, "Pressure ulcer found on res [resident's] sacrum during HS [hour of sleep] cares this evening. . . ." * 10/14/16, ". . . Author also viewed this area on 10-7-16. Size has not changed on these dates. Measurements taken today and are as follows: .5 cm [centimeters] wide x [times] .5 cm long with depth of less than .2 cm. Wound has stayed the approximate size of a pencil eraser throughout above dates. . . ." The physician's order, dated 10/06/16, identified,	F 314	not getting foot wet. b) Spray bottles of Kangen water have been labeled. c)Lane staff were educated on the importance of following the routine care sheets and to ensure that Resident #10 has blue boots on at all times. 2. The facility has determined that any resident with pressure ulcers has the potential to be affected. 3. Staff were educated on providing the necessary treatment, interventions and services to promote healing of pressure ulcers at the mandatory all-staff meeting on 11-10-16 and will be again at the mandatory nurses meeting on 11-17-16 and the mandatory CNA meeting on 11-23-16. 4. The QA director or designee will conduct an audit of all residents with pressure ulcers to ensure interventions are being implemented and followed, weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16. The results will be discussed at the monthly quality assurance meeting and the appropriate action will be taken if indicated.	

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"Vaseline to buttocks with every brief change every shift."

The pressure area care plan, dated 06/02/16, stated, ". . . Pressure area . . . Follow pressure area protocol, ROHO cushion in recliner, Treatment as ordered." The facility failed to provide additional information regarding the "pressure area protocol."

Review of a facility document (located in resident's bathroom) titled "Routine Care Sheets" occurred 10/20/16. This document, revised 10/10/16, failed to identify the following as indicated in the doctor's orders: "Vaseline to buttocks with every brief change every shift."

Observations showed the following:
* 10/18/16 at 8:35 a.m., a Certified Nursing Assistant (CNA) (#21) assisting Resident #3 with toileting cares. Observation showed the CNA (#21) failed to apply Vaseline to Resident #3's buttocks after performing pericares.
* 10/18/16 at 9:48 a.m., a CNA (#22) assisting Resident #3 with toileting cares. Observation showed the CNA (#22) failed to apply Vaseline to Resident #3's buttocks after performing pericares.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a pressure ulcer to the buttock. The admission MDS, dated 09/15/16, identified extensive assistance from one or more persons required for toileting and personal hygiene.

The progress note, dated 10/14/16, identified, ". . . Buttock . . . Wound measures 0.7 cm by 0.3 cm

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by 0.1 cm. . . ."

The current care plan stated, ". . . Pressure area . . . Follow pressure area protocol, Treatment as ordered." The facility failed to provide additional information regarding the "pressure area protocol."

The "Pressure Area Prevention Protocol," dated October 2013, identified, ". . . Products to minimize shearing/friction . . . skin sealants . . ."

During an interview on 10/18/16 at 11:40 a.m., an administrative nurse (#14) stated "Vaseline is a skin sealant. We don't have to have an order for Vaseline. It should be applied with toileting cares."

A fax sent to the physician, dated 10/07/16, identified, "Resident [#5] has a Stage II area to her (L) [left] buttocks right beside her tailbone that measures 1.3 cm [centimeters] x 4 cm. We will try Vaseline with each brief change & [and] pressure off-loading."

Review of a facility document (located in resident's bathroom) titled "Routine Care Sheets" occurred 10/20/16. This document, revised 09/28/16, failed to identify the treatment plan the staff faxed to Resident #5's physician.

Observations showed the following:
*10/18/16 at 3:30 p.m., a CNA (#20) assisting Resident #5 with toileting cares. Observation showed the CNA (#20) failed to apply Vaseline to Resident #5's buttocks after performing pericares. The CNA (#20) stated, "They [other staff members] put lotion on at night."

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* 10/19/16 at 8:56 a.m., a CNA (#19) assisting Resident #5 with toileting cares. Observation showed the CNA (#19) failed to apply Vaseline to Resident #5's buttocks after performing pericares.

- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included pressure ulcers on the left medial foot, underneath the scrotum and between buttocks, and cellulitis of the left foot. The quarterly MDS, dated 09/11/16, identified a supra pubic catheter, always incontinent of stool, two stage II pressure ulcers, total assist of two for transfers, and extensive assistance of two for bed mobility, dressing, toileting, bathing and personal hygiene.

