STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 7, 2012 and completed on January 10, 2012, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		

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

Executive Director 2/14/13

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

Executive Director | Revised 3/6/13

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of abuse/neglect investigations, and staff interview, the facility failed to report 2 of 3 alleged incidents of neglect or abuse immediately to the administrator of the facility and to the state survey and certification agency and failed to report the results of the investigations by the fifth day of the incident. Failure to report and thoroughly investigate all alleged violations involving neglect or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include: Review of the facility policy titled "Abuse Prohibition Policy and Procedure" occurred on 01/10/13. This policy, revised 01/01/10, stated, ". . . 4. IDENTIFICATION . . . Staff will be informed that all bruising . . . or injuries must be reported to their immediate supervisor for follow-up . . . All incident reports with regard to suspicious injury must be completed within 24 hours of the find so the internal investigation process may begin. The Administrator will be notified of any suspected abuse by the DON, QA Manager, or Unit Manager via daily report at QA meetings and by review of each resident incident. . . . 6. INVESTIGATION	F 225		

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F 225	Continued From page 2 Upon receipt of an alleged charge of abuse, neglect, or misappropriation of property, management will immediately notify the State Department of Health (within one (1) working day) and management will then investigate the allegation utilizing staff, residents, or those individuals likely to provide information. This will be done within 48 hours of the receipt of the alleged charge and not later than five (5) working days. . . . " Review of investigations of alleged abuse/neglect incidents occurred on 01/10/13 with an administrative nurse (#12) and revealed the following: - "The Initial Allegation of Mistreatment, Abuse, Neglect, or Theft Reporting Form" identified an incident had occurred on 03/22/12 [Thursday]. Nursing staff reported the incident to administrative staff on 03/28/12. The form identified the facility then notified the state survey and certification agency on 03/28/12, six days after the incident. - "The Initial Allegation of Mistreatment, Abuse, Neglect, or Theft Reporting Form" identified an incident had occurred on 09/15/12 [Saturday]. Nursing staff reported the incident to administrative staff on 09/21/12. The form identified the facility then notified the state survey and certification agency on 09/21/12, six days after the incident. During an interview on the morning of 01/10/13, the administrative nurse (#12) confirmed staff failed to follow the facility's current policy and procedure; by failing to notify the administrator	F 225	F 225 (revised) 1. N/A 2. Recent allegations of abuse/neglect have been reviewed to make sure that they were reported timely from staff to administration and then to the State Department of Health. Any incidents where injury may have resulted have also been investigated to make sure process was carried out as appropriate. 3. Nursing staff have been re-educated on what is considered abuse/neglect, and the reporting process. Staff/Supervisors are to notify the nurse manager on call immediately so the investigation and appropriate measures can be initiated. Eventide's Vulnerable Adult policy was updated. 4. Corrective action completed by 5. Audits have been completed as allegations of abuse/neglect by nursing administration. This audit monitors the date of allegation, the date of the 24-hr report sent to the Department of Health and the date of the final report. It identifies any concerns, so if any corrections are needed they can be addressed at that time. The nurse administrator and administrator will continue to review four incidents a quarter for 3 quarters (if that many exist). Results will be shared with the QA committee and re-education, changes, or interventions implemented as needed.	2/14/2013

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F 225	Continued From page 3 and the state survey and certification agency immediately of any alleged incidents of abuse or neglect; and by failing to report the results of the investigation within five days of the incidents.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, the facility staff failed to develop and implement effective policies and procedures requiring immediate reporting of and investigating of alleged incidents of neglect or abuse for 2 of 3 incidents reviewed during the survey. Failure to report possible neglect or abuse incidents in a timely manner to administrative staff did not allow the facility to determine causative factors of the incidents or implement corrective action, and placed the residents at risk for possible neglect or abuse. Findings include: Review of the facility policy titled "Abuse Prohibition Policy and Procedure" occurred on 01/10/13. This policy, revised 01/01/10, stated, ". . . 4. IDENTIFICATION . . . The Administrator will be notified of any suspected abuse by the DON, QA Manager, or Unit Manager via daily report at QA meetings . . . 6. INVESTIGATION Upon receipt of an alleged charge of abuse, neglect, or	F 226	**F 226** 1. N/A 2. Audit form created and random audits have completed. 3. Nursing staff have been re-educated on regulatory requirements regarding immediate reporting allegations of neglect or abuse to the Administrator. Eventide's Vulnerable Adult policy was updated. 4. Corrective action completed by 5. Random audits will be completed 2 times weekly times a month by nurse management or designee and then per QA. Results will be reviewed at QA meetings.	2/14/2013

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F 226	Continued From page 4 misappropriation of property, management will immediately notify the State Department of Health (within one (1) working day) and management will then investigate the allegation utilizing staff, residents, or those individuals likely to provide information. This will be done within 48 hours of the receipt of the alleged charge and not later than five (5) working days. . . . " The facility policy conflicts with regulatory requirements regarding immediate reporting [within 24 hours] allegations of neglect or abuse to the facility's Administrator and to the State survey and certification agency.	F 226	**F 226 (revised)** **1.** N/A **2.** N/A **3.** Nursing staff have been re-educated on regulatory requirements regarding immediate reporting allegations of neglect or abuse to the Administrator. Eventide's Vulnerable Adult policy was updated. **4.** Corrective action completed by **5.** The policy was reviewed by corporate QA and is in compliance with the regulation.	2/14/2013
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, record review, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity and respect for 1 of 1 sampled resident (Resident #4) requiring total assistance with feeding. Failure to ensure dignity and respect in the dining room does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: When requested, the facility failed to submit a	F 241		

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F 241	Continued From page 5 policy on feeding dependent residents. Observations revealed the following: * On 01/08/13 at 10:00 a.m., the CNA (#16) fed Resident #4 a Magic Cup for her morning snack. After two teaspoons, the resident began drooling. Using the spoon, the CNA (#16) scraped the saliva/food from the resident's face, mixed it into the food remaining in the cup, and continued to feed her. * On 01/08/13 at 12:15 p.m., the CNA (#16) fed Resident #4 a Magic Cup at lunch. After two teaspoons, the resident began drooling. Using the spoon, the CNA (#16) scraped the saliva/food from the resident's face, mixed it into the food remaining on her plate, and continued to feed her. * On 01/09/13 at 9:55 a.m., the CNA (#11) fed Resident #4 hot cereal for breakfast. As the CNA (#11) fed Resident #4, she dripped cereal on the resident's clothing protector five times. In addition, Resident #4 began drooling slightly. Using the spoon, the CNA (#11) scraped the saliva/food from the resident's face and the drips of food from her clothing protector, mixed them into the food remaining on her plate, and continued to feed her. Review of Resident #4's medical record occurred on January 7-10, 2013. Diagnoses included cerebral vascular accident (CVA), facial muscle weakness, dysphagia, history of aspiration pneumonia, and esophageal reflux. The quarterly Minimum Data Set (MDS), dated 12/13/12, identified severely impaired cognitive skills and extensive to total assistance of one person required for eating.	F 241	**F 241** 1. N/A 2. Audit form created and random audits have been completed. 3. Nursing aids and PFAs will have received the brochure (compiled by our QA nurse and speech therapist) containing education on dignity and no "spooning" food off lips, chin or napkins, etc. Eventide policy was reviewed and continues to be appropriate. 4. Corrective Action completed by 5. Random audits will be completed 2 times weekly times a month as well as daily with meal monitors and then per QA with assistance by nursing management or designee. There will be re-education of staff as necessary. Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	2/14/2013

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F 241	Continued From page 6 During an interview on 01/10/13 at 9:45 a.m., an administrative dietary staff member (#21) confirmed staff are taught to use napkins to wipe saliva/food from residents' faces.	F 241	**F 241 (revised)** **1.** N/A **2.** Audit form created and random audits have been completed. Audits monitor a sample of residents during mealtime, in their room and dining room. Staff are monitored for close to a 90 degree position, dysphagia diagnoses, signs/symptoms of dysphagia, if staff responded appropriate if issues were noted, staff assisting correctly (ex. no spooning), appropriate height and closeness to table and if any concerns noted appropriate accommodations made and referrals made as needed. **3.** Nursing aids and PFAs will have received the brochure (compiled by our QA nurse and speech therapist) containing education on dignity and no "spooning" food off lips, chin or napkins, etc. Eventide policy was reviewed and continues to be appropriate. **4.** Corrective Action completed by **5.** Random audits will be completed 2 times weekly times a month as well as daily with meal monitors, then 2 times a month for 3 months, and then 3 times quarterly for a year. There will be re-education of staff as necessary. Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	2/14/2013
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to ensure a reclining wheelchair was available for use for 1 of 1 sampled resident (Resident #4) who required a reclining wheelchair [Geri-chair] for positioning purposes. Failure to ensure the resident's reclining wheelchair was available resulted in her having to remain in bed, and miss scheduled activities within the facility. Findings include: Observation revealed the following: * On 01/08/12 at 8:31 a.m., Resident #4 lay in bed. A certified nurse assistant (CNA) (#18) stated, "She'll stay in bed, because someone on the 400 wing needs her chair to get to a dentist appointment. Sometimes they borrow chairs for appointments. Her chair leans back, so . . ." * At 10:00 a.m., after feeding Resident #4 her	F 246		

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F 246	Continued From page 7 morning snack in bed, CNA (#19) laughed and stated, "Oh, so you've had to stay in bed this morning." * At 11:58 a.m., Two CNAs (#16 and #20) transferred the resident from her bed to her reclining wheelchair [Geri-chair]. They stated, "They just brought her chair back not too long ago." Review of Resident #4's medical record occurred on January 7-10, 2013. Diagnoses included depression, contractures, and osteoarthrosis. The quarterly Minimum Data Set (MDS), dated 12/13/12, identified severely impaired cognitive skills and extensive to total assistance of one or more people for bed mobility, transfers, and locomotion. The current care plan identified, ". . . Focus: ADL Self Care Performance Deficit . . . Interventions: . . . I use Geri-chair for positioning-propelling per staff . . ." During an interview on 01/10/13 at 10:30 a.m., an administrative nurse (#12) stated, "We can't use a lift at the dentist's office. The resident has to be able to lie down at the dentist's office. All of the Geri-chairs are being used. Staff decide whose chair to use." She confirmed Resident #4 should have had access to her wheelchair. 2. Based on observation, record review, and staff interview, the facility failed to ensure reasonable accommodation of individual needs regarding positioning for 3 of 14 sampled residents observed at meals (Resident #12, #14, and #19). Failure to provide appropriate seating for dining may limit the quality of the dining experience,	F 246	**F 246 (revised)** **1.** Staff involved was educated on accommodating resident #4's needs by making sure she was at close to a 90 degree angle with all meals, not leaning over to the side. Resident #12, #14, and #19's mealtime positioning was evaluated and corrected. Resident #12 was evaluated by OT and positioning changes made. Resident #14 is to sit in wheel chair with pedals off. Resident # 19 has a TV tray in her room to use as she still requests to sit in her recliner. Care Plans and CNA daily care plans were updated. **2.** All residents mealtime positioning reviewed and adjustments made as necessary, therapy referrals as needed, and TV trays added as needed. **3.** Staff educated at CNA & Nurses meeting that if in the rare chance in the future a resident's chair is borrowed the resident's needs still must be met using other accommodations. If a chair is needed and no extra ones available the other residents who have the kind of chair needed will be evaluated. If this will not interfere with that resident's daily activities permission will be asked for by resident or POA. If this is not appropriate then PT/OT will be asked to assess the resident needing the chair for an acceptable chair to use. Audit form created and random audits have been completed monitoring resident's positioning at mealtimes. (Close to 90 degree and height and closeness to table)	

