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 _____	11/06/2013

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 November 3, 2013 and completed on November 6, 2013, the sample included 5 residents for complete review, 12 residents for focused review, 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	F241 1. For the residents specifically identified: Resident #13—All C.N.A. staff were educated to close bathroom door and close privacy curtains as appropriate when toileting any resident. Education was provided on 12-02-13 at Acorn Lane meeting in both verbal and written format by nurse manager and DON. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. Resident #9—All staff educated to knock on closed doors and wait for response prior to entering room. Education provided on 11-18-13 in verbal and written format at Cottonwood Lane meeting by Nurse Manager and DON. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. Resident #12 – Additional outlet installed in resident bathroom on 11-25-13 to have warm wipes readily accessible. An additional warmer was bought on 12-03-13	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to provide care for 4 of 17 sampled residents (Resident #8, #9, #12, and #13) and two supplemental residents (Resident #21, and #22) in a manner and environment that maintained or enhanced each resident's dignity and with respect for each resident's individuality. Failure to prevent exposure during cares for Resident #9 and #13; failure to close drapes or pull privacy curtains during insulin administration for Resident #8, #21, and #22; and failure to use of the proper sanitary wipes for Resident #12 did not maintain respect, enhance dignity or recognize the resident's individuality. Findings include:	F 241		

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

Timothy N. Burchill | President/CEO | 12/5/13

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 - Observation on 11/05/13 at 4:12 p.m., showed two CNAs (certified nursing assistants) (#10 and #11) in the room with Resident #13. The CNA (#10) transported the resident into the bathroom and assisted the resident to stand. While the resident held onto the grab bar, the CNA (#10) pulled down Resident #13's pants, and assisted the resident onto the commode. The bathroom door remained open during these cares and Resident #13's roommate sat within view of the bathroom. The CNA (#10) then closed the bathroom door and re-entered the bathroom when the resident said she had finished. During an interview on the morning of 11/06/13, an administrative nurse (#5) confirmed leaving the bathroom door open is a privacy issue. - Observation on the morning of 11/04/13 showed a CNA (#8) assisted Resident #9 with morning cares. At 8:00 a.m., an unidentified employee knocked and opened the door without waiting for a response. The employee closed the door after seeing the CNA in the room. At 8:10 a.m., Resident #9 stood by the bed partially dress and the same unidentified employee knocked on the door and opened the door without waiting for a response. During an interview on the morning of 11/06/13, an administrative nurse (#9) confirmed staff need to knock and wait for a response before opening a resident's door. - Review of Resident #12's medical record occurred November 3-6, 2013. Diagnoses included Alzheimer's disease, anxiety, and episodic mood disorder.	F 241	placed close to resident bedside. Lane staff educated at daily Safety Huddle and information written in Huddle communication book on 12-03-13. Residents #8, #21 and #22 – Licensed nurse was educated to pull window shades and privacy curtains when administering insulin injections. All licensed nurses educated verbally and in written format at nurses meeting 11-21-13 by DON. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. 2. All residents receiving personal cares have the potential to be affected. 3. All staff have been educated on the importance of respecting and protecting resident privacy and dignity at facility meetings, as follows: 11-11-13 Bison Lane 11-18-13 Cottonwood Lane 11-21-13 Nurses Meeting 11-25-13 Dakota Lane 11-25-13 All staff e-mail 11-27-13 CNA Meeting	