PRESSURE ULCER TO LEFT MEDIAL FOOT
The current physician's orders stated:
* "DO NOT get Foot Wound Wet."
* "check placement of left foot dressing every shift to see if dressing is dislodged."
* " . . . may change outer dressing if foot wound is heavily draining, but leave the Grafix . . . in place.
* "Grafix applied to L [left] foot. May change outer dressing if wound is heavily draining but leave Grafix in place . . . RTC [return to clinic] 1 week (10/19/16 2pm)."

Discharge Instruction Details (Wound Care) from a local hospital, dated 10/12/2016, indicated, " . . . Should you experience any significant changes in your wound(s) or have any questions regarding your home care instructions please contact the wound center . . . if you have any signs and symptoms of infection as unusual increased drainage, increasing odor . . . please

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F 314	Continued From page 26 notify your PCP [primary care provider] or go to the ER [emergency room] . . . Wound Cleansing & Dressings . . . Right Gluteus Apply thin film of Barrier ointment [Desitin zinc] to protect skin surrounding the wound . . . reapply EACH time the brief is changed . . . Left Medial Malleolus [bone located on the inside of the ankle] . . . do not get the wound or dressing wet . . . Keep the wound and dressing dry . . . DO NOT CHANGE DRESSING UNTIL THE NEXT WOUND CLINIC VISIT . . . Grafix has been applied to the wound. Keep this in for a week. If the dressing become [sic] saturated . . . return to the wound center . . ." The current care plan stated, " . . . Focus: Pressure area to (L) [left] foot and moisture r/t [related to] skin breakdown . . . and decreased mobility . . . Interventions: . . . Follow pressure area protocol . . . Follow up with wound clinic as ordered . . . Treatment as ordered . . . Focus: Cellulitis of (L) foot . . . Interventions . . . Elevate extremity as much as possible . . . Monitor each shift . . . Update medical doctor [MD] as needed . . ." The facility failed to provide additional information regarding the "pressure area protocol." Review of a facility document (located in resident's bathroom) titled "Routine Care Sheets" occurred 10/20/16. This document, revised 06/07/16, failed to identify the following as indicated in the doctor's orders: "Left Medial Malleolus . . . do not get the wound or dressing wet . . . Keep the wound and dressing dry . . . DO NOT CHANGE DRESSING UNTIL THE NEXT WOUND CLINIC VISIT . . ." The current assessment form "PRESSURE	F 314		

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F 314	Continued From page 27 ULCER/WOUND RECORD" for the left medial foot showed: * 10/11/16 "Length 1 cm, Width 0.9 cm, Depth . . . 0.3 cm, Serosanguineous [drainage containing serum and blood], no odor, Macerated . . ." * 10/18/16 following wound care procedure on 10/12/16, "Length 2 cm, Width 1.8 cm, Depth (Stage 3) 1 cm . . . Necrotic [dead tissue] sloughing . . . Strong odor . . ." Observations showed the following: * 10/17/16 at 3:50 p.m., Resident #10 laid in bed with his left foot resting directly on the mattress. * 10/18/16 at 9:25 a.m., a CNA (#12) removed Resident #10's ace wrap from the left lower leg. Observation showed part of the outer dressing not secure on the left foot, and a foul odor present. * 10/18/16 at 9:45 a.m., a CNA (#23) completed Resident #10's shower with the outer wound dressing not secure and the dressing/foot not covered to keep dry. Observation showed Resident #10 sat in the shower chair with the left foot uncovered and the resident incontinent of a bowel movement (BM) on the floor of the shower. * 10/18/16 at 10:05 a.m., a staff nurse (#15) entered Resident #10's room after his shower and verified the left foot outer dressing was not secure, was saturated, and a foul odor present. The staff nurse (#15) informed Resident #10 they would need to send him to the wound clinic today. Observation showed the saturated dressing remained on the left foot and the staff nurse (#15) wrapped the left foot with an ace wrap. * 10/18/16 at 2:40 p.m., Resident #10 laid in bed with his left foot resting directly on the mattress. Staff failed to elevated the left foot.	F 314		

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* 10/18/16 at 4:30 p.m., a staff nurse (#16) informed Resident #10 he would not be going to the wound clinic today to change the dressing on his left foot.

During an interview on 10/18/16 at 4:55 p.m., a nurse manager (#13) confirmed Resident #10 did not go to the wound clinic today. The left foot should have been covered during the shower and the staff nurse applied a different dressing (Prisma) until Resident #10 could be seen on 10/19/16 at the wound clinic tomorrow.