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F 246	Continued From page 8 cause discomfort, unnecessary fatigue, and decreased meal intake. Findings include: - Observations in the dining room on 01/08/13 at 5:15 p.m. and on 01/09/13 at 9:20 a.m. and 5:55 p.m., showed Resident #12 seated in her wheelchair at a dining room table eating meals. Resident #12's wheelchair arms, level with the table, resulted in her being approximately one foot from the table. While seated in this position, observations showed Resident #12 dropping food, including soup, on her clothing protector when not assisted by staff. Review of Resident #12's medical record occurred on January 7-9, 2013. Medical diagnoses included dementia, hemiplegia, macular degeneration. The most recent quarterly Minimum Data Set (MDS), dated 10/24/12, identified Resident #12 as requiring extensive assistance with eating. - Observations in Resident #14's room on 01/07/13 at 12:15 p.m. and 01/08/13 at 8:20 a.m. showed Resident #14 seated in his wheelchair with a meal tray on an overbed table in front of him. Resident #14's wheelchair pedals, attached at the front of his wheelchair, resulted in him being approximately one foot from the overbed table.The resident, identified as interviewable by the facility, stated he had been ill and not eaten well the whole week and needed to "get something in me." Observation showed Resident #14 struggling to pull the overbed table closer to him on 01/07/13 at 12:15 p.m. While seated in this position, observation showed Resident #14	F 246	Staff also educated at these meetings in relation to positioning at meals. Eventide's policy reviewed and continues to be appropriate. 4. Corrective action completed. 5. Nurses/Managers/Meal time monitors will perform random audits 2 times weekly times a month, then 2 times a month for 3 months, and then 3 times quarterly for a year. They will be monitoring appropriate seating, positioning, and table height.	2/14/2013

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F 246	Continued From page 9 dropping food onto his lap. Observation in Resident #14's room on 01/09/13 at 5:55 p.m., showed Resident #14 seated in a recliner with a meal tray on an overbed table in front of him. The overbed table, in its lowest position and as close as the recliner allowed, remained approximately one foot from the resident. While seated in this position, observation showed Resident #14 leaning forward, reaching up to eat, and dropping food in his lap. When this surveyor entered the resident's room on 01/09/13 at 5:55 p.m., Resident #14 stated, "Too high up in air [overbed table] not know if I can do this." Review of Resident #14's medical record occurred on January 7-9, 2013. Medical diagnoses included muscle weakness, osteoarthrosis, backache, and dysphagia. The resident's most current annual MDS, dated 12/10/12, identified Resident #14 as requiring set help with eating. - Observation in Resident #19's room on 01/09/13 at 6:00 p.m., showed Resident #19 seated in a recliner with a meal tray on an overbed table in front of her. The overbed table in its lowest position and as close as the recliner allowed, remained approximately one foot from the resident. While seated in this position, observation showed Resident #19 leaning forward to eat. When questioned regarding her positioning for meals in her room on 01/10/13/at 9:30 a.m.,	F 246	**F 246** **1.** Staff involved was educated on accommodating resident #4's needs. Resident #12, #14, and #19's mealtime positioning was evaluated and corrected. Resident #12 was evaluated by OT and positioning changes made. Resident #14 is to sit in wheel chair with pedals off. Resident # 19 has a TV tray in her room to use as she still requests to sit in her recliner. Care Plans and CNA daily care plans were updated. **2.** All residents mealtime positioning reviewed and adjustments made as necessary, therapy referrals as needed, and TV trays added as needed. **3.** Staff educated at CNA & Nurses meeting that if in the rare chance in the future a resident's chair is borrowed the resident's needs still must be met using other accommodations. Audit form created and random audits have been completed. Staff also educated at these meetings in relation to positioning at meals. Eventide's policy reviewed and continues to be appropriate. **4.** Corrective action completed. **5.** Nurses/Managers/Meal time monitors will perform random audits 2 times weekly times a month and then per QA and reviewed at QA meetings.	2/14/2013

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	355078	A. BUILDING _____ B. WING _____	01/10/2013

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F 246	Continued From page 10 Resident #19, identified as interviewable by the facility, confirmed, "Back hurts it's not very comfortable." Review of Resident #19's medical record occurred on January 7-9, 2013. Medical diagnoses included osteoarthrosis, myalgia (muscle pain), muscle weakness, and dysphagia. The resident's most current annual MDS, dated 10/14/12, identified Resident #19 as requiring set up help with eating. During an interview on 01/09/13 at 4:20 p.m., an administrative nurse (#12), stated if staff notice a concern with the resident's distance from the table, they should report it to administrative staff. The nurse confirmed these resident observations should be reported. During an interview on 01/10/13 at 9:45 a.m., an occupational therapist (#25) stated she had not received a referral to assess Resident #12, #14, and #19 for positioning at meals. She confirmed these residents should be further assessed.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to	F 248		

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F 248	Continued From page 11 implement an individualized activity program for 2 of 21 sampled residents (Resident #4 and #5). Failure to implement an individualized activity program to respond to the interests and current capabilities of the resident has the potential to affect their physical, cognitive, and emotional health. Findings include: - When requested, the facility failed to submit a policy on providing residents with activities. Observations of Resident #4 revealed the following: * On 01/08/12 at 8:31 a.m., Resident #4 lay in bed [no TV/radio on]. A certified nurse assistant (CNA) (#18) stated, "She'll stay in bed, because someone on the 400 wing needs her chair to get to a dentist appointment. [approximately 1 hour 30 minutes of silence] At 10:00 a.m., after providing cares, the CNA (#16) turned on the resident's TV. [This was the only observation of facility staff turning on the resident's TV/radio throughout the survey.] * Sitting in reclining wheelchair near the nurse's station: 01/07/13 at 4:35 p.m., 01/08/13 at 12:15 p.m. and 5:50 p.m., and 01/09/13 at 11:55 a.m. * Sitting in reclining wheelchair in her room [no TV/radio on]: 01/09/12 at 7:43 a.m. to 9:30 a.m. [approximately 2 hours 10 minutes of silence] * Lying in bed in her room [no TV/radio on]: 01/08/13 at 8:31 a.m., 9:45 a.m., 10:45 a.m., 1:05 p.m., 3:30 p.m., and 4:13 p.m. [approximately 3 hour 10 minutes of silence] * 01/09/13 at 7:43 a.m., Resident #4 sat in her reclining wheelchair [Geri-chair] [no TV/radio on]: as two CNAs (#11 and #15) stated, "We don't	F 248	**F 248 (revised)** 1. Resident #4 expired on 1/17/13. Her family was at her bedside throughout the days prior. Supportive care was provided to resident and family as needed. Chaplain visits and prayer were provided as desired. Resident #5 was provided scheduled 1-1 visits and PRN visits by activity staff. Scheduled 1-1 visits were started on 1/7/13 due to a decline in group activity attendance. Resident #5 expired on 1/24/13. **2.** Residents at risk are identified on the MDS as having cognitive/communication deficits or total assistance with mobility. Also changes are monitored at IDT meetings along with appropriate changes in the plan of care. **3.** Activity and Nursing staff will provide or facilitate in room activity and 1-1 visits as care planned. Activity Programming for residents identified at risk include small group activities scheduled daily Monday through Friday. At risk residents attend these small groups 1-3 times a week as care planned. These groups provide sensory, social, cognitive activities in a small group setting with approaches appropriate to the resident's needs. At risk residents also are assisted to scheduled larger group activities such as music programs, church services,	

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F 248	Continued From page 12 have any PFAa [paid feeding assistants] working today, so it will be awhile [before we feed her breakfast]." At 9:50 a.m., staff transferred the resident into the dining room for breakfast. This coincided with the chapel service. [approximately 1 hour 50 minutes of silence] Review of Resident #4's medical record occurred on January 7-10, 2013. Diagnoses included depression and malaise. The quarterly Minimum Data Set (MDS), dated 12/13/12, identified severely impaired cognitive skills. The annual MDS, dated 06/13/12, identified having books, newspapers, and magazines to read, listening to music, being around animals, and keeping up with the news, and participating in religious services as very important to her, and participating in group and/or outdoor activities as somewhat important to her. The current care plan identified, ". . . Focus: I need encouragement and assistance to attend group activities . . . Interventions: . . . I like the following independent activities: reading magazines . . . I need 1 to 1 bedside/in-room visits and activities if unable to attend out of room events, I need encouragement to attend activity functions, My preferred activities are: music programs, Chapel service, devotions, current events, Provide 1:1 visits PRN . . ." The activity progress note, dated 01/07/13, identified, ". . . [Resident #4] attends church services, music programs, and current events. She watches t.v. in her room and gets along well with her roommate. She is out of her room daily sitting by the 3-5 [300-500 unit] nurse's desk. She needs reminders and assistance to attend group	F 248	games such as balloon volleyball as care planned for each individual. Discussions concerning resident changes and activity needs are ongoing between Activity Coordinators and Activity Director. Activity Staff discuss and report information from weekly IDT meetings to other Activity Coordinators. Monthly activity staff meetings are scheduled to discuss programming. Daily Activity schedules are provided to Nursing staff (CNAs) daily. This schedule also indicates which residents should be encouraged to attend specific activities. In room activity is monitored by the QA process and documentation by activity and nursing staff. Staff education has been provided. CAN education addressed the following; the role of CNAs with activities. CNAs assist/provide activities such as 1-1 visits, reading, reminisce, manicures along with offering assistance with TV, radio, computer as needed by each resident. Activity staff education included monitoring activity participation closely to respond to changes in activity needs. Inform residents, when in resident's rooms, of activities, offer assist with TV/radio, reading material. Provide 1-1 visits/activity as schedules and PRN as on	

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F 248	Continued From page 13 activities. Her family visits often. She is meeting her act. [Activity] goal at this time . . ." The resident activity record identified the following: * December 1-31, 2012 - The activity and/or CNA staff recorded "1:1 visits and/or TV/radio" as the activities of the day on 17/31 days. In addition, staff failed to assist Resident #4 to music the second week of December and to devotions/chapel service the fourth week of December. * January 1-8, 2013 - The activity and/or CNA staff recorded "1:1 visits and/or TV/radio" as the activities of the day on 4/8 days. In addition, staff failed to assist the resident to devotions/chapel service and/or music the first week of January. - During a resident interview on 01/08/13 at 7:37 a.m., when asked how she finds out about the activities scheduled throughout the day, Resident #5 stated, "If I ask, they'll [staff] tell me." She indicated she has difficulty seeing, and therefore has difficulty reading the activity calendar. When asked if staff invited her to participate in activities, she stated, "Activities [staff] asks [me] sometimes." Observations of Resident #5 revealed the following: * Sitting in wheelchair near the nurse's station: 01/07/13 at 4:40 p.m. * Sitting in recliner in her room [no TV/radio on]: 01/08/13 at 1:00 p.m. to 3:30 p.m. [approximately 2 hour 30 minutes of silence] * Sitting in wheelchair in her room [no TV/radio on]: 01/08/13 at 8:16 a.m., 10:35 a.m. and 12:55 p.m. [approximately 1 hour 35 minutes of silence	F 248	care plan. Remind nursing staff of activities. **4.** Corrective action completed by **5.** Beginning February 11, 2013 the activity Director or designee began the monitoring of 10 residents weekly x 4 weeks for adequate and appropriate involvement in activities and as care planned, then 10 residents a month x 2 months, then quarterly x 3 quarters, and then based on compliance. Results will be shared with the QA committee and changes/interventions implemented.	2/14/2013