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F 241	Continued From page 2 Review of Resident #12's care plan, dated 11/07/12, showed the following: * "Focus: At risk for falls . . . Intervention . . . Mattress on floor . . ." * "Focus: Urinary incontinence . . . Intervention . . . Wipe warmer used for incontinence wipes." * "Focus: . . . inappropriate behaviors . . . Intervention . . . A warming machine for the sanitary wipes was purchased for her in hopes to decrease the behavioral reaction she has to her peri cares. This is located in her bathroom. . . ." * Review of the "Routine Care Sheet" showed, "Has wipe warmer in bathroom. Has mattress on floor . . ." Observation of peri care on 11/04/13 at 10:56 a.m. showed two CNAs (#2 and #3) used room temperature peri wipes located in the resident's bathroom. Resident #12 grabbed at the CNAs (#2 and #3) and then tried to cover herself, to prevent the CNAs from providing peri care. One CNA (#3) stated, "Not now (resident's preferred name)," as she tried to distract the resident from interfering with peri care. Observation of peri care on 11/04/13 at 3:20 p.m. showed two CNAs (#6 and #7) used the room temperature peri wipes located in the resident's bathroom. As the CNAs (#6 and #7) assisted Resident #12 to stand, the resident held onto the CNAs (#6 and #7) upper arms. As one CNA provided the cleansing, the other CNA stated the resident pinched her. During the observation of peri care, the CNAs failed to use the heated wipes provided for Resident #12. Failure to use the heated wipes showed a lack of respect for the resident's comfort and may have contributed to the	F 241	12-02-13.1 Acorn Lane 4. A QA tool has been developed and implemented to monitor privacy and dignity whenever cares are provided. This QA tool will be completed by the quality assurance manager or nurse manager on a random sample of residents. The tool will be completed weekly x 1 month, monthly x 3 months and quarterly thereafter. Results will be recorded on QA form, and presented at regular QAPI meetings, or special meeting as indicated. Appropriate measures will be taken immediately to correct any identified concerns. 5. December 11, 2013	

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F 241	Continued From page 3 behaviors expressed by Resident #12 during peri care. During an interview on 11/06/13 at 9:55 a.m., an administrative nurse (#5) confirmed staff are to use the heated wipes for Resident #12's peri cares. - During observation of insulin administration on the afternoon of 11/03/13, a nursing staff member (#19) failed to ensure privacy for three residents (#8, #21, and #22). The nurse injected insulin into each residents' abdomen. The nurse left the curtain open between Resident #21 and roommate, and left the shade open to the outside window for both Resident #8 and #22.	F 241		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 16 sampled residents (Resident #8, #13, and #14) and 1 closed record resident (Resident #18) identified with falls. Failure to provide necessary supervision and assistive devices resulted in	F 323	F323 1. For the residents that were specifically identified: Resident #8 – Lane staff were educated to provide extensive assist of 2 for ambulation at all times and to read routine care sheets. Verbal education provided at Safety Huddle after occurrence. Education	

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F 323	Continued From page 4 avoidable falls and injuries. Findings include: - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included generalized muscle weakness, atrial fibrillation, and gout. Resident #8's current care plan, stated, "AMBULATION: [Resident #8] requires extensive assist of two for ambulation [initiated 10/15/12] . . ." A fall incident report, dated 08/20/13, stated, ". . . Incident Description . . . Resident was lowered to the floor per CNA [certified nursing assistant] utilizing gait belt. . . . Resident Description: 'My feet just gave out on me.' . . . Notes . . . 08/20/13 . . . 2 assist required with ambulation per care plan. . . ." Resident #8's nurses' notes stated the following: * 08/20/13 at 11:12 p.m.: ". . . Type of Fall: . . . Observed. Time of Fall: 9:00 p.m. Location: Residents bathroom. Description of Incident: Feet were giving out was lowered to the floor utilizing gait belt. . . . Neurochecks initiated and WNL [within normal limits] due to bumping left side of head on the railing next to the toilet. . . ." * 08/21/13 at 7:09 a.m.: ". . . Acetaminophen - per S.O. [standing order] . . . c/o [complains of] severe pain in the left knee. 8/10 [8 out of 10 on the pain scale] . . ." * 08/21/13 at 1:29 p.m.: ". . . c/o knee pain from fall, will be going to clinic for evaluation at 3pm today. . . ." * 08/21/13 at 2:38 p.m.: ". . . Dauhgter [sic] called author at 7am asking if we should send her dad to the clinic to have his knee checked out due to the fall. He called her at around 6:30am c/o left	F 323	was also provided on 11-25-13 at Dakota Lane meeting in both verbal and written format. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. Resident #13 – Lane staff were educated to utilize AFO braces with all transfers and to read routine care sheets. Verbal education provided at Safety Huddle after occurrence. Education was provided at Acorn Lane meeting on 12-2-13 in both verbal and written format. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. Resident #14 – Lane staff educated to use extensive assist and standing lift for transfers and toileting and to read routine care sheets. Verbal education provided at Safety Huddle after occurrence. Education was provided on 11-11-13 at Bison Lane meeting in both verbal and written format. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13.	