During an interview on 10/20/18 at 2:05 p.m., a nurse manager (#13) identified the Grafix dressing is applied by the wound nurse and the Prisma dressing is a collagen dressing used at their facility. The nurse manager (#13) confirmed the wound nurse or doctor did not give orders before the staff nurse (#15) changed the dressing and applied the Prisma dressing on Resident #10's left foot.

BUTTOCKS AND SCROTUM
The current physician's orders stated:
* "Cleanse buttocks and scrotum with Kangen Water. Then apply Desitin to buttocks and scrotum with each brief change . . ."

The current care plan stated, " . . . Focus: . . . moisture r/t [related to] skin breakdown (R) [right] buttocks r/t poor circulation, moisture and decreased mobility . . ."

Review of a facility document (located in resident's bathroom) titled "Routine Care Sheets" occurred 10/20/16. This document, revised 06/07/16, failed to identify the following as

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indicated in the doctor's orders: "Right Gluteus Apply thin film of Barrier ointment to protect skin surrounding the wound . . . Desitin zinc ointment. reapply EACH time the brief is changed . . ."

The current assessment form "PRESSURE AREA/ULCER/WOUND RECORD" for between the buttock showed:
* 10/04/16 "Length 20 cm, Width 8 cm, red, serous drainage . . ."
* 10/11/16 "Length 20 cm, Width 17 cm, red, inflamed . . ."

The current assessment form "PRESSURE AREA/ULCER/WOUND RECORD" for under the scrotum showed:
* 10/11/6 "Length and width - scattered areas, red, granulation, serous drainage, and painful."

Observations showed the following:
* 10/17/16 at 3:50 p.m., two CNAs (#6 and #7) provided Resident #10 with perineal cares. The CNA (#7) removed an incontinent brief soiled with stool and 4 by 4 dressing from between Resident #10's buttocks and underneath the scrotum. The CNA (#7) cleansed Resident #10's buttock and underneath the scrotum with a premoistened disposable wipe and then sprayed the area with a bottle labeled Kangen water. Observation showed the pressure ulcer on Resident #10's buttock inflamed, and underneath the scrotum two small inflamed areas. The CNA (#7) placed a folded 4 by 4 dressing in between the buttock and underneath the scrotum and applied a clean brief. Observation showed the CNA (#7) failed to apply Desitin around Resident #5's pressure ulcers on the buttocks and underneath the scrotum with the brief change

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F 314	Continued From page 30 after performing pericares. * 10/18/16 at 4:30 p.m., two CNA's (#7 and #24) provided Resident #10 with perineal cares. The CNA (#7) removed Resident #10's brief soiled with stool. A staff nurse (#16) provided pressure ulcer cares to Resident #10. When asked what was in the unlabeled spray bottle, the staff nurse stated, "I'm not sure if it's normal saline or water." The staff nurse (#16) sprayed the resident's buttocks with the contents of the unknown, unlabeled spray bottle. Resident #10 stated, "I would like a second opinion to heal up these ulcers. This has been going on way too long, they should have healed by now." The staff nurse (#16) applied desitin to the surrounding skin of the pressure ulcer on Resident #10's buttocks and underneath the scrotum. The staff nurse (#16) placed a folded 4 by 4 dressing between the buttock and underneath the scrotum and then the two CNAs (#7 and #24) applied a clean brief. Failure to ensure consistent implementation of interventions and treatment may have resulted in the deterioration of existing pressure ulcers for Resident #3, #5, and #10.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		11/24/16

