DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	12/19/2013

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 12/16/13 and completed on 12/19/13, the sample included 5 residents for complete review, 14 residents for focused review, and 3 closed records for review. The sample included 32 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157: 1. Resident 10 Physician notified on change in condition & resident 3 facility staff notified family on change of condition. 2. All residents who have a change of condition have the potential to be affected. 3. All Nurses were re-educated on importance of notifying family and physician when a resident has a change of condition per policy. All residents with a change of condition will be reviewed to determine that both family and physician were made aware of the change. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor if family and physician were notified with a resident change of condition. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/12/14

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

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and family interview, the facility failed to notify the physician of a change in condition for 1 of 1 sampled resident (Resident #10) hospitalized for a rapidly deteriorating pressure ulcer and failed to notify responsible family members for 1 of 1 sampled resident (Resident #3) who received an x-ray after a surgically repaired hip fracture. Failure to promptly notify the physician limited the physician's ability to determine the potential need for changing treatment and resulted in Resident #10's hospitalization for surgical intervention of the pressure ulcer. Failure to notify Resident #3's family members of the scheduled x-ray limited their ability to be involved in the resident's care. Findings include: Review of Resident #10's medical record occurred on all days of survey. Resident #10's current medical diagnoses included dementia, diabetes mellitus type II, and unstageable pressure ulcers to the left heel. Review of Resident #10's Nursing Progress Notes identified the following: *11/30/13 - "Resident has a 4.8 by 3.6 cm [centimeter] fluid filled area to outer left heel. Heelers are now in place, MD [medical doctor] notified. . . ." NOTE: This is the first time staff identified the blister area on the left heel in the medical record.	F 157		

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F 157	Continued From page 2 *12/02/13 - "Skin asst [assessment] done and has left heel fluid like filled area and is on TX [treatment] to check. . . ." *12/03/13 - 8:49 a.m. - ". . . note still a fluid lilled [sic] area present and skin dark. 1:15 p.m. - To wlak [sic] - in clinic via bus and dtr [daughter] met her there to have left heel checked. . . . Culture obtained after opening blister. No puss noted. Will await culture results before starting antibiotics. Suspect pressure ulcer, to keep moist with aquaphor and non-adherent dressing. Change BID [twice a day] Continue with heel protectors." *12/08/13 - ". . . note small amt [amount] of dry blood on old drsg [dressing]. " *12/10/13 - ". . . some areas dark and another fluid filled area present and intact. . . . Dr. . . . faxed an update on current pressure areas and status of healing. . . . Final culture results returned and faxed it to Dr. . . ." *12/11/13 - ". . . note the 1 area still open where Dr. opened up and the other area still fluid filled. Heel is odorous. . . ." *12/12/13 - ". . . Area on left heel has loose skin where Dr. opened up it up and has another loosely fluid filled pockt [sic]. Tx done as per order." *12/13/12 at 4:01 p.m. - "Tylenol with Codeine #3 . . . complaints of left foot pain." 10:02 p.m. - "Tylenol with Codeine #3 . . . left heel" *12/14/13 - "Tylenol with Codeine #3 . . . pain in left foot. resident states that it hurts really bad." *12/15/13 - "Tylenol with Codeine #3 pain in left foot. resident states it hurts real bad." *12/16/13 - "Tylenol with Codeine #3 . . . resident crying out asked if she was having pain stated yes unable to give me a number." *12/17/13 - "Tylenol with Codeine #3 . . . pain in back/heel unable to say number but resident	F 157		

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F 157	Continued From page 3 crying. . . . Cleansed with normal saline and telfa applied and wrapped with Kling. Did not apply aquaphor as too moist and has a very foul odor to it . . . " 4:25 p.m. - "Dr. . . . faxed at 6:40 am this am re: left heel wound and update. 9:40 am. very sleepy probably from pain pill earlier . . . This afternoon received fax Dr . . . to send to walk-in clinic. . . . resident went via bus . . ." 5:33 p.m. - "Nurse on wing 3 notified at approximately 1625 [4:25 p.m.] that [name of resident] was being admitted to Jamestown Regional Medical center. . . ." Review of the Medication Administration Record (MAR) showed Resident #10 received Tylenol with Codeine #3 on December 6, 11, 13 (twice) 14, 15, 16, and 17. The nurses notes identify the resident complained of left foot pain. Facility staff notified the physician regarding the culture result and the development of a new blister area on the heel on 12/10/13, however did not describe the size, appearance, or the foul odor as identified on the Wound Care Flow Sheet dated, 12/10/13. The next day, 12/11/13, the nurses notes again identify the heel as odorous. The Wound Care Flow Sheet, dated 12/16/13 identified the foul smell to the wound and the enlargement of the pressure areas on the heel. Resident #10 complained of foot pain on December 13-17, 2013 requiring administration of Tylenol with Codeine #3. Observations on December 16, 2013 identified redness and swelling of Resident #10's left lower leg, pain in the leg, and a strong, foul odor in the residents room, yet the facility did not notify the physician until the following day. Facility staff transported Resident #10 to the clinic	F 157		