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F 323	Continued From page 5 sided knee pain. . . ." * 08/21/13 at 9:15 p.m.: ". . . Denied pain this evening. Voiced only hurts when repositioning in bed. Neur [sic] checks within normal limits. . . ." * 08/22/13 at 11:56 a.m.: ". . . Acetaminophen - per S.O. . . . c/o left knee pain. . . ." * 08/23/13 at 8:01 a.m.: ". . . Acetaminophen - per S.O. . . . Given per request for complaints of (L) [left] hip pain level 6 of 10. . . ." * 08/23/13 at 8:44 p.m.: ". . . Acetaminophen - per S.O. . . . for left leg pain . . ." * 08/24/13 at 2:14 p.m.: ". . . Acetaminophen - per S.O. . . . 650 mg [milligrams] po [by mouth] to alleviate (L) knee pain 6/10. . . ." Resident #8 complained of no further pain after 08/24/13 A provider's progress note, dated 08/21/13 at 3:10 p.m. stated, ". . . Chief Complaint . . . Fall . . . fell on 8/20/13 at HS [bedtime], injuries to/left knee/question hitting head . . . [Resident #8] . . . states he was being assisted to the bathroom by one CNA and usually there are 2 helping him to the bathroom. He states he simply lost his balance due to muscle fatigue and slid to the floor, landing on his left side. States he did not hit his head. . . . PLAN: 1. I have reviewed both the left hip and left knee x-rays with the patient and his daughter. They are unremarkable. I recommend using tylenol prn [as needed] for pain. He should also have 2 assist when ambulating to the bathroom. . . ." Review of the facility's investigation of the incident occurred on 11/06/13 at 10:00 a.m. with a supervisory nurse (#12). The investigation regarding Resident #8's fall identified the CNA ambulated with the resident from his recliner to	F 323	Resident # 18 -- Lane staff educated at the time of occurrence to use two assist for all transfers and to read routine care sheets. **(Note: On pages 11-17 of the 2567, we believe resident #2 was identified incorrectly and should be resident #18.)** Verbal education provided at Safety Huddle after occurrence. Education was also provided on 11-18-13 at Cottonwood Lane meeting in both verbal and written format. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. **NOTE: All of the above incidents were reported to the NDDOH as potential neglect situations and all CNA's involved in the incidents were placed in the disciplinary process.** Residents # 1, #10 and #12— All staff were educated on proper transfer techniques with use of gait belt including	

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F 323	Continued From page 6 the bathroom. Resident #8 lost his footing, and the CNA lowered him to the floor. The investigation identified Resident #8's care plan and routine care sheet (used by the CNAs to direct resident care) stated Resident #8 required two staff members to ambulate. - Review of Resident #14's medical record occurred on Nov. 05-06, 2013. Diagnoses included lumbago (back pain) and generalized muscle weakness. The most recent MDS, date 09/16/13, identified Resident #14 required extensive assist of one person for bed mobility, transfers, and toilet use. Review of Resident #14's current care plan stated: " . . . Focus: Decreased ADL (activity of daily living) function L/E (lower extremity) r/t (related to): Weakness . . . Interventions: 09/16/13 Standing lift . . . " Review of Resident #14's CNA Routine Care Sheet, dated 09/17/13, identified the following: ". . . Transfer: Extensive assist of 1 with standing lift. Toileting: Extensive assist of 1 with standing lift. . . ." A fall incident report, dated 09/26/13 at 3:10 p.m., stated, "Incident Location: Resident's Room . . . Nursing Description: Resident was being transferred and she had to be lowered to the floor as she couldn't keep standing. Received a skin tear on her left shin 2 in [inches] x [by] 3 in. in size. Old skin tear on right elbow reopened. No other c/o [complaint of] [sic] before gotten off the floor with two assist. Able to move her extremities as usual. Resident denied any discomfort at this time. Did'nt [sic] know what happened but	F 323	not lifting a resident under the arms. All staff were educated on the importance and necessity of reading routine care sheets and each incident was discussed with Lane staff during huddle. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. 2. Any resident requiring assistance with transfers/ambulation has the potential to be affected. 3. All staff have been educated on the importance of reading routine care sheets and providing necessary assistance, using equipment properly and appropriate transfer techniques at the following meetings: 11-11-13 Bison Lane 11-18-13 Cottonwood Lane 11-21-13 Nurses Meeting 11-25-13 Dakota Lane 11-25-13 All staff e-mail 11-27-13 CNA Meeting 12-02-13 Acorn Lane	