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F 323	Continued From page 31 by: Based on observation, record review, and review of facility policy, the facility failed to provide adequate supervision and assistive devices for 1 of 4 sampled residents (Resident #3) with a fracture. Failure to ensure proper bed positioning has the potential to place residents at risk for possible falls with/without injury. Findings include: Review of the facility policy titled "Standards of Care" occurred on 10/20/16. This policy, revised 02/05/15, stated, " . . . Keep bed in assigned position when resident in bed . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included right hip fracture. The significant change Minimum Data Set (MDS), dated 10/05/16, identified severely impaired cognition and extensive-to-total assistance from two or more persons required for bed mobility and transfers. The progress notes identified the following: * 01/29/16, 01/30/16, 03/29/16, and 04/08/16, Resident #3 fell. In each instance, staff found her near/next to her bed. * 05/12/16, Resident #3 crawled out of her bed. * 09/23/16, "Resident's roommate had her call light on and was out in hall yelling for help as she had gotten up and found resident [#3] lying on the floor. Resident [#3] lying on her left side on the floor parallel to bed. . . . Resident with c/o [complaint of] right hip pain. . . . Resident assisted to feet to stand with walker by 2 staff. Resident unable to stand/put weight on right leg. Complained of severe pain when attempted.	F 323	1. Lane staff was reeducated on 10-27-16 on the importance of making sure Resident #3's bed is in the low position after cares are provided and before staff exits the room. 2. The facility has determined that any resident who has an intervention of a low bed has the potential to be affected. 3. Education was provided to staff at the mandatory all-staff meeting on 11-10-16 and further education will be provided at the mandatory nurses meeting on 11-17-16 and the mandatory CNA meeting on 11-23-16. 4. The QA director of designee will conduct an audit of all residents who are care planned for having their bed in the low position weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16 The results will be discussed at the monthly quality assurance meeting and the appropriate action and follow-up will be taken if indicated.	

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F 323	Continued From page 32 Resident assisted to sit on seat of walker. Called on-call MD [medical doctor] and obtained order to send resident to ER [emergency room]. . . . updates were given . . . fractured right hip reports from them. . . ." The fall risk care plan identified staff added "Low bed" to Resident #3's care plan on 09/26/16. Observation on 10/18/16 at 9:48 a.m. showed a Certified Nursing Assistant (CNA) (#22) raised Resident #3's bed into a high position and provided pericares. Following the cares, the CNA (#22) lowered the bed approximately 2 inches (leaving the bed in a thigh-high position) before exiting the room. The CNA (#22) failed to ensure Resident #3's bed was in a low position prior to exiting the room, leaving Resident #3 at risk of an additional fall with/without injury. Additional observations throughout the survey showed Resident #3's bed in the low position.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		11/24/16

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F 325	Continued From page 33 by: Based on record review and staff interview, the facility failed to ensure 1 of 1 closed record resident (Resident #18) identified with severe weight loss, received the necessary care and services in a timely manner to maintain adequate nutritional status. Failure to assess for underlying causative factors, implement appropriate and effective interventions, and promptly notify the physician regarding the resident's poor intake, resulted in Resident #18 experiencing an unplanned severe weight loss in less than one month. Findings include: Review of Resident #18's medical record occurred on October 19-20, 2016. Resident #18 was admitted to the facility on 02/25/16. Diagnoses included down syndrome with profound intellectual disabilities. The admission Minimum Data Set (MDS), dated 03/03/16, identified severely impaired cognition and extensive-to-total assistance of one or more persons for all activities of daily living (ADLs). The care plan, dated 02/26/16, identified, ". . . Self Care deficit r/t [related to] Down Syndrome . . . Eating: Extensive . . . Potential alteration in nutrition r/t weakness, lethargy . . . Dietary evaluation, Eats in Dining room, Monitor and record meal intakes, Not approved for a PFA [paid feeding assistant], Weight on admission two times per week for 2 weeks. . . ." Resident #18's hospitalization record identified the following: * Admission report, dated 01/28/16, ". . . This	F 325	1. Resident #18 is no longer at the facility, therefore no corrective action is possible for him. 2. The facility has determined that all residents at risk for weight loss have the potential to be affected. 3. A tracking tool will be developed for use by dietary and nursing staff to monitor resident intake of less than 25% at any meal and appropriate intervention will be implemented as indicated. All staff were educated at the mandatory all staff meeting on 11-10-16 and nursing staff will be further educated at the mandatory nurses meeting on 11-17-16, at the mandatory CNA meeting on 11-23-16. Dietary staff will be further educated at the mandatory dietary department meeting on 11-17-16. 4. The QA director or designee will conduct a random audit of ten (10) residents weekly for ten (10) weeks, then monthly thereafter, starting 10-31-16. The results will be discussed at the monthly quality assurance meeting and the appropriate interventions and follow up will be taken if indicated.	

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gentleman was transferred here from Jamestown in regard to a small-bowel obstruction. . . ."
* Progress note, dated 02/22/16, ". . . He appears well-developed and well-nourished. No distress. . . . Small Bowel Obstruction - Resolved. . . ."