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F 248	Continued From page 14 prior to the noon meal]; and 01/09/13 at 10:15 a.m. Review of Resident #5's medical record occurred on January 7-10, 2013. Diagnoses included anxiety, depression, and macular degeneration. The quarterly MDS, dated 12/17/12, identified moderately impaired cognitive skills. The annual MDS, dated 06/17/12, identified using the telephone, listening to music, being around animals, keeping up with the news, and participating in religious services as very important to her, and participating in group and/or outdoor activities as somewhat important to her. The current care plan identified, ". . . Focus: I am dependent on staff for reminders and assistance to activities . . . Interventions: . . . I like the following independent activities: listening to music, Staff will assist as needed, I need 1 to 1 bedside/in-room visits and activities if unable to attend out of room events, I need assistance/encouragement to attend activity functions, My preferred activities are: Devotions, Chapel Service, Socials and Music Activities, Provided 1:1 visits 2x's [times] aweek [sic] . . . " The activity progress note, dated 12/11/12, identified, ". . . [Resident #5] is meeting her act goal at this time. She is coming out to the dining room for meals and visits with staff and residents. She attends devotions, chapel service, and socials. She needs reminders and assistance to attend group activity. She listens to the radio and CDs in her room . . . She responds well to 1-1 visits . . ." The resident activity record identified the	F 248	F 248 1. Resident #4 expired on 1/17/13. Her family was at her bedside throughout the days prior. Supportive care was provided to resident and family as needed. Chaplain visits and prayer were provided as desired. Resident #5 was provided scheduled 1-1 visits and PRN visits by activity staff. Scheduled 1-1 visits were started on 1/7/13 due to a decline in group activity attendance. Resident #5 expired on 1/24/13. 2. Activities are reviewed at IDT meetings as are changes that may require increase of in room activity. 3. Activity and Nursing staff will provide or facilitate in room activity and 1-1 visits as needed. This may include assisting with turning on TV to favorite programs, turning on radio or music, offering books, newspaper or magazines, assisting with talking books and offering manipulative items. Staff education was provided to CNAs on 1/23/13 and to Activity staff on 1/22/13. 4. Thirty-five (35) days from the date of survey, which is 2/14/2013	

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F 248	Continued From page 15 following: * December 1-31, 2012 - The activity and/or CNA staff recorded "1:1 visits and/or radio" as the activities of the day on 17/31 days. In addition, staff failed to assist Resident #5 to devotions/chapel service the last week of December. * January 1-8, 2013 - The activity and/or CNA staff recorded "1:1 visits and/or radio" as the activities of the day on 5/8 days. In addition, staff failed to assist the resident to devotions/chapel service and/or music the first week of January. During interviews on 01/09/13 at 10:35 a.m. and 01/10/13 at 11:45 a.m., an administrative activity staff member (#13) stated "It is important to engage people, to talk to them. One on one visits can be either scheduled or prn [as needed] and are 5, maybe 10 minutes [in length]." When asked if staff listen to music or watch a program with the residents [when they mark "radio or TV" on the activity record], she stated, "No, they turn on the radio or TV for the resident [and leave the room]." She also emphasized the residents are often brought out of their rooms to "sit near the nurse's station."	F 248	5. A QA process is in place to assure that the activity plan of care for all residents are followed. Audits to ten (10) residents will be completed weekly by designated staff for four (4) weeks, then in on (1) month, then quarterly of two (2) quarters, then based on compliance will continue to be completed as needed by Activity Director or designee. Additional education will be provided to individuals as necessary. Audit data will be forwarded to Quality Assurance.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

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F 278	Continued From page 16 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), record review, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 4 of 6 sampled residents (Resident #5, #6, #7, and #8) observed with toileting and coded on the current MDS for a toileting program. Failure to provide sufficient data to support a toileting program, including the resident's potential for maintaining/improving continence, does not allow the facility to accurately code the MDS and does not allow each resident's comprehensive assessment to direct the development of a care plan consistent with their individual needs and problems.	F 278		

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F 278	Continued From page 17 Findings include: The Long-Term Care Facility RAI User's Manual, dated October 2012, pages H-5 and H-6, states "Toileting programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to: simply tracking continence status . . . random assistance with toileting or hygiene." Requirements include, "implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern . . . notations of the resident's response to the toileting program and subsequent evaluations . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The quarterly MDSs, dated 08/15/12 and 11/15/12, both indicated the resident was on a current toileting program or trial and frequently incontinent of urine and bowel. Resident #7's bladder assessment, dated 11/12/12, indicated the resident demonstrated "urge incontinence . . . nocturia >2 times [more than twice a night], urine loss on the way to the bathroom, moderate to large amount of leakage, and enuresis [involuntary loss of urine]" and the treatment plan: "Keep dry or 'check and change' - the resident is inconsistently incontinent; difficult to establish a regular voiding pattern. The care plan specifies exact intervals to check and change and/or toilet."	F 278		

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F 278	Continued From page 18 Resident #7's current care plan for Activities of Daily Living (ADLs) stated, ". . . Frequently incontinent of bowel and bladder . . . Toilet per schedule and check and change prn [as needed]. . . ." During an interview on 01/08/13 at 1:30 p.m., a certified nurse aide (CNA) (#11) stated staff toilet Resident #7 every 2-3 hours and about 50% of the time the resident is dry. The facility's assessment of Resident #7's continent status as "inconsistently incontinent" and treatment plan to "keep dry or check and change" does not support the definition of an individualized toileting program. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. The significant change MDS, dated 08/10/12, indicated the resident was not on a current toileting program or trial, and was frequently incontinent of urine and bowel. The quarterly MDS, dated 11/10/12, indicated the resident was on a current toileting program or trial and frequently incontinent of urine and bowel. Resident #8's bladder assessment, dated 08/13/12, showed symptoms of "stress urinary incontinence . . . incontinence without sensation of urine loss" and "functional urinary incontinence . . . mobility/manual dexterity impairments" and the treatment plan: "Toielted [sic] every 2 hours if res. [resident] is agreeable and checked and changed prn [as needed] if res. is not agreeable to using the toilet." The bladder assessment,	F 278	**F 278 (revised)** **1.** The last MDS' for resident's #5, #6, #7, and #8 were corrected on 1/11/2013. These corrections did not result in a change of classification for any of these individuals. **2.** The MDS coordinators have gone through the entire list of current resident's MDS' and corrections have been made in reference to toileting programs as needed. No corrections resulting in a classification change. Completed by 1/31/13. Audit form created and random audits have been completed to make sure that if toileting programs are coded on MDS it has been after 3 day assessment and scheduled to benefit the resident. **3.** The MDS coordinators currently look at a resident's toileting schedule, compare with the bowel/bladder assessment, see if any adjustments for individualization have been made, and resident is benefiting from the plan. The MDS coordinators have been re-reviewed the guidelines and MDS manual for capturing a toileting schedule on the MDS. **4.** Corrective action completed by **5.** Random audits will be completed weekly for a month, for accuracy of coding a toileting program, then per month x 2 months, then quarterly x 3 quarters, and then per QA with assistance by nursing management or designee. There will be re-education as necessary.	2/14/2013

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F 278	Continued From page 19 dated 11/12/12, indicated the resident demonstrated "urge incontinence . . . nocturia >2 times, urine loss on the way to the bathroom, and enuresis" and the treatment plan: "Keep dry or 'check and change' - the resident is inconsistently incontinent; difficult to establish a regular voiding pattern. The care plan specifies exact intervals to check and change and/or toilet." Resident #8's current care plan for ADLs stated, "I am frequently incontinent of bladder and bowel. I am physically abusive to staff and will refuse toileting, walking . . . Toilet Use: I am toileted every 2-3 hours per schedule and request. . . . " Resident #8's CNA task schedule for toileting included daily at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 10:30 a.m., 1:00 p.m., 4:00 p.m., 7:00 p.m., 10:00 p.m., and PRN. The facility's assessment of Resident #8's continent status as "inconsistently incontinent" and treatment plan to "keep dry or check and change" does not support the definition of an individualized toileting program. During an interview on 01/10/13 at 3:00 p.m., discussing the coding of Resident #7 and #8's toileting programs on their MDSs, an MDS nurse (#17) stated, "I do not disagree that they [toileting programs] should not be [coded] on the MDS." - Review of Resident #5's medical record occurred on January 7-10, 2013. Diagnoses included incontinence. The quarterly MDS, dated 12/17/12, identified on a current toileting program and frequent urinary incontinence. The bladder assessment, dated 12/16/12,	F 278	Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	

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	355078	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

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F 278	Continued From page 20 identified, ". . . Incontinence Symptom Profile . . . UI [urinary incontinence] in small amounts . . . frequency of urination . . . symptoms of both stress and urge [incontinence] . . . Treatment Plan . . . Prompted voiding . . . At a specified interval/time the staff will: check on the resident, ask if resident knows if they are wet or dry, prompt to use toilet even if is already wet, praise for either the effort to use the toilet or being dry, correct if the resident was wet and remind them that the expectation is to stay dry . . ." The current care plan identified, ". . . Focus: ADL Self Care Performance Deficit . . . Interventions: TOILET USE: I am toileted every 2-3 hours and res [resident] will also toilet self . . . Encourage me to use bell to call for assistance . . ." The facility's assessment of Resident #5's continent status as "[urinary incontinence] in small amounts" and treatment plan to "check on the resident" does not support the definition of an individualized toileting program. - Review of Resident #6's medical record occurred on January 7-10, 2013. Diagnoses included dementia, history of urinary tract infection, and constipation. The quarterly MDS, dated 10/21/12, identified on a current toileting program and frequent urinary/bowel incontinence. The bladder assessment, dated 01/06/13, identified, ". . . Incontinence Symptom Profile . . . incontinent without sensation of urine loss, nocturia [excessive urination during the night] . . . moderate to large amount of leakage, enuresis [urination after the age at which bladder control should have been established], symptoms of both	F 278	F 278 1. The last MDS' for resident's #5, #6, #7, and #8 were corrected on 1/11/2013. These corrections did not result in a change of classification for any of these individuals. 2. The MDS coordinators have gone through the entire list of current resident's MDS' and corrections have been made in reference to toileting programs as needed. No corrections resulting in a classification change. Completed by 1/31/13. Audit form created and random audits have been completed. 3. The MDS coordinators currently look at a resident's toileting schedule, compare with the bowel/bladder assessment, see if any adjustments for individualization have been made, and resident is benefiting from the plan. All of these things must be met before the MDS coordinator marks a toileting program on the MDS. 4. Corrective action completed by 5. Random audits will be completed weekly for a month, and then per QA with assistance by nursing management or designee. There will be re-education as necessary. Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	2/14/2013