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F 323	Continued From page 7 remembered being on the floor. Immediate Action Taken: . . . Skin tear left shin cleansed and dressed. Right elbow skin tear steri-strips put over it after cleansing area. Vitals taken . . . Care plan evaluated and updated with new fall intervention.: updated/reviewed." The progress notes included a "Fall Followup" note on 09/27/13 at 2:07 p.m. which stated, ". . . Steristrip and dressing to [right] elbow wound as [sic] area is seeping blood and steri strips are coming off. No swelling, redness or warmth to area. Resident deneis [sic] further aching or new pain follwong [sic] fall." Review of the facility's investigation of the incident occurred on 11/06/13 at 10:00 a.m. with a supervisory nurse (#12). The investigation regarding Resident #14's fall identified the CNA transferred the resident with a gait belt, the resident was unable to stand and the CNA lowered the resident to the floor. The investigation identified Resident #14's care plan and routine care sheet stated the resident required a standing lift for transfers. During an interview on the morning of 11/06/13, an administrative nurse (#9) stated the CNA failed to follow the resident's care plan and routine care sheet. The CNA transferred the resident with a gait belt instead of using a standing lift. - Review of Resident #13's medical record occurred on Nov. 05-06, 2013. Diagnoses included hemiplegia affecting dominant side due to cerebral vascular disease. The current MDS, dated 08/18/13, identified Resident #13 required extensive assist of one to two persons with dressing, toilet use, and personal hygiene.	F 323	Facility will continue to monitor incidents as previously done within facility policies and procedures, by completing mapping, trending, graphs, education and random quality checks. QA monitoring and findings will continue to be reviewed and discussed at QA meetings, Medical Directors meetings, and other staff meetings. A Performance Improvement Plan will be developed and implemented if indicated. 4. A QA tool has been developed and implemented to monitor transfer techniques and following routine care sheets whenever cares are provided. QA tool will be completed by quality assurance manager or nurse manager to monitor a random sample of residents. The tool will be completed by nursing managers weekly x 1 month, monthly x 3 months and quarterly thereafter. Results will be recorded on QA form and presented at regular QAPI meeting. Appropriate measures will be taken immediately to correct any identified concerns.	

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F 323	Continued From page 8 Review of Resident #13's current care plan stated: " . . . Focus: At risk for falls r/t [related to] CVA [cerebral vascular accident] with hemiplegia . . . Interventions: . . . Make sure to have AFO [ankle foot orthotic] on for all transfers. . . ." Review of Resident #13's CNA Routine Care Sheet, dated 09/17/13, and revised on 10/16/13 identified the following: ". . . Transfers *AFO must be on 10/16/13. . . . Brace: AFO brace . . . Right L/E [lower extremity] at all times with transfers 10/16/13. . . ." Resident #13's nurses notes' identified the following: * 10/16/13 15:25 "Type of fall: Observed. Time of Fall: 7:20 a.m. Location: resident's bathroom. Description of incident: CNA [name] was transferring resident from wheelchair to commode in the bathroom. She had a gait belt on resident and resident had grabbed the bar in the bathroom. Her legs gave out and she could no longer stand; CNA lowered resident to the floor without injury. . . ." Review of the facility's investigation of this incident occurred on 11/06/13 at 10:00 a.m. with a supervisory nurse (#12). The investigation identified the CNA transferred Resident #13 from the bed to the wheelchair and then onto the toilet. The CNA failed to apply the resident's AFO brace. The investigation identified Resident #13's routine care sheet and care plan stated to use the AFO for all transfers. During an interview on 11/06/13 at 1:20 p.m., an administrative nurse (#6) confirmed that Resident #13 needed to wear AFO brace with every	F 323	5. December 11, 2013	