The physician's progress note, dated 02/26/16, identified, "[Resident #18] is admitted to the nursing home. He has had problems with an ileus following a redo of a colostomy and bowel obstruction. . . . He actually has done pretty well here. . . . The staff really does not have any concerns as to how he is getting along. . . ."

During an interview on 10/20/16 at 3:00 p.m., a licensed/registered dietitian (#1) reported the "Point Click Care" program generates a "Nutrition/Weight Change" report which staff utilize during the weekly "Nutrition-At risk" meetings. Staff discuss the resident's status, possible causes for weight loss, and intervention needs.

Resident #18's weight report identified the following:
* 02/25/16, 110 pounds (weight upon admission to the facility)
* 03/10/16, 108 pounds
* 03/18/16, 102 pounds (-8.0 pounds = -7.2% severe weight loss in 23 days)
* 03/23/16, 99 pounds (-11.6 pounds = -10.5% severe weight loss in 28 days)
* 03/24/16, 94 pounds (-16.6 pounds = -15% severe weight loss in 29 days)

The interdisciplinary progress notes identified:
* 02/25/16 at 3:20 p.m., ". . . [Group home] staff . . . are really hoping that [Resident #18] can

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return to [Group home] when he gets some strength back. . . ."
* 02/26/16 at 10:45 a.m., "[Dietary] . . . Res [Resident] diet order is Liberal Geriatric . . . Pureed per MD [medical doctor]."

The "Nutritional Risk Assessment", dated 03/04/16, identified, "Weight: 109 lbs. . . . Receives . . . Pureed [diet]. . . . Visited with [Group home] caregiver for food preferences. Plan: Added Carnation Instant Breakfast to snacks. Continue to individualize diet and accommodate requests. Will monitor weight & [and] meal intakes."

The interdisciplinary progress notes further identified:
* 03/07/16 at 4:44 p.m., ". . . The team met today to review his care plans. [Resident #18's] Legal Guardian . . . and . . . RN [Registered Nurse] . . . [who] managed his healthcare needs and concerns . . . Discussed his appetite, and weight loss concerns. He will have ensure 3 times per day, and nursing assured his care providers that we discuss concerns with dietary staff regularly and have scheduled meetings every other week. His care providers wanted to ensure that [name of provider] would continue to be his primary care physician. . . ."
* 03/07/16 at 10:49 p.m., ". . . Catheter went well with 55 cc [cubic centimeters] output of yellow mucous drainage. . . ."
* 03/08/16 at 6:04 a.m., ". . . catheter . . . Had immediate output of cloudy yellow urine returned approx. [approximate] 75 cc . . ."
* 03/12/16 at 8:14 p.m., "Ensure . . . Offered but only took in sips."
* 03/13/16 at 11:47 a.m., ". . . only sips of ensure.

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F 325	Continued From page 36 . . ." * 03/13/16 at 10:29 p.m., ". . . He refused . . . supper. Took in minimum amount of fluids. . . ." * 03/17/16 at 5:51 p.m., "Ate and drank less than 10% supper. . . ." The record failed to show staff notified Resident #18's physician regarding his -8.0 pounds = -7.2% severe weight loss 03/18/16. * 03/19/16 at 9:28 p.m., "resident was very incont [incontinent] of urine and there was no urine in the Foley cath [catheter] bag. Irrigated the catheter with 60 cc of sterile water and the urine that returned was very white, thick matter. . . ." * 03/21/16 at 9:06 p.m., "Resident refused supper and has refused fluids this shift. . . " * 03/22/16 at 9:13 p.m., "Resident had minimum amount of urine output. . . . Resident refused supper and has refused fluids this shift. . . ." * 03/22/16 at 10:30 p.m., ". . . Resident has been refusing fluids. He had minimal output this shift. . . ." The "Fax Tracking Log" identified a fax had been sent to Resident #18's physician on 03/22/16. The "issue/concern" read, "FYI [not] eating drinking . . ." The log failed to identify when [what time of day] the fax was sent and the physician's response. The interdisciplinary progress notes further identified: * 03/23/16 at 9:55 a.m., "[Dietary] WEIGHT WARNING: . . . [7.2% (weight loss) . . .] Meal intakes poor. . . . Res [resident] receives C/B [Carnation Instant Breakfast] with meals and snacks. . . ." This was the first Dietary note entered since 02/26/16.	F 325		