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F 278	Continued From page 21 stress and urge [incontinence] . . . Treatment Plan . . . Keep dry or "check and change" - the resident is inconsistently incontinent; difficult to establish a regular voiding pattern. The care plan specifies exact intervals to check and change and/or toilet . . ." The current care plan identified, ". . . Focus: ADL Self Care Performance Deficit . . . Interventions: TOILET USE: The resident requires assist of 1 to use toilet. I am toileted per request . . ." The facility's assessment of Resident #5's continent status as "moderate to large amount of leakage" and treatment plan to "keep dry or check and change" does not support the definition of an individualized toileting program. During interviews on the morning of 01/10/13, an administrative nurse (#12) confirmed Resident #5 and #6's toileting programs were not individualized to meet their specific needs.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, review of facility policy and	F 309		

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F 309	Continued From page 22 procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #4), identified as having a history of aspiration pneumonia, received the care and services necessary to attain the highest degree of safety possible while being fed in her room and/or in the dining room. Failure to adequately assess and provide services based on the assessment has the potential to affect the resident's overall swallow safety, placed her at greater risk of aspiration and limited her nutritional intake. Findings include: Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, 2007, pages 9, 15-16 and the educational handouts identified the following: * "Signs and Symptoms of Dysphagia: . . . Drooling . . . Weight loss . . . Coughing/Choking . . . Pocketing . . . Pneumonia . . . Changes in diet . . . Reflux . . ." * "Neurological Causes [of dysphagia]: . . . Stroke . . ." * "What are some signs of dysphagia?: Signs of oral phase dysphagia include pocketing of food in the cheeks, losing food or liquid out the front of the mouth . . . Signs of pharyngeal dysphagia are coughing or choking during a meal . . ." * "What good are postural changes?: Some postural changes [being as close to 90 degrees as possible] can provide increased airway protection . . . " The facility policy titled "Resident Care Standards," revised 03/29/12, stated ". . . 2. Provides for the fluid and nutrition needs of the resident . . . a. Maintains adequate and	F 309	F 309 1. Nursing staff involved were educated regarding resident #4 on resident positioning at meals, dysphagia, and following residents diet as ordered. Direct staff care guides updated in greater detail. 2. Audit form created and random audits completed and other residents in Geri-chairs, reclining chairs, or if they eat in bed was also reviewed. Policy reviewed. 3. Nursing staff will have received the brochure (compiled by our QA nurse and speech therapist) containing education on positioning at meals, dysphagia, and following residents diet as ordered. CNA/Nursing meetings held and education completed at meetings. 4. Corrective action completed by 5. Random audits will be completed 2 times weekly times a month with assistance by nurse management or designee, and then per QA. There will be re-education of staff as necessary. Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	2/14/2013

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F 309	Continued From page 23 prescribed diet under the direction of the dietician . . . h. Monitors eating, chewing, and swallowing abilities. Keeps the head of the bed elevated if being fed in bed . . ." Review of Resident #4's medical record occurred on January 7-10, 2013. Diagnoses included cerebral vascular accident (CVA), facial muscle weakness, dysphagia, history of aspiration pneumonia, and esophageal reflux. The quarterly Minimum Data Set (MDS), dated 12/13/12, identified severely impaired cognitive skills and extensive to total assistance of one person required for eating, weight loss not physician prescribed, and mechanically altered/therapeutic diet. The current care plan identified, ". . . Focus: ADL Alt [alteration] in nutrition. Dx of Dysphagia [and] esophageal reflux. Schatzki's ring at the distal esophagus w [with]/sliding hiatal hernia . . . Goal: Resident will have no episodes of aspiration . . . Interventions: . . . 07/20/12 Consistency changed to pureed, and continue nectar thick liquids, per speech therapist . . . Dysphagia precautions prn. Monitor for s/s [signs/symptoms] of aspiration . . ." During an interview on 01/09/12 at 4:30 p.m., a managerial nurse (#14) explained "dysphagia precautions" meant "a paid feeding assistant (PFA) could not feed this resident." An administrative nurse (#10) provided an inservice on dysphagia, undated, which included the signs/symptoms of aspiration. She stated, "The staff are educated on what to look for." A physician visit note, dated 07/23/12, stated, ". . .	F 309	**F 309 (revised)** **1.** Nursing staff involved were educated regarding resident #4 on resident positioning at meals, dysphagia, and following residents diet as ordered. Direct staff care guides updated in greater detail. **2.** Audit form created and random audits completed to monitor that residents are sitting close to 90 degree angle, upright in their chair with the appropriate table height and distance from table. Other residents in Geri-chairs, reclining chairs, or residents who eat in bed were also reviewed. Policy reviewed. **3.** Nursing staff will have received the brochure (compiled by our QA nurse and speech therapist) containing education on positioning at meals, dysphagia, and following residents diet as ordered. CNA/Nursing meetings held and education completed at meetings. **4.** Corrective action completed by **5.** Random audits will be completed 2 times weekly times a month with assistance by nurse management or designee, then x 2 months, then quarterly x 3 quarters, and then per QA. There will be re-education of staff as necessary. Audit Data will be reported and given to the director of QA and reviewed at QA meetings.	2/14/2013

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F 309	Continued From page 24 It was noted that she was pocketing her food. Swallow evaluation was done, her diet was changed to a liberal geriatric diet with puree and nectar thickness . . . Impression: 1. Pneumonia . . . Plan: due to clients recent history of having swallowing concerns her associated hypoxia and her fever as well as her mildly elevated white blood cell count. Likely she has pneumonia . . ." The physician orders, dated 10/31/12, stated, ". . . Type: Liberal Geriatric diet . . . Texture: Puree Fluid Consistency: Nectar Thick . . ." A nutritional assessment, dated 12/07/12, stated, ". . . Hx. [history] of coughing with any consistency. Coughing not as frequent with altered consistency. Resident no longer attempts to feed self. Eats in DR [dining room]. CNA only to assist as dysphagia precaution . . ." The daily meal ticket also stated, ". . . CNA TO ASSIST ONLY/NECTAR THICK LIQUIDS . . ." The Nutrition Progress Notes identified the following: *12/07/12, ". . . Altered consistency of puree with nectar thick liquids since 07-20-12. No c/o [complaints of] GI [gastro-intestinal] distress. Right side hemiparesis r/t [related to] past CVA. Also has Schatzki's ring at the distal esophagus. PO [oral] intake of meals range 25-100%, with intake often 50% or greater . . . No sxs [signs/symptoms] of aspiration . . ." Observations revealed the following: * On 01/08/13 at 10:00 a.m., the CNA (#16) raised Resident #4's bed to a 35-40 degree angle, and then fed her a Magic Cup for "morning snack." After two teaspoons, the resident began	F 309		

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F 309	Continued From page 25 drooling. The CNA (#16) then handed Resident #4 a glass containing nectar thickened water. She took a sip, and began drooling. * On 01/08/13 at 12:15 p.m., the CNA (#16) raised Resident #4's reclining chair to an 80 degree angle and fed her lunch. After two teaspoons of her Magic Cup, the resident began drooling. * On 01/08/13 at 5:22 p.m., the CNA (#8) raised Resident #4's reclining chair to a 50 degree angle and fed her supper. While answering the surveyor's question regarding the consistency of the foods on Resident #4 tray, the CNA (#8) stated, "Her pie is totally thin." She then requested thickener be brought to the table. When the CNA (#8) offered the resident a drink of nectar thickened milk, she began coughing and drooling. * On 01/09/13 at 9:55 a.m. the CNA (#11) raised Resident #4's reclining chair to a 80-85 degree angle and fed her breakfast. When the CNA (#8) offered the resident hot cereal, she began drooling. * On 01/09/13 at 5:10 p.m., the CNA (#9) raised Resident #4's reclining chair to a 55 degree angle and fed her supper. Resident #4 leaned heavily to the left, with her right hip near the right arm rest, her body leaning to the left, and her left arm hanging over the side of the chair. After two teaspoons of her Mighty Shake, the resident began drooling. While answering the surveyor's question regarding the consistency of the foods on Resident #4's tray, the CNA (#8) identified she had also received thin chocolate milk and then went to the kitchen for a thickened liquid. * On 01/09/13 at 5:25 p.m., an administrative nurse (#10) attempted to reposition Resident #4, moving her closer to midline. The administrative	F 309		

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F 309	Continued From page 26 nurse (#10) sat down next to Resident #4, and began feeding her by offering her a drink of [thin] chocolate milk. The resident immediately began coughing. A CNA (#9) returned to the table at this time, carrying a nectar thickened milk. After asking the CNA who the milk belonged to, the administrative nurse (#10) stated, "Oh, she's supposed to have thickened? " During an interview on 01/10/13 at 10:30 a.m., an administrative nurse (#12) confirmed staff are taught the signs/symptoms of aspiration, about diet modifications, and proper feeding positions. The facility failed to ensure Resident #4 received the care and services necessary to attain the highest degree of safety possible while being fed in her room and in the dining room. They failed to 1) offer nectar thickened-liquids as ordered; not thin liquids, 2) position the resident as close to 90 degrees as possible [in her bed and/or reclining wheelchair], and 3) identify the resident's signs/symptoms of dysphagia (drooling and coughing during a meal).	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview,	F 312		

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F 312	Continued From page 27 the facility failed to provide supervision and assistance for 2 of 2 sampled residents (Resident #6 and #15) observed during meals and requiring assistance to modify their regular consistency foods. Failure of the facility to provide supervision and assistance during meals has the potential to affect the residents' ability to maintain their caloric intake and/or nutritional status. Findings include: The facility policy titled "Resident Care Standards," revised 03/29/12, stated ". . . 2. Provides for the fluid and nutrition needs of the resident . . . b. Feeds resident as needed . . . F. Recognizes that several factors may have an effect on nutritional intake . . . Poor eyesight or other physical handicaps . . . I. Alters the consistency of the diet as necessary to meet the resident's needs . . ." - Review of Resident #15's medical record occurred on January 9-10, 2013. Diagnoses included senile dementia, aphasia, macular degeneration, dysphagia, potential for aspiration, anemia, protein/calorie malnutrition, history of significant weight loss, and adult failure to thrive. The annual Minimum Data Set (MDS), dated 10/03/12, identified severely impaired cognitive skills and supervision and one person assist with eating. The current care plan identified, ". . . Focus: Alteration in Nutrition . . . Goals: Resident will show no s/s [signs or symptoms] of aspiration. Wt. [weight] will remain above 80# [pounds] . . . Interventions: Assist and encourage with meals prn [as needed] . . . Diet as ordered; select menu	F 312		