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F 323	Continued From page 9 transfer. - Review of Resident #18's closed record occurred on November 05-06, 2013. Resident #18's medical diagnoses included arthritis and macular degeneration. Review of Resident #18's significant change MDS, dated 01/25/13, identified Resident #18 required extensive assistance with transfers. The Care Area Assessment (CAA), dated 01/25/13, for ADLs stated, " . . . had had a decline in her ADL's. ADL function triggers as . . . needs extensive assist with her ADL's r/t [related to] weakness, DJD [degenerative disc disease] and CHF [congestive heart failure]. . . . She now needs extensive assist with her ambulation, transfers . . . She needs 2 assist or the standing lift for transfers. . . ." A fall CAA, dated 01/25/13, stated, ". . . now needs extensive assistance to stabilize with transfers and ambulation. . . . Staff also use the standing lift as needed. She has not had any falls." Resident #18's quarterly MDS, dated 03/07/13, identified the resident required extensive assistance of one person for transfers. The MDS identified Resident #18 with no falls during the assessment reference period (ARD). An entry in the nursing progress notes identified that Resident #18 experienced an observed fall on 05/02/13 at 2:30 p.m. in the bathing area. The description of the incident stated, "Resident wanting to [sic] uncooperative with standing during transfer to w/c. Staff assisted resident to the floor. Transfer from bath chair to w/c. Nursing assessment . . . Noted re-opened scratch to the	F 323		

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right elbow. Resident denies pain. Is uncomfortable on the floor. Assisted to w/c with 3 staff and gait belt. . . . Care plan evaluated and updated with new fall intervention. . . ."

Resident #2's current care plan, printed 02/01/13, identified the problem of "Decreased ADL function L/E [lower extremities] r/t arthritis" with interventions which included, ". . . Extensive assist needed for transfers." An entry in the care plan, dated 04/24/13, identified discontinuing "OK to use standing lift as needed." A handwritten, undated, entry adjacent to the extensive assist intervention showed "(2)." The "Routine Care Sheet," with a revision date of 03/27/13, (after the quarterly MDS dated 03/07/13) identified the resident required extensive assistance with a gait belt and walker for transfers by 1 person, and an undated change to extensive assistance of 2. The care sheet identified the discontinued entry on 04/24/13 of "use standing lift for toileting" within the transfers intervention. An entry, dated 05/03/13, stated for transfers "fluctuates, [check with] nurse."

Review of the facility's investigation of this incident occurred on 11/06/13 at 10:00 a.m. with a supervisory nurse (#12). The investigation regarding the fall stated "Called to bathing room at 2:30 p.m. Resident laying on the floor on right side. Asked CNA . . . what happened. Stated that she was transferring resident alone with the gait belt and resident would not stand trying to sit down right away. Informed CNA that resident is a 2 person transfer. Stated that she had not cared for her for a long time and didn't know that. . . . CNA was late and behind for the bath. Resident care sheet states that resident is a 2 person transfer."