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F 325	Continued From page 37 * 03/23/16 at 6:26 p.m., "Continues to eat and drink poorly. Today's weight was 99.0 lbs [pounds]. Will do a reweight tomorrow and update MD [medical director] of weight loss if weight is accurate." * 03/23/16 at 7:00 p.m., "Ensure . . . drank just a sip." The record failed to show staff notified Resident #18's physician regarding his -16.6 pounds = -15% severe weight loss in less than one month (February 25 - March 24, 2016). * 03/26/16 at 10:24 p.m., "Resident refused food, fluids . . . this shift. . . ." * 03/27/16 at 7:30 a.m., "CNA [Certified Nursing Asssistant] . . . found resident without respirations [Resident #18 expired.]. . . ." The facility failed to recognize Resident #18's severe weight loss, failed to promptly notify Resident #18's physician regarding his poor meal/fluid intake, and failed to implement appropriate interventions per his physician and/or the interdisciplinary team which resulted in continued weight loss/dehydration.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/24/16

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F 371	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of the sanitizer log, and staff interview, the facility failed ensure the correct concentration of sanitizing solution in 1 of 1 main kitchen. Failure to ensure sanitizing solutions are at the correct concentration has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared and served in the area. Findings include: Review of the manufacturer's instructions for "Sani-T-10 Plus Food Contact Sanitizer" occurred on 10/20/16. The instructions stated, ". . . prepare a solution of 0.75 to 2 ounces of this product per 4 gallons of water, 150-400 ppm [parts per million] active. . . ." - An initial dietary tour of the facility's main kitchen occurred on 10/17/16 at 10:30 a.m. Observation showed two red buckets containing sanitizing solution in the main kitchen. Two managerial Dietary staff members (#1 and #10) tested the solutions which indicated a sanitizing concentration of 0 ppms per bucket. During an interview, the two managerial staff members (#1 and #10) reported they had been "having troubles with the sanitizer and the chemical guy was [at the facility] last week to check the chemicals." - Observation on 10/19/16 at 4:00 p.m. showed a red bucket containing sanitizing solution in the main kitchen. The managerial staff member (#10) tested the solution which indicated a sanitizing	F 371	All residents in the facility have the potential to be affected by the deficient practice. To ensure the sanitizing solution continues to be dispensed in the proper concentration or corrected in a timely manner these measures will be put in place: A. Daily, both the AM and PM cooks will use test strips, according to the manufacturer's recommendations, to test the filled sanitizing portion of the three-compartment sink. The dietary aides in the main kitchen and also in the satellite kitchens will use test strips twice daily, according to the manufacturer's recommendations, to test filled sanitizing buckets. Dietary staff will compare test strip to the standard color chart and record parts per million the color comes closest to, and document accordingly on designated calendars. If the color does not match at least 200 ppm, she/he will alert the dietary director or the dietary supervisor promptly for further testing. The director or supervisor will contact the technician if indicated. B. Twice weekly for three (3) months, and weekly thereafter ongoing, the dietary director or the dietary supervisor will perform additional random tests of the sanitizing solutions with test strips. If the solutions are found to be out of	

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F 371	Continued From page 39 concentration of 0 ppms. An unidentified Dietary staff member refilled the red bucket with the sanitizing solution. The managerial staff member (#10) retested the solution which indicated a sanitizing concentration of < 100 ppms. Review of the "Sanitizer" log for October 17-19, 2016, showed dietary staff initialed the form one-to-two times daily and wrote "okay" in the space provided. Staff failed to ensure the sanitizing solutions equaled 150-400 ppm active (per the manufacturers instructions) prior to use in the main kitchen.	F 371	compliance, the technician will be notified promptly to recalibrate the dispensing machine. Results will be recorded and presented at the monthly quality assurance meeting for potential action and further follow-up. If the technician is unable to correct the problem in a timely manner, the sanitization solutions will be mixed by hand, according to manufacturer's recommendations. Staff will be educated on these calendars and procedures at the mandatory dietary meetings on 11-17-16. QA monitoring by dietary director or dietary supervisor will begin 11-18-16.	
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	F 441		11/24/16