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F 312	Continued From page 28 . . . Offer softer foods prn . . . Dysphagia precautions prn . . . Focus: ADL Self Care Performance Deficit. . . Goals: I will participate as able in . . . Eating . . . Interventions: I am able to feed myself after set up . . ." A physician's order, dated 12/18/12, identified, "Diet Type: Liberal Geriatric diet . . . Texture: Regular . . ." A nutritional assessment, dated 12/28/12, stated, ". . . Feeds self. Needs tray set up . . . Swallowing/chewing problems . . . resident is dysphagic . . . some chewing problems due to poor teeth condition. select menu offers softer foods . . ." The daily meal ticket also stated, ". . . SIPPER CUP/PLATEGUARD . . ." The Nutrition Progress Notes identified the following: * 01/01/13, ". . . Wt. . . . 89.2#. * 12/28/12, ". . . Wt. remains below her IWR [ideal weight range] of 99-121# but stable. PO [oral] intake is very inconsistent. Poor at times, other times very good. Averages 50-75% . . . Select menu does offer softer foods. Resident comes to the dining room for her meals. CNA [certified nurse assistant] does sit with her as dysphagia precaution due to hx. [history] of swallowing problems. She does feed herself but needs set up and encouragement to eat." * 12/21/12, "Nursing requested plate-guard at meals for this resident." * 10/03/12, ". . . Weight remains well below her IWR of 99-121#. However, weight has been usually stayig [sic] between 84-90# . . . Goal is for wt. to stay above 80# . . . Select menu does offer softer foods. PO intake ranges 25-100% . . . she	F 312		

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F 312	Continued From page 29 was persuaded to come to the dining room for meals, now does that regularly. She does eat better now than when trays sent to the room . . ." Meal observations revealed the following: * On 01/08/13 at 5:22 p.m., Resident #15 sat at an assisted table in the dining room a CNA (#8). Staff had partially prepped her supper tray; cutting one of two chicken strips into bite-sized pieces. Resident #15 attempted to feed herself. She began by eating three-fourths of her mashed potatoes [using the spoon]. By the time she finished the mashed potatoes, she had accidentally pushed all of the bite-sized pieces of chicken on the table. Resident #15 picked up [with her fingers] the whole chicken strip that lay on her plate, bit one-third off, and began chewing. She spit a large piece back into her hand, after which the CNA (#8) looked up and stated, "Go ahead and eat that." Resident #15 put the piece back in her mouth. After swallowing the chicken, Resident #15 picked up a small dish and ate the gravy inside. After finishing the gravy, she spooned the place where her mashed potatoes had once been, and ate five spoonfuls of "air". She then located and picked up the remaining mashed potatoes with her fingers and ate them. Approximately five minutes later, Resident #15 announced, "I'm done." All of the remaining chicken [1 2/3 chicken strips] lay on top of the table or on her clothing protector. Staff failed to provided cuing, adaptive equipment [colored plate, plate-guard], encouragement, and/or assistance during the meal. Her overall intake was 30%. * On 01/09/13 at 5:10 p.m., Resident #15 sat at an assisted table in the dining room with a CNA (#9). Staff positioned her wheelchair	F 312		

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F 312	Continued From page 30 approximately six inches from the table and prepped her supper tray. Resident #15 attempted to feed herself, beginning with a bowl of soup [using the spoon]. She dropped two noodles on her clothing protector, searched for them, and ate them [using her fingers] after locating them in the folds of the protector. After attempting, and failing, to pick up a chicken strip with her fork, the resident picked a strip up with her fingers and ripped it in two. One half landed on top of the table and the other in her lap. An administrative nursing staff member (#10) approached the table and offered to assist the resident. She picked up both strips, put them back on the resident's plate, and cut them into bite-sized pieces. Resident #15 ate the pieces of chicken with her fingers, occasionally spitting a piece back into her napkin. The administrative nursing staff member (#10) sat next to the resident throughout the remainder of the meal offering encouragement and assistance as needed. Resident #15's overall intake increased to 50%. * On 01/10/13 at 7:40 a.m., Resident #15 sat at a table on the independent side of the dining room. Although staff had prepped her breakfast tray, no staff were present at the table. Resident #15 attempted to feed herself hot cereal, toast, and coffee, but not her bacon. The resident dropped cereal on her clothing protector and asked dining room staff for additional napkins. Staff failed to provided cuing, encouragement, and/or assistance during the meal. Her overall intake was 25%. - Review of Resident #6's medical record occurred on January 7-10, 2013. Diagnoses included dementia, delirium, reflux, anemia, and weakness. The quarterly Minimum Data Set	F 312	**F 312 (revised)** **1.** Resident #6, and # 15's care plan and CNA care guide updated. Staff educated to assist these residents as care planned. **2.** Audit form created and random audits have completed in room and dining room to monitor all residents needing assistance are receiving appropriate assistance and if not it was addressed, and corrected. **3.** Staff educated at meetings related to assisting residents with their food as care planned or to make appropriate accommodations. CNAs Standards of care updated, and resident's daily care guides state whether resident needs assistance. Mealtime monitor will monitor to ensure that all residents in the dining room are receiving appropriate assistance with tray, cueing or assistance with eating as per their plan of care. **4.** Corrective action completed by **5.** Beginning immediately, a designated personnel will monitor 10 residents a day x 1 week for appropriate set-up of meal tray and cueing or assistance with eating, then 10 residents a week for a month, then 10 residents a month for 3 months, then quarterly x 3 quarters and then per QA. There will be re-education as necessary. Results will be reviewed at QA meetings and changes/interventions implemented as necessary.	2/14/2013

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	355078	A. BUILDING _____ B. WING _____	01/10/2013

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F 312	Continued From page 31 (MDS), dated 10/21/12, identified moderately impaired cognitive skills and set-up assist with eating. The current care plan identified, ". . . Focus: Alteration in Nutrition: . . . Potential weight loss d/t [due to] hx. [history] of Psychosis/Mental Disorder/Depression/inconsistent meal intake. . . . Interventions: Diet as ordered; select menu . . . Focus: ADL Self Care Performance Deficit. . . Interventions: I am able to feed myself . . ." A physician's order, dated 12/18/12, identified, "Diet Type: Liberal Geriatric diet . . . Texture: Regular . . . " Meal observations revealed the following: * On 01/07/13 at 5:18 p.m., Resident #6 sat at a table in the dining room. Following tray set-up, she attempted to feed herself. Resident #6 cut/ripped her chicken strip in half, and stabbed one of the halves with her fork. An unidentified staff member stood at her side, taking her table mate's meal order. Staff failed to provided cuing and/or assistance during the meal. During interviews on the morning of 01/10/13, two administrative [nursing and dietary] staff members (#12 and #13) confirmed facility staff should provide cues, adaptive equipment, encouragement, and/or assistance during meals. Although staff were present in the dining room, they failed to provide supervision and assistance during mealtimes, which could have potentially decreased the residents' caloric intake and/or contributed to their continued weight loss.	F 312	F 312 1. Resident #6, and # 15's care plan and CNA care guide updated. Staff educated to assist these residents as needed. 2. Audit form created and random audits have completed. 3. Staff educated at meetings related to assisting residents with their food as needed or to make appropriate accommodations. CNAs Standards of care updated. 4. Corrective action completed by 5. Random audits will be completed 2 times weekly times a month by nurse management or designee and then by mealtime monitor, and then per QA. Results will be reviewed at QA meetings.	2/14/2013
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 32 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, manufacturer's instructions review, and staff interview, the facility failed to utilize a sit to stand mechanical lift correctly and failed to assess the safety of the lift for 1 of 6 sampled residents (Resident #13) observed transferred with a sit to stand lift. Failure to use the lift correctly and assess if it is the appropriate assistive device for transfer resulted in pain and has the potential for injury. Findings include: Review of the Medcare manufacturer's instruction manual for the sit to stand lift occurred on the afternoon of 01/10/13. The instructions stated, ". . . Have the patient place their feet on the foot support plate, (assist if necessary) with their shins against the shin support pad. . . Raise the patient to the standing position by pushing the "Up" button on the hand control. . . ." - Review of Resident #13's medical record occurred on January 7-10, 2013. Diagnoses included osteoarthritis, backache, disc disorder,	F 323		

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F 323	Continued From page 33 and osteoporosis. The most recent quarterly Minimum Data Set (MDS), dated 11/11/12, identified extensive assistance of one person for transfers. Resident #13's current care plan stated, ". . . I have an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] Dementia . . . Transfer: Transfer with assist of 1-2 and/or medistand/hoyer lift. . . ." The "Daily Care Guide"(an abbreviated care plan) stated, "Transfers: Assist of 1-2 and medilift and hoyer prn [as needed]." - On 01/08/13 at 9:10 a.m., a certified nursing assistant (CNA) (#27) utilized the Medcare sit to stand lift and assisted Resident #13 from her bed to the bathroom. As the CNA began to raise the resident, observation showed her feet did not touch the support plate of the lift until she began to rise and her feet slid down onto the support plate. Resident #13 stated, "Owwww." The CNA (#27) stated, "[the resident's] arm is sore this morning. She doesn't like to go up in the lift too far either." When Resident #13 finished in the bathroom, the CNA utilized the lift and raised her off the toilet and the resident stated, "Ah, Ah." The CNA stated, "She doesn't like it." - Observation on 01/08/13 at 9:25 a.m. showed a bath aide (#33) utilized a sit to stand lift and assisted Resident #13 from her wheelchair to the whirlpool tub. When the bath aide raised Resident #13 upright with the lift, the resident stated loudly, "Owww." The bath aide stated, "You usually don't yell; sore this morning." - On 01/08/13 at 1:50 p.m., two CNAs (#28 and	F 323	**F 323 (revised)** **1.** Resident #13 was evaluated by PT on 1/16/2013. Staff was trained by PT after to transfer resident safely. Staff educated on lift use and how to monitor. **2.** Audit form created and random audits have been completed to monitor a random sample of residents who use a lift that proper use of lift occurred, and concerns noted were reported and if any changes needed it is reflected on resident's plan of care. **3.** Proper lift use has been reviewed at the CNA meetings and appropriate what to do if resident status changes. **4.** Corrective action completed by **5.** Nurse Managers or designee will perform random audits 2 times weekly times a month, then 2 times a month x 3 months, then 3 x quarterly times a year, and then per QA. Findings will be reviewed at QA meetings and re-education provided if necessary.	2/14/2013

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F 323	Continued From page 34 #29) utilized a Medcare sit to stand lift and assisted Resident #13 from her bed to the bathroom. As the CNA (#28) began to raise the resident, observation showed her feet did not touch the support plate of the lift until she began to rise and her feet slid down onto the support plate. Resident #13 stated, "Ahh." When the CNA (#28), raised the lift to assist the resident with pericares after the resident had voided, the CNA stated, "Will only be lifted a certain way." to the other CNA (#29). Resident #13 stated, "Ahh." and the CNA (#28) lowered the lift slightly. A sign posted above Resident #13's bed identified, "Please tell me what you are doing as you do it. Some things are very painful to me." During an interview on the afternoon of 01/09/13, a physical therapist (#32) identified Resident #13 had not been evaluated for transfers by physical therapy since February of 2012. The therapist stated an evaluation would be completed if resident has an issue with pain and it would be ordered by the physician. The physical therapist (#32) confirmed the resident's feet should touch the lift's foot support plate prior to initiating the transfer.	F 323	F 323 1. Resident #13 was evaluated by PT on 1/16/2013. Staff was trained by PT after to transfer resident safely. Staff educated on lift use and how to monitor. 2. Audit form created and random audits have been completed. 3. Proper lift use has been reviewed at the CNA meetings and appropriate what to do if resident status changes. 4. Corrective action completed by 5. Nurse Managers or designee will perform random audits 2 times weekly times a month and then per QA. Findings will be reviewed at QA meetings and re-education provided if necessary.	2/14/2013
F 325 SS=D	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	F 325		