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	355082	A. BUILDING _____ B. WING _____	11/06/2013

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

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F 323	Continued From page 11 The facility investigation of each fall which occurred to Resident #8, #13, #14 and #18 identified staff not following or not knowing what was on each respective resident's care plan/care card. Review of the facility policy titled "Abuse" occurred on 11/06/13. This policy, dated January 2013, stated, ". . . All alleged abuse investigations will be reviewed through the QA [quality assurance] to identify any occurrences for patterns and trends; and the need to revise policies and procedures to prevent further incidents. . . ." During interview on the morning of 11/06/13, an administrative staff member (#12) stated the nurse is responsible for documenting changes in care in a 24 hour communication book; a supervisory nurse (#13) stated she expected staff to check residents' care sheets during their shifts; and a quality assurance nurse (#18) stated the facility had not performed quality assurance monitoring on the above incidents. Review of the Quality Measures for the reporting period of April 28, 2013 and October 28, 2013 identified falls and falls with major injury as triggered areas. The facility failed to identify quality deficiencies regarding resident falls, and develop and implement a plan to address the quality deficiencies with falls including those related to facility staff not following the 24 hour communication book/resident's care sheets/care plans. 2.) Based on observation, record review, review	F 323		

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of facility policy/procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 3 of 7 sampled residents (Resident #1, #10, and #12) observed during transfers when staff failed to properly utilize a gait belt. Failure to ensure staff used gait belts appropriately placed residents at risk for falls, injuries, and increased pain.

Findings include:

Review of the facility policy/procedure "Mandatory Lift" occurred on 11/05/13. The policy/procedure, dated 01/13, stated, "Gait Belts or mechanical lifts will be used for all residents requiring assistance with transfer. . . . To promote the safety of residents and staff. . . . Gait belts should be used with all assisted transfers unless contraindicated or resident refusal. Contraindications or resident refusal must be documented. . . ."

- Review of Resident #1's medical record occurred November 3-6, 2013. Diagnoses included history of shoulder fracture, dementia, and chronic pain. A quarterly Minimum Data Set (MDS), dated 10/22/13, identified extensive assist of one person for transfer and toilet use, with functional limitation of range of motion to both upper and lower extremities.

Observation on 11/04/13 at 9:40 a.m. showed two Certified Nurse Assistants (CNAs) (#1 and #2) transferred Resident #1 with a gait belt from her wheelchair to the toilet. While assisting Resident #1 to undress a CNA (#1) let go of the gait belt and placed her forearm under the resident's axilla to assist her to sit down on the toilet. The resident

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yelled out in discomfort. The resident did not sit far enough back on the toilet and could not push herself back. The CNAs (#1 and #2) placed their forearm under the resident's axilla, causing the resident's shoulders to shrug, and pulled the resident up and back onto the toilet. Resident #1 yelled out in discomfort, to which the CNA (#1) responded, "I know."

- Review of Resident #10's medical record occurred November 3-6, 2013. Diagnoses included dementia. An admission MDS, dated 09/30/13, identified extensive assist of two persons for transfer and toilet use.

Observation on 11/04/13 at 10:15 a.m. showed two CNAs (#2 and #3) assisted the resident with morning cares while the resident remained in bed, then transferred Resident #10 to her wheelchair using a gait belt. The CNAs (#2 and #3) removed the gait belt and directed the resident to push herself back in her wheelchair. Resident #10 could not push herself all the way back in her wheelchair. The CNAs (#2 and #3) positioned themselves on each side of Resident #10, placed their forearms under the resident's axilla, causing the resident's shoulders to shrug, and pulled the resident up and back into the wheelchair.

- Review of Resident #12's medical record occurred November 3-6, 2013. Diagnoses included Alzheimer's disease, anxiety, and osteoporosis. A quarterly MDS, dated 08/01/13, identified extensive assist of two or more persons for transfer and toilet use.

Observation on 11/04/13 at 10:56 a.m. showed two CNAs (#2 and #3) assisting Resident #12