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F 441	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to follow infection control practices for 4 of 9 sampled residents (Resident #2, #3, #5, and #10) observed during personal and pressure ulcer cares and failed to clean 1 of 3 glucometers during observation of medication administration. Failure to follow infection control practices related to perineal cares, pressure ulcer cares, and hand hygiene has the potential to spread infection within the facility. Failure to clean glucometers according to facility policy may result in the spread of a blood borne pathogen between residents. Findings include: PROPER PERINEAL CARES	F 441	1. For Residents #2, #3, and #5, Lane staff were reeducated on proper peri-care technique on 11-1-16 and 11-4-16. All licensed nursing staff have since been reeducated on the proper technique for cleaning the glucometer machines per facility policy. For Resident #10, Lane staff has been reeducated on way of proper hand hygiene protocol. 2. All residents have the potential to be affected by improper hand hygiene. All residents who do not perform their own perineal care have the potential to be affected by improper peri-care technique. Any resident that has orders for blood glucose monitoring has the potential to be affected by the nurse not following proper cleaning procedures. Any resident with a	

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F 441	Continued From page 41 Review of facility policy titled "Perineal Care . . ." occurred on 10/20/16. This policy, dated January 2015, stated, "Purpose: Prevent infections and skin irritation . . . Procedure for female . . . wipe labia front to back, wipe down each side of labia then down center over urethra and vaginal openings [sic] using a different part of the wipe for each stroke." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included incontinence, and history of urinary tract infections (UTI). The resident's quarterly Minimum Data Set (MDS), dated 10/05/16, identified long and short term memory problems, moderately impaired problem solving skills, and extensive assist of one person for dressing and toileting cares. Observation on 10/18/16 at 2:50 p.m., showed two certified nursing assistants (CNA's) (#3 and an unidentified) assisting Resident #2 with toileting cares. Both CNA's (#3 and an unidentified) washed their hands, donned gloves, and removed Resident #2's incontinence pad, soiled with stool. One CNA (#3) performed perineal cares of the rectal area by wiping first from front to back with a disposable cleansing wipe. The resident sat onto the toilet and voided. The CNA (#3) squatted down in front of Resident #2 while she sat on the toilet and wiped from back to front with a disposable cleansing wipe twice without folding turning the wipe to a clean area. The CNA (#3) failed to wipe from front to back and use a clean area of the disposable wipe or to obtain a fresh wipe when cleansing the resident's perineum.	F 441	pressure ulcer has the potential to be affected by improper hand hygiene during pressure ulcer cares. 3. All staff were educated on proper hand hygiene at the mandatory all staff meeting on 11-10-16. Further education on hand hygiene as it relates to peri-care, proper peri-care technique, and hand hygiene relating to pressure ulcer care will be provided at the mandatory nurses meeting on 11-17-16 and the mandatory CNA meeting on 11-23-16. Education on proper cleaning procedures for blood glucose monitors will be provided at the mandatory nurses meeting on 11-17-16. 4. The QA director or designee will conduct a random audit of ten (10) residents receiving peri-care weekly for ten (10) weeks, then monthly thereafter, beginning 10-31-16 The results will be discussed at the monthly quality assurance meeting and the appropriate action and follow up will be taken if indicated. Further, the QA director or designee will conduct an audit of all residents with pressure ulcers (if there are any in the facility) in regards to staff hand hygiene, weekly for ten (10) weeks, then monthly thereafter, beginning 11-17-16. Finally, the QA director or designee will complete a random audit of nurses cleaning blood glucose meters used on individual residents to assure proper procedure is being followed, weekly for ten (10) weeks, then monthly thereafter, starting 11-17-16	

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- Review of Resident #3's medical record occurred on all days of survey. The significant change MDS, dated 10/05/16, identified severely impaired cognitive skills and extensive assistance of two or more persons required for bed mobility and toileting.

Observation on 10/17/16 at 3:45 showed a CNA (#4) assisting Resident #3 with toileting cares. Observation showed the resident lying on the bed, incontinent of urine. The CNA (#4) donned gloves and provided pericares using disposable cleansing wipes. The CNA (#4) wiped the resident's perineum from the labia to the rectum twice without turning the wipe to a clean area. The CNA (#4) failed to use a different area of the disposable wipe or to obtain a fresh wipe when cleansing the resident's perineum.

- Review of Resident #5's medical record occurred on all days of survey. The admission MDS, dated 09/15/16, identified extensive assistance of two or more persons required for transfers and toileting.

Observation on 10/17/16 at 3:40 showed a CNA (#5) assisted Resident #5 with toileting cares. Observation showed the resident voided in the toilet. The CNA (#5) donned gloves, assisted the resident to stand, and provided pericares using disposable cleansing wipes. The CNA (#5) wiped the resident's perineum from the labia to the rectum twice without turning the wipe to a clean area. The CNA (#5) failed to use a different area of the wipe or to obtain a fresh wipe when cleansing the resident's perineum.