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F 325	Continued From page 35 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on review of facility protocol, observation, record review, and staff interview, the facility failed to ensure that 3 of 7 sampled residents (Resident #4, #8, and #12) with significant weight loss maintained acceptable parameters of nutritional status. Failure to meet residents' nutritional needs through diet, supplements, assistance, or other interventions contributed to the residents' significant weight loss. Findings include: Review of the facility protocol titled "Wt. [weight] Loss Protocol" occurred on 01/10/13. This undated protocol stated, "Any unexplained/undesirable wt. loss, as determined by the LRD [licensed registered dietician]; and/or 5% loss in 1 mth. [month], 7.5% in 3 mths., or 10% loss in 6 mths. . . . 2. Assess intake, chewing abilities, swallowing abilities, difficulties feeding self, etc [etcetera]. Make appropriate changes to consistency, meal seating, etc. . . . 4. Monitor for stabilization or re-gaining of wt. If this does not occur within 1-2 wks. [weeks], begin the use of high calorie snacks or nutritional supplements. The type of nourishments provided depends on resident preference, degree of need, acceptance of supplements, need for especially concentrated supplements such as Resource 2.0, etc. . . . 5. Continue to monitor wt. as ordered, making further changes to plan of care as	F 325		

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F 325	Continued From page 36 needed. . . ." - On 01/08/13 at 9:23 a.m., observation showed a certified nurse aide (CNA) (#23) transferred Resident #8 to his wheelchair after completing morning cares. The CNA set up the resident's breakfast tray on an overbed table and placed it in front of the resident. The CNA offered the resident a bite of scrambled eggs, and after several attempts the resident took a bite and spit it out. The CNA stated Resident #8 often will start feeding himself if we leave him alone, and the more staff push him to do something (eat) the more he resists. At 9:43 a.m., a certified medication aide (CMA) (#24) entered the room and attempted to administer the resident's medications mixed with applesauce. The resident resisted and cursed, but after several attempts took the medicine and a bite of scrambled eggs from the CMA. At 10:50 a.m., observation showed Resident #8 only ate a few bites of eggs and sips of orange juice from his breakfast tray. Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and decubitus ulcers. The annual Minimum Data Set (MDS), dated 05/10/12, indicated the resident ate independently with setup help only, a significant change MDS, dated 08/10/12, and quarterly MDS, dated 11/10/12, indicated the resident required extensive assistance of one person with eating. Resident #8's weight summary showed his weight consistently in the 150 pound (#) range from January through June, reading 159.4# on 01/06/12 and 154.7# on 06/29/12. The resident had significant weight loss beginning in July as	F 325		

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F 325	Continued From page 37 follows: * 07/20/12 - 134.0# (13.5% decrease over 30 days, 10.4% in 90 days, and 13.4% in 180 days) * 12/21/12 - 122.1# (21.1% decrease over 180 days) Resident #8's current care plan included the focus area "ADL [Activity of Daily Living] Self Care Performance Deficit r/t [related to] Alzheimer's [disease]. . . .I am physically abusive to staff and will refuse toileting, walking, etc. . . . Interventions: . . . Eating: I am able to feed myself at times, most of the time I need assist of one. . . ." The facility failed to address interventions for staff to implement if the resident refused to eat or resisted assistance with eating. Resident #8's current care plan included the focus area "Alteration in Nutrition: hx. [history] of poor intake with significant wt. loss. Hx. of refuses any scheduled nourishments/supplements. Below IWR [ideal weight requirement] of 155-189# [pounds]. . . . 10-15-12 difficulty chewing due to dentures not fit well. . . . Interventions: 10-15-12 consistency changed to mechanical soft per nursing due to chewing difficulty. . . . 11-15-12 nutritional supplement prn [as needed]- 12-14-12 increase the Enlive supplement to bid [twice daily] at meals. Enlive supplement is a juice not a milky supplement. . . . Offer between meal snacks of choice. 10-5-12 try with scheduled PM [afternoon] daily snack of ice cream. . . . Use of nutritional supplements as/if needed. 8-1-12 Physician discontinued the Resource 2.0 supplement due to resident refusing it. This places the resident at higher risk for wt. loss and poor healing of skin." The facility failed to include additional	F 325		

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F 325	Continued From page 38	F 325		

interventions in the care plan to counteract the resident's significant weight loss beginning in July until the ice cream was added in October, 2012.

Resident #8's quarterly nutrition assessment, dated 08/07/12, noted, "Diet: Liberal Geriatric; Eating Ability: Feeds self with reminders; Height: 71" [inches]; Weight: 134#; Usual Weight: 160-170#; IBW [ideal body weight]: 155-189#; Significant weight change: No; Appetite: Poor (> [greater than] 25%); Supplements: None scheduled; resident refuses scheduled nourishments; Labs: Res. [resident] has a history of anemia; Skin: Res. has an open area on his hip. . . , Adequate protein difficult to provide, as meal intake is poor, and he refuses scheduled nourishments/supplements." The dietician completing this assessment failed to consider the resident's weight decline as significant or consider alternative methods to address the resident's weight loss and refusal of supplements.

Resident #8's Care Area Worksheet (CAA), dated 08/13/12, for nutritional status, stated, "Nature of the problem/condition: This resident had a significant wt. loss, followed by a significant wt. gain. However, his wts. have been fluctuating large amounts, and so I question the accuracy of some of the wts. He is currently below his IWR. Meal intake is poor, even with encouragement. He was receiving a nutritional supplement, but he did not particularly like it, and so the physician discontinued it. Therefore, he is not currently receiving any extra calories or other nutrients. . . . There is skin breakdown present, which may be difficult to heal because of his poor intake and refusal of scheduled nourishments/supplements." The facility failed to trial alternative nutritional

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F 325	Continued From page 39 supplements after discontinuing the Resource 2.0, offer any extra calories or nutrients, or assess/implement interventions for other factors that may have contributed to this significant weight loss. Resident #8's nutrition progress notes included the following: * 06/11/12 - "This resident has a new open area on his hip. His protein needs are approx. [approximately] 80-85 gms [grams]/day . . . His meals and the Resource 2.0 nutritional supplement offer approx 90 gms of protein daily. . . ." * 07/16/12 - "The resident has had a wt. loss, although it has been almost 30# in the past 2 wks., which seems excessive for a 2 wk. period of time. However, his intake has not been good some days, and he has a hx. of wt. loss, so his nutritional supplement (Resource 2.0) will be increased to 2 oz [ounce] qid [4 times daily]." * 08/01/12 - "Resource 2.0 - 2oz qid was discontinued by physician due to [name of resident] not drinking the supplement." * 08/06/12 - "The discontinuation of the Resource 2.0 supplement that occurred last week places the resident at risk for additional wt. loss and poor healing of skin. Meal intake probably not sufficient to maintain wt. and skin integrity at this time. * 08/10/12 - "WEIGHT WARNING: Value: 138.4 [pounds] . . . [plus] 5.0% change over 30 days . . . [minus] 7.5% change over 90 days . . . [minus] 10.0% change over 180 days . . . Wt. is recorded as 138.4# which would represent a wt. gain of 13.9# over the past 4 wks. despite a poor meal intake and the discontinuation of his nutritional supplement. No change in nutrition plan; monitor additional wts. for accuracy."	F 325		

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F 325	Continued From page 40 * 08/31/12 - "WEIGHT WARNING: Value 128.5 [pounds] . . . [minus] 5.0% change over 30 days . . . [minus] 7.5% change over 90 days . . . [minus] 10.0% change over 180 days . . . Wt. is 128.5#, down 6.3# the past week if accurate. This does continue a slow decline, with wt. loss continuing over time. . . ." * 09/07/12 - "Wt. today is 126.8#, down a further 1.7# the past week; resident showing a continual decline." * 10/15/12 - "Staff reports that res is having difficult time chewing regular food. Will switch to mechanical soft diet and see if this will improve his intake." * 11/06/12 - ". . . Now since 11-2 [11/02/12] seeing 75-100% of meals. . . . Enlive supplement is being tried as this supplement is a juice form- not milky as the ensure and resource supplements which he refuses to drink. . . . Wt. is down significantly in 6 months. Wt. stabilized from 9-14 [09/14/12] to present. . . ." * 01/01/13 - "Update regarding protein needs/skin breakdown. Current wt. 121.6#. Protein needs: 65 gms per day . . . Meals should provide approximately 70 to 80 grams per day but intake is inconsistent. Extra protein of approx. 30 gms per day from nutritional supplement enlive bid and ice cream daily." During an interview on 01/10/13 at 9:30 a.m., a dietary manager (#21) stated, "I don't believe the prior dietician did anything [to increase calories/intake] after discontinuing the resident's Resource supplement on August 6th." This staff member stated the dietician should assess a resident triggered with a weight alert, add more supplements or new food items with increased protein and/or calories, and assess for	F 325		

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F 325	Continued From page 41 satisfaction. During an interview on 01/10/13 at 10:55 a.m., a dietary staff member (#22) stated the facility started offering Resident #8 ice cream daily on 10/05/12 in the late afternoon as the resident likes ice cream, and on 11/05/12 started Enlive daily at noon, increasing the Enlive to twice daily with meals on 12/14/12. Failure to trial additional nutritional supplements when staff noticed the resident refusing the Resource 2.0 and again when the Resource 2.0 was discontinued in August; and failure to implement effective interventions and continually consider alternative interventions when the resident refused to eat, may have contributed to Resident #8's significant weight loss and possibly delayed healing of his pressure ulcers. - Review of Resident #4's medical record occurred on January 7-10, 2013. Diagnoses included cerebral vascular accident (CVA), facial muscle weakness, dysphagia, history of aspiration pneumonia, and esophageal reflux. The quarterly MDS, dated 12/13/12, identified severely impaired cognitive skills, extensive to total assistance of one person required for eating, weight loss not physician prescribed, and mechanically altered/therapeutic diet. The current care plan identified, ". . . Focus: ADL Alt [alteration] in nutrition. Dx [diagnoses] of Dysphagia [and] esophageal reflux. Schatzki's ring at the distal esophagus w [with]/sliding hiatal hernia. Inconsistent meal intake. 06-18-12 hx. [history] of significant wt. loss. 07-16-12 pocketing foods. 09-05 hx. rapid wt. loss. 11-19 rapid loss	F 325		

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	355078	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 42 again. 12-27-12 wt. stable x [times] 5 weeks . . . Goal: Resident will have no episodes of aspiration. Wt. will be and remain stabilized. Interventions: . . . 06-18-12 Scheduled AM [morning] snack daily due to hx. of wt. loss . . . 07/18/12 Non-Select menu. Substitutions are available. 07/20/12 Consistency changed to pureed, and continue nectar thick liquids, per speech therapist. 09-05-12 Nutritional supplement resource 2.0- 10-09-12 increase to 4 oz [ounces] bid. [twice daily] . . . Dysphagia precautions prn. Monitor for s/s [signs/symptoms] of aspiration . . . Encourage adequate fluid intake. Follow Resident Care Standards Magic cup will be offered at meals which provides approx. [approximately] 870 calories per day . . . " A physician order, dated 10/31/12, stated, ". . . Type: Liberal Geriatric diet . . . Texture: Puree Fluid Consistency: Nectar Thick . . . Supplement: Resource 2.0 Special Instructions: Nectar Thick 4 oz - bid . . . Everyday, 8:00 a.m. 5:00 p.m. . . . " A nutritional assessment, dated 12/07/12, stated Resident #4, ". . . Resident no longer attempts to feed self. Eats in DR [dining room]. CNA only to assist . . . Nutritional supplement resource 2.0 at 4 oz bid. Magic cup at all meals. Daily AM snack . . . " The daily meal ticket also stated, ". . . GIVE MAGIC CUP CNA TO ASSIST ONLY . . ." The Nutrition Progress Notes identified the following: *12/07/12, ". . . PO [oral] intake of meals range 25-100%, with intake often 50% or greater. Hx of continued wt. loss. Hx. of and continues to have wt. down significantly. Interventions are in place to try to stabilize wt. Wt. will stabilize for a time	F 325		