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F 323	Continued From page 14 with morning cares. Using a gait belt, the CNAs (#2 and #3) transferred the resident from her bed to a rolling commode. Using the commode, the CNAs (#2 and #3) transferred Resident #12 to the toilet. At the toilet, the CNAs (#2 and #3) stood the resident to remove her brief. The CNA (#3) failed to hold onto the gait belt and placed her forearm under the resident's axilla to assist her to stand. When Resident #12 sat back down onto the commode, she sat too far forward. The CNAs (#2 and #3) placed their forearms under the resident's axilla and pulled the resident up and back onto the commode. During an interview on 11/06/13 at 9:55 a.m., an administrative nurse (#5) confirmed staff should not pull on residents arms/shoulders, but are to use the gait belt.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 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 fluids to maintain adequate hydration for 2 of 7 sampled residents (Resident #3 and #4) who required staff assistance with food/fluid intake. Failure to offer fluids to residents who are unable to access them independently placed these residents at risk for dehydration, constipation, and urinary tract infections.	F 327	F327 1. For specifically identified residents #3 and #4--Lane staff educated to offer fluids with each resident contact at the Dakota Lane meeting on 11-25-13 in both verbal and written format. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. 2. All residents requiring assistance with food/fluid intake have the potential to be affected.	

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F 327	Continued From page 15 Findings include: Review of the facility's "Standards of Care" occurred on 11/06/13. This undated policy stated, ". . . Each of the following is to be provided as routine care by the Nursing Assistants, unless otherwise directed. . . . 16. Encourage and offer fluids with each contact. Keep fluids within reach if resident can independently access them. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included presenile dementia. The current Minimum Data Set (MDS), dated 09/09/13, identified short term and long term memory problems, moderately impaired daily decision-making skills, and extensive assistance from one person for eating. Resident #3's current care plan stated, ". . . Mild dehydration risk . . . Provide [more than] 400 ml [milliliters] water in room . . ." Observation on 11/03/13 at 3:53 p.m. showed two Certified Nursing Assistants (CNAs) (#6 and #14) assisted Resident #3 out of bed. The CNAs checked and changed the resident's brief and brought her to the nurses' station. The CNAs failed to offer/encourage fluids during cares. Observation on 11/04/13 at 3:57 p.m. showed two CNAs (#14 and #17) assisted Resident #3 out of bed. The CNAs checked and changed the resident's brief and brought her to the nurses' station. The CNAs failed to offer/encourage fluids during cares. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The current MDS,	F 327	3. All staff have been educated on the importance of assisting/encouraging residents with food/fluid intake and the importance of hydration. For staff unable to attend meeting, all staff e-mail was sent on 11-25-13. Education was provided at the following meetings: 11-11-13 Bison Lane 11-18-13 Cottonwood Lane 11-21-13 Nurses Meeting 11-25-13 Dakota Lane 11-25-13 All staff e-mail 11-27-13 CNA Meeting 12-2-13 Acorn Lane 4. A QA tool has been developed and implemented to monitor the offering/provision of fluids with each resident contact. This tool will be completed by the quality assurance manager or nurse manager to monitor a random sample of residents. It will be completed weekly x 1 month, monthly x 3 months, and quarterly thereafter. Results will be recorded on QA form and presented at regular QA meeting. Appropriate	

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F 327	Continued From page 16 dated 10/12/13, showed short term memory problems, severely impaired daily decision-making skills, and extensive assistance from one person for eating. Resident #4's current care plan stated, "Urinary incontinence At risk for UTI [urinary tract infection] r/t [related to] Decreased mobility . . . Interventions . . . Encourage fluids. . . ." Observation on the afternoon of 11/03/13 showed Resident #4 seated at a table near the nurses' station. At 4:02 p.m., two CNAs (#6 and #14) assisted Resident #4 to the bathroom in her room. Upon completion of cares, the CNAs brought the resident back to the nurses' station. The CNAs failed to offer/encourage fluids during cares. Observation on 11/04/13 showed staff failed to offer fluids to Resident #4 during/following personal cares at 10:39 a.m., midway between breakfast and lunch meals. Observation on 11/04/13 at 5:37 p.m. showed two CNAs (#14 and #17) assisted Resident #4 to the bathroom. Upon completion of cares, the CNAs brought the resident to the nurse's station and failed to offer/encourage fluids during cares. During an interview on 11/06/13 at 8:15 a.m., a supervisory nurse (#13) stated she expected staff to offer fluids with each resident contact.	F 327	measures will be taken immediately to correct any identified concerns. 5. December 11, 2013	