HAND HYGIENE DURING PRESSURE ULCER

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F 441	Continued From page 43 CARES Review of facility policy titled "Hand Hygiene" occurred on 10/20/16. This policy, dated January 2015, stated, "PURPOSE: To prevent cross-contamination between staff and residents . . . PROCEDURE: HAND HYGIENE SHOULD BE PRACTICED: . . . Before and after caring for each resident . . . After using the toilet or assisting at toilet . . . Before and after changing dressings . . . Before applying and after removing gloves . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included pressure ulcers on right and left buttocks. The resident's quarterly MDS, dated 09/11/16, identified extensive assist of one person for dressing, personal cares, toileting cares, total assist of two for transfer, and always incontinent of bowel. Review of Resident #10's document titled, "Discharge Instructions Details" regarding wound care, occurred on 10/20/16. This document, dated 10/12/16, stated, ". . . Hand Hygiene . . . Wash hands before and after wound care . . ." Observation on 10/17/16 at 3:50 p.m., showed two certified nursing assistants (CNA's) (#6 and #7) assisted Resident #10 with toileting cares. Both CNA's (#6 and #7) washed their hands, donned gloves, and removed Resident #10's incontinence pad soiled with stool. The CNA (#7) performed perineal cares of the rectal area by wiping first from front to back with a disposable cleansing wipe. The CNA (#7) removed her gloves and without performing hand hygiene,	F 441		

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collected supplies to cleanse Resident #10's pressure ulcer. The CNA (#7) performed hand hygiene, applied gloves, cleansed the large pressure ulcer on Resident #10's buttocks and applied a dressing. Both the CNA's (#6 and #7) removed their gloves and without performing hand hygiene, adjusted the resident's clothing and transferred him to his wheelchair using the total mechanical lift. The CNA (#7) bagged the soiled brief and dressing in a garbage bag with bare hands. Both CNA's (#6 and #7) failed to perform hand hygiene following perineal care, after a dressing change, before completing other tasks and exiting the resident's room.

Observation on 10/18/16 at 9:25 a.m., showed two certified nursing assistants (CNA's) (#11 and #12) assisted Resident #10 with toileting cares. Both CNA's (#11 and #12) washed their hands, donned gloves, and removed Resident #10's incontinence pad soiled with stool. The CNA (#12) performed perineal cares of the rectal area by wiping first from front to back with a disposable cleansing wipe. The CNA (#12) removed her gloves, performed hand hygiene and applied clean gloves. The CNA (#12) cleansed the large pressure ulcer on Resident #10's buttocks and removed her gloves. The CNA (#12) then removed the ace wrap (in preparation for a shower) from the resident's stage 3 pressure ulcer located on the left foot with bare hands. The CNA (#12) performed hand hygiene. The other CNA (#11) removed her gloves and without performing hand hygiene, adjusted the resident's clothing and bagged the soiled brief and dressing in a garbage bag with bare hands. The CNA (#11) failed to perform hand hygiene following perineal care, before

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completing other tasks and exiting the resident's room. The CNA (#12) failed to perform hand hygiene following pressure ulcer cares and before removal of the ace wrap from a stage 3 ulcer.

During an interview on 10/19/16, a nurse manager (#13) confirmed staff are expected to wash their hands after removing gloves, following personal cares, after a dressing change, and prior to exiting the resident's room.

GLUCOMETER CLEANING

Review of the facility's policy titled "Blood Glucose Meter" occurred on 10/19/16. This policy, dated October 2015, stated, "The Blood Glucose Monitoring System will be set up and care for as directed by the Manufacturer's Users Manual as required. . . . Clean the meter using a sanitizer wipe and allow to air dry. . . ."

Observation during medication pass on afternoon of 10/17/16 showed a licensed nurse (#16) used a glucometer to test a resident's blood sugar. After completing the test, the nurse wiped off the glucometer using an alcohol pad.

During an interview on 10/18/16 at 11:20 a.m. a licensed nurse (#15) stated glucometers should be cleaned with Oxivir wipes after each use.

During an interview on 10/19/16 at 3:45 p.m. a nurse manager (#14) stated alcohol wipes should not be used to clean the glucometer, and staff should use the special wipes per facility policy.