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F 325	Continued From page 43 then start decreasing again. Scheduled AM snack started in 06/12. Resource 2.0 started in 09/12; increased in 10/12. 11-19-12 started Magic cup nourishment to be given 3 times a day at meals . . . but she refused this at times. Wts: June 155 down to 143; August stable at 139-141#; Sept. [September] 140-132#; from Oct [October] to Nov. [November] 131-132#. Now current wt. down to 120#. For now, will continue with all nourishments as scheduled. However, will assess her wt. on next weigh in on Monday. May have to increase the resource again. Goal is to get wt. to stabilize . . .Wt. loss has been addressed." The weights and vitals summary, dated 01/10/13, identified the following weights: * 06/04/12, "155.1" * 07/02/12, "145.4" * 08/06/12, "141.9" * 09/03/12, "133.7" * 10/01/12, "133.8" * 11/05/12, "132.7" * 12/03/12, "120.6" * 01/07/13, "122.5" 7.5% weight loss within a 3 month time span [10/01/12-01/07/13]. 10% weight loss within a 6 month time span [07/02/12-01/07/13]. Observations revealed the following: * 01/07/13 at 5:30 p.m., Resident #4 sat in her reclining wheelchair [Geri-chair] in the dining room. An unidentified staff member reported she had just fed her "a Magic Cup and puree beets." * On 01/08/13 at 8:31 a.m., Resident #4 lay in bed. A certified nurse assistant (CNA) (#18) stated, "She'll stay in bed, because someone on the 400 wing needs her chair to get to a dentist	F 325		

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F 325	Continued From page 44 appointment." Another CNA (#16) reported a third CNA (#20) had fed the resident [in bed] earlier, and stated, "I know she had cream of wheat." * On 01/08/13 at 10:00 a.m., a CNA (#16) fed Resident #4 a Magic Cup for "morning snack." She ate approximately 75%. * On 01/08/13 at 12:15 p.m., a CNA (#16) fed Resident #4 lunch. Resident #4 ate approximately 25%. The CNA failed to cue and/or encourage the resident to eat more. * On 01/08/13 at 5:22 p.m., a CNA (#8) fed Resident #4 supper. Resident #4 ate approximately 25%. The CNA failed to cue and/or encourage the resident to eat more. * On 01/09/13 at 7:43 a.m., Two CNAs (#11 and #15) transferred Resident #4 from her bed into her reclining wheelchair. The CNAs (#11 and #15) stated, "We don't have any PFAs [paid feeding assistants] working today, so it will be awhile [before we feed her breakfast]." * On 01/09/13 at 9:30 a.m., an unidentified staff member stated, "We're almost at a point where we can feed [her]." * On 01/09/13 at 9:55 a.m., a CNA (#11) fed Resident #4 a late breakfast. Resident #4 ate approximately 50-75%. * On 01/09/13 at 5:10 p.m., a CNA (#9) fed Resident #4 supper. Resident #4 ate approximately 25%. * On 01/09/13 at 5:25 p.m., an administrative nursing staff member (#10) sat down next to Resident #4, and began feeding her. She sat next to the resident throughout the remainder of the meal offering cues, encouragement and assistance as needed. Resident #4's intake increased to 75%. During an interview on 01/10/13 at 9:45 a.m.,	F 325		

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F 325	Continued From page 45 when asked what interventions would be implemented for a resident with weight loss, an administrative dietary staff member (#21) stated, "We would look at a lot of things, like supplements, milkshakes, fortified [foods], dining room placement, if cueing is needed, if therapy is needed." She also confirmed [due to an identified significant weight loss] the facility may need to offer Resident #4 additional high calorie foods, provide cues and/or encouragement throughout meals, and provide meal service in a timely manner. - Review of Resident #12's medical record occurred on January 7-9, 2012. Medical diagnoses included dementia, major depressive disorder, hemiplegia, macular degeneration, diaphragmatic hernia, and constipation. The most recent quarterly MDS, dated 10/24/12, identified Resident #12 as having severely impaired cognitive skills, requiring extensive assistance with eating, and experiencing a weight loss not physician prescribed. The weights and vitals summary identified the following weights: *04/07/12 - 104.4# *06/04/12 - 102.1# *07/02/12 - 94.5# *09/03/12 - 93.1# (severe weight loss more than 7.5% in 3 months (06/04/12 - 09/03/12) *11/05/12 - 88.2# *01/07/13 - 86.2# A physician's order, dated 05/01/12, stated, "Discontinue Resource 2.0 - 2 oz. [ounces] 4x/day."	F 325		

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F 325	Continued From page 46 The Nutrition Progress Notes identified the following: *05/01/12, no time - ". . . Family requested that nutritional supplement resource be discontinued. . . . Dietitian did inform them that [resident's name] most likely will have wt. loss with the supplement discontinued. They are aware of this but still want it done. . ." *06/18/12 at 2:02 p.m. - "Wt. [weight] is down approximately 5# since Resource supplement discontinued on 05/01/12, per family request. Wt. loss has been gradual and family is aware that wt. loss may occur. Current wt. is within her IWR [ideal weight range] of 83-101#. BMI [body max index] at 22 which is within the desirable range. No nutrition changes. *06/26/12 at 12:18 p.m. - "Wt. is down 8.1# in the past week. Wt. loss has been expected since resident no longer receives the nutritional supplement. However, Monitor wt. for accuracy as this is the first time her wt. has decreased such a large amount in a short period of time." *06/29/12 at 16:17 - "[Resident's name] is progressively deteriorating. Family would like us to stop a lot of her medications." *07/09/12 at 2:42 p.m. - "[Resident's name] wt. is down significantly from wt. 3 months and 6 months ago. However, only down 3.5# from wt. 4 weeks ago. In fact, current wt. is actually up 5# in 2 weeks. Wt. remains within her IWR of 83-101# with BMI at 21.5 which is still within desirable range. Family is aware that wt. loss could occur since they requested the Resource supplement discontinued on 05/01/12. No changes will be made." *08/03/12 at 2:21 p.m. - "This is regarding the wt. alert of wt. down significantly in 6 months. The wt.	F 325		

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F 325	Continued From page 47 loss has been anticipated due to discontinued nutritional supplement per family. However, her weight has been staying between 93-96# since 07/02/12. No changes." *08/27/12 at 12:10 p.m. - "Today weight is recorded as 91#. Now weight is down 10# since resource supplement discontinued on 05/01/12. The weight loss has been gradual and somewhat steady and anticipated. Will start on am scheduled snack daily to see if she will accept it. In the past, scheduled snack was tried, but she eventually would not eat it. Monitor acceptance." The facility failed to trial alternative nutritional nourishments/fortified/high calorie foods after discontinuing the Resource 2.0 supplement. The current care plan identified: "Focus: Alteration in nutrition: Large Hiatel Hernia. Hx. [history] emesis at times. Meal intake is usually 25% to 50%, needs much encouragement to eat. 05/01/12 Family requested to have Resource supplement discontinued, significant wt. loss since supplement d/c [discontinued] 25% to refusal of scheduled daily snack." "Interventions: (initiated since supplement d/c'd) "06/11/12 Monitor intake of meals prn [as needed]. Encourage good intake as able/as she allows. 08/27/12 Am scheduled snack daily. Monitor acceptance. 11/19/12 Encourage higher calorie foods at meals from select menu. Examples: whole milk, extra butter, pie, and ice cream. . . ." Observations in the dining room on 01/08/13 at 5:15 p.m. and on 01/09/13 at 9:20 a.m. and 5:55 p.m., showed Resident #12 seated in her wheelchair at a dining room table eating meals.	F 325	**F 325 (revised)** **1.** Resident's #4, #8, and #12's charts were reviewed and nutritional assessment completed. Supplements added and care plans updated. **2.** All residents with significant weight loss will be thoroughly assessed by using anthropometic data available in Point Click Care and a corrective action plan will be developed. This will include assessments by therapy, nursing and dietary and residents care plan will be updated and policy followed. **3.** Resident Weight Loss, Risk of Malnutrition and Intake & Output policies were updated and revised as needed. **4.** Corrective action completed by **5.** Beginning 2/12/13 the Director of Nutrition or designee will monitor 3 residents with weight loss for appropriate interventions once a week x 1 month, then once a month x 3 months, then quarterly x 3 quarters, and then per QA. Results will be reviewed at QA meetings and changes/interventions implemented as necessary.	2/14/2013

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F 325	Continued From page 48 Resident #12's wheelchair arms, level with the table, prevented her from being less than approximately one foot from the table. While seated in this position, observations showed Resident #12 dropping food, including soup, on her clothing protector when not assisted by staff. Poor positioning may have contributed to Resident #12's severe weight loss. During an interview on 01/10/13 at 1:10 p.m., an administrative dietary staff member (#21) confirmed the "gap" in provision of nutritional interventions for Resident #12. Failure to trial alternative nutritional nourishments/fortified/high calorie foods after discontinuing the Resource 2.0 contributed to Resident #12's severe/rapid weight loss experienced between May and August. Failure to assess Resident #12's positioning at meals may have further contributed to the resident's ongoing weight loss.	F 325	F 325 1. Resident's #4, #8, and #12's charts were reviewed and nutritional assessment completed. Supplements added and care plans updated. 2. All residents with significant weight loss will be thoroughly assessed by using anthropometic data available in Point Click Care and a corrective action plan will be developed. This will include assessments by therapy, nursing and dietary and residents care plan will be updated and policy followed. 3. Resident Weight Loss, Risk of Malnutrition and Intake & Output policies were updated and revised as needed. 4. Corrective action completed by 5. The Director of Nutrition or designee will be responsible to audit. Random audits will be completed 2 times weekly times a month and then per QA. Results will be viewed at QA meetings.	2/14/2013
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 49 Based on observation, record review, professional literature review, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen. These practices placed residents at risk for contamination of food during preparation which can lead to foodborne illness. Findings include: The 2009 Food and Drug Administration Food Code, Public Health Reasons, page 444, states, ". . . Multiuse equipment is subject to deterioration because of its nature i.e. intended for use over extended period of time. . . . Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment become contaminated. . . ." The 2009 Food and Drug Administration Food Code, Public Health Reasons, page 380, states, ". . . Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. . . ." - An initial dietary tour of the kitchen occurred on 01/07/13 at 10:25 a.m. with an administrative dietary staff member (#21). Observation of the walk-in cooler showed 22, four ounce containers of yogurt, dated December 9, 2012 (28 days prior). - The main dietary tour of the kitchen occurred on 01/08/13 at 12:40 p.m. with an administrative dietary staff member (#21) and showed the following: *a meat slicer, used to prepare raw meat and	F 371	**F 371 (revised)** **1.** The outdated yogurt containers were immediately disposed of on 1/7/13 and staff re-directed to monitor use by dates on dairy products and use FIFO procedures. The Lead Kitchen Supervisor monitors the use by dates of items located in the walk-in cooler daily. This is noted on the inventory and production sheets. Completed 1/8/13. The food debris found on the slicer blade on 1/8/13 was immediately removed by thoroughly cleaning the slicer. The butcher block table the slicer sits on was thoroughly cleaned as well. The butcher block table will be replaced with a stainless steel table. Completed 2/14/13. Microwave was immediately cleaned (1/8/13) upon finding dried foods on turntable. The microwave was all added as a daily cleaning item on the Dietary Cleaning Schedule. The Dietary Cleaning Schedule monitored by Lead Kitchen Supervisor and or The Director of Nutrition and Culinary Services on a daily/weekly and monthly basis. Completed 1/8/13. The wall mounted fan in pot sink area was immediately cleaned on 1/8/13 and is routinely cleaned by maintenance on a weekly basis. Completed 1/8/13. The 12 scrappers/spatulas found to have rough edges were immediately 1/8/13 disposed	

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F 371	Continued From page 49 Based on observation, record review, professional literature review, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen. These practices placed residents at risk for contamination of food during preparation which can lead to foodborne illness. Findings include: The 2009 Food and Drug Administration Food Code, Public Health Reasons, page 444, states, ". . . Multiuse equipment is subject to deterioration because of its nature i.e. intended for use over extended period of time. . . . Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment become contaminated. . . ." The 2009 Food and Drug Administration Food Code, Public Health Reasons, page 380, states, ". . . Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. . . ." - An initial dietary tour of the kitchen occurred on 01/07/13 at 10:25 a.m. with an administrative dietary staff member (#21). Observation of the walk-in cooler showed 22, four ounce containers of yogurt, dated December 9, 2012 (28 days prior). - The main dietary tour of the kitchen occurred on 01/08/13 at 12:40 p.m. with an administrative dietary staff member (#21) and showed the following: *a meat slicer, used to prepare raw meat and	F 371	F 371 1. The outdated yogurt containers were immediately disposed of on 1/7/13 and staff re-directed to monitor use by dates on dairy products and use FIFO procedures. The Lead Kitchen Supervisor monitors the use by dates of items located in the walk-in cooler daily. This is noted on the inventory and production sheets. Completed 1/8/13. The food debris found on the slicer blade on 1/8/13 was immediately removed by thoroughly cleaning the slicer. The butcher block table the slicer sits on was thoroughly cleaned as well. The butcher block table will be replaced with a stainless steel table. Completed 2/14/13. Microwave was immediately cleaned (1/8/13) upon finding dried foods on turntable. The microwave was all added as a daily cleaning item on the Dietary Cleaning Schedule. The Dietary Cleaning Schedule monitored by Lead Kitchen Supervisor and or The Director of Nutrition and Culinary Services on a daily/weekly and monthly basis. Completed 1/8/13. The wall mounted fan in pot sink area was immediately cleaned on 1/8/13 and is routinely cleaned by maintenance on a weekly basis. Completed 1/8/13. The 12 scrappers/spatulas found to have rough	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 50 ready-to-eat sandwich meat and tomatoes, with dried food debris on the blade, . *a microwave with dried food debris on the interior surface. *a fan with a build up of dust. *12 rubber scrapers with rough, uncleanable surfaces. *a butcher block table, used to store the meat slicer, with a gouged, uncleanable surface. *four food cans with dented seams or rolled seams Review of the cleaning schedule did not include the microwave. During an interview on afternoon of 01/10/13, an administrative dietary staff member (#21) confirmed dietary staff should ensure cleaniness of the identified equipment on a routine basis, discard uncleanable equipment, and discard/return expired food/damaged food cans.	F 371	edges were immediately 1/8/13 disposed of and replaced with new heat resistant scrappers. New scrappers were received on 1/11/13. All dented cans will be refused at delivery by the Lead Kitchen Supervisor or staff person assigned to receiving. Receiving policy reviewed with staff at bi-monthly meeting. Completed 1/17/13. 2. N/A 3. Food Receiving, Meat Slicer Use and Cleaning, Food Preparation and Service Guidelines policies reviewed and updated as needed. 4. Corrective action completed by 5. The Director of Nutrition or designee will be responsible to audit. Random audits will be completed 2 times weekly times a month and then per QA. Results will be viewed at QA meetings.	2/14/2013
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		

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	355078	A. BUILDING _____ B. WING _____	01/10/2013

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EVENTIDE AT HI-ACRES MANOR	1300 2ND PL NE JAMESTOWN, ND 58401

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F 431	Continued From page 51 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, the facility failed to ensure only authorized personnel have access to 4 of 4 medication rooms. Failure to limit access to the medication rooms has the potential to endanger the security of the drugs stored in those rooms. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding access to medications which states a facility is required to limit access to authorized personnel consistent with state and federal requirements. The facility must have a system to	F 431	**F 431(revised)** **1.** Medication room locks were replaced 1/17/2013. **2.** N/A **3.** Keys placed on Nurses and CMAs key rings. The nurse managers have a key and a spare key is kept in a lock box in DON office. All CMAs/nurses/nurse management instructed at January nurses meeting to not give medication room access to another staff without a nurse/CMA present. **4.** Corrective action completed by **5.** Random audits will be completed once a week times a month my nurse management or designee for access to the medication rooms by appropriate personnel only, then once a month x 2 months, then quarterly x 3 quarters, and then per QA. These findings will be reviewed at QA meetings and re-education will be completed as needed.	2/14/2013

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F 431	Continued From page 52 limit who has security access and when access is used. A tour of the special care unit medication room occurred on 01/10/13 at 8:30 a.m. with a nursing staff member (#5). Observation showed controlled medications to be destroyed by the facility in a plastic container on the counter. The nursing staff member (#5) stated the nurse on duty and the maintenance supervisor have keys to the medication room. During an interview on 01/10/13 at 2:05 p.m., the maintenance supervisor staff (#6) confirmed having a master key that opens the medication rooms. The staff member (#6) confirmed three other maintenance personnel also have master keys that open the medication rooms. During an interview on the afternoon 01/10/13, an administrative nurse (#2) indicated the facility lacked a policy identifying which personnel the facility considered authorized to have access to the medication rooms.	F 431	**F 431** 1. Medication room locks were replaced 1/17/2013. 2. N/A 3. Keys placed on Nurses and CMAs key rings. The nurse managers have a key and a spare key is kept in a lock box in DON office. All CMAs/nurses/nurse management instructed at January nurses meeting to not give medication room access to another staff without a nurse/CMA present. 4. Corrective action completed by 5. Random audits will be completed weekly times a month my nurse management or designee and then per QA. These findings will be reviewed at QA meetings and re-education will be completed as needed.	2/14/2013
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;	F 441		

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F 441	Continued From page 53 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to follow standard infection control practices for 4 of 14 sampled residents (Resident #3, #9, #10, and #13) observed during toileting/pericare. Failure to follow infection control practices related to glove usage and hand hygiene has the potential to cause or spread infection within the facility.	F 441		

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F 441	Continued From page 54 Findings include: Review of the facility policy titled "Perineal Care" occurred on 01/10/13. This policy, dated 11/04/09, stated "PURPOSE - Bathing the perineal area . . . after urination and bowel movements, promotes cleanliness, prevents infection . . . For the resident with perineal skin breakdown, application of an ointment or cream aids healing. . . . PROCEDURE . . . After Providing Perineal Care . . . 3. Wash Hands. . . . Procedure for Ointment Application 1. Do pericare as outline above. 2. Don a new pair of gloves. 3. Apply a small amount of ointment . . . " - Review of Resident #9's medical record occurred January 07-10, 2013. A progress note, dated 12/04/12, identified three small fluid filled blisters on Resident #9's coccyx to which corona cream was applied. Observation on 01/08/13 at 10:10 a.m., showed a certified nurse aide (CNA) (#4) toileted Resident #9. After providing perineal care, the CNA failed to change her gloves prior to applying an ointment to Resident #9's coccyx. - Review of Resident #10's medical record occurred January 07-10, 2013. A physician order, dated 12/18/12 identified "decubitus ulcer care per protocol to sacral area." Observation on 01/08/13 at 2:10 p.m., showed a CNA (#3) changed Resident #10's brief and provided pericare after an episode of incontinence. Observation showed a dressing present on Resident #10's coccyx. Resident #10 requested ointment be applied. The CNA failed to	F 441		

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F 441	Continued From page 55 change her gloves prior to using her gloved hand to obtain ointment from the jar and applying it to the sacral area. During an interview on 01/10/13 at 1:15 p.m., an administrative nurse (#2) stated she expected staff to use clean gloves when applying creams and ointments. - Observation on 01/08/13 at 3:35 p.m., showed a CNA (#26) assisted Resident #13 with toileting. The CNA donned gloves and provided perineal care after the resident had a bowel movement and voided. The CNA removed the gloves, applied a clean brief, and transferred the resident into her wheelchair. The CNA failed to perform hand hygiene after completing perineal care, once the resident had been transferred to her wheelchair. The CNA then opened a can of Ensure (a nutritional supplement) placed a straw into the supplement, and offered it to the resident who drank from the straw. - Observation on 01/08/13 at 8:15 a.m. showed a CNA (#1) assisted Resident #3 to her room for morning cares. The CNA donned gloves and provided perineal care, removed the gloves, applied a clean brief, and transferred the resident into the wheelchair. The CNA (#1) combed the resident's hair, obtained Resident #3's toothbrush, applied toothpaste and gave the resident the toothbrush. The CNA transported Resident #3 to the dining area. The CNA failed to perform hand hygiene after completing perineal care, before completing other tasks, and before exiting the resident's room. During an interview on the afternoon of 01/10/13,	F 441	**F 441(revised)** **1.** Nurse Aids involved in the direct infection control concerns witnessed were educated regarding resident # 3, #9, #10, and #13. **2.** Audits have been compiled and completed monitoring the correct procedure of peri-cares and hand washing. **3.** Staff educated on proper peri-care and hand washing at CNA meetings as well as infection control practices. Policies reviewed. **4.** Corrective action completed by **5.** Random audits will be completed 2 times weekly times a month by director of QA or designee. Then once a month x 2 months, then quarterly x 3 quarters then per QA. There will be re-education of staff as necessary. Audit Data will be reviewed at the QA meeting.	2/14/2013

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F 441	Continued From page 56 an administrative nurse (#2) agreed staff are expected to perform hand hygiene after assisting residents with perineal care.	F 441	**F 441** 1. Nurse Aids involved were educated regarding resident # 3, #9, #10, and #13. 2. Audits have been compiled and completed. 3. Staff educated on proper pericare and hand washing at CNA meetings as well as infection control practices. Policies reviewed. 4. Corrective action completed by 5. Random audits will be completed with 2 times weekly times a month, and then per QA with assistance by nursing management or designee. There will be re-education of staff as necessary. Audit Data will be reported to the QA committee.	2/14/2013