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F 157	Continued From page 4 the afternoon of 12/17/13, and nurses notes later identified Resident #10's admission to a local hospital. On the morning of 12/18/13, a staff nurse stated Resident #10 would be having surgery for debridement of the pressure ulcer. A physician examined Resident #10's heel on December 3, 2013, but did not exam the heel again until December 17, 2013, and admitted the resident to the hospital. Facility staff failed to promptly notify/consult with the physician when Resident #10's heel ulcer began to rapidly deteriorate as evidenced by increased pain, redness and swelling of the lower leg, and the development of foul smelling drainage. - Review of Resident #3's medical record occurred on December 16-19, 2013. The facility re-admitted the resident to the facility on 10/02/13 after a surgical repair of a fractured right hip. Physician orders on the resident's return to the facility included scheduling for follow-up x-rays of the right hip. The facility staff scheduled the x-rays on 10/14/13. Resident #3's nurse's notes on 10/14/13 stated the following: *2:34 p.m. - "Out at 2:00 p.m. to [facility name] for x-ray right hip." *3:42 p.m. - "Came back from x-ray at 3:15 p.m. with no new orders." During interview, on 12/18/13 at 11:25 a.m., two of Resident #3's family members who make healthcare decisions (#4) and (#5) reported the facility notified them of the x-ray after it was completed. These family members (#4) and (#5) expected to be notified in advance of all appointments and stated a family member would	F 157		

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F 157	Continued From page 5 have accompanied Resident #3 to the x-ray. Resident #3's current care plan, revised 09/13/13, stated "Focus, I have mood/behavior issues rt [related to] my dx [diagnosis] of Alzheimers Disease w [with]/memory and communication issues noted by anxiety and agitation . . . Interventions, Communicate with family/caregivers regarding my capabilities and needs. . . ." During interview, on 12/19/13 at 9:05 a.m., a management nursing staff member (#1) confirmed the facility staff failed to notify the family members of Resident #3's x-ray appointment and confirmed the staff should have notified them.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, resident interview, and staff interview, the facility failed to assess the safety of self administration of medication (SAM) for 2 of 3 sampled residents (Resident #4 and #16) observed with medications left at the bedside. Failure to assess a resident's ability to self administer medications, and failure to obtain a physician's order and care plan for SAM, increases the risk of a medication error.	F 176		

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F 176	Continued From page 6 Findings include: Review of the facility policy and procedure, "Medications - Self Administration of Meds," occurred on 12/19/13. This document, revised in May 2013, stated "Policy: After meeting specific criteria the resident may participate in the self-administration process. A practitioner order is required. The process/set-up will be monitored daily by the nurse. The resident's self-administration ability will be reviewed quarterly, with a change of condition, prior to discharging home, or as the interdisciplinary team determines necessary. . . . Procedure: . . . If the resident is in agreement with self-administration of medication: Initiate the Self Administration of Medication Assessment & [and] Flowsheet . . . To take own medications during meals the resident: . . . The nurse will document the decision to allow this in the chart and add the information to the care plan and the eMAR [electronic medication administration record]. . . . Special Considerations for Certain Types of Medications . . . Inhalers, The resident must demonstrate the correct administration technique . . . The resident must be able to verbalize the time(s) the inhaler was used . . . record this on the eMAR. . . ." - Observation during the initial facility tour, on 12/16/13 at approximately 10:20 a.m., identified a medication cup containing several medications at Resident #4's bedside. During interview, on 12/19/13 at approximately 10:30 a.m., Resident #4 reported the staff leave medications at his bedside "all the time."	F 176	F 176: 1. Resident 4 expired on 12/30/13. Resident 16 will be reassessed for self-medication administration per policy. Care Pan will be reviewed and updated as needed. 2. All residents who choose to want to self-administer medications have the potential to be affected. 3. All Nurses were re-educated on the policy and proper procedure for residents to self-administer medications. All residents that are currently on self-administering medications will be reassessed to determine if they meet the requirements of the Self Administration of Meds policy. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that the policy is followed for Self Administration of Medications. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 176	Continued From page 7 Review of Resident #4's medical record occurred on December 16-19, 2013. The facility admitted the resident in July 2013. Current diagnoses included back pain and benign prostatic hypertrophy (enlargement of the prostrate gland which may cause urine retention). The resident's quarterly Minimum Data Set, dated 10/22/13, identified a Brief Interview for Mental Status (BIMS) score of "12" or moderately cognitively impaired. The facility identified the resident as interviewable. Resident #4's physician orders identified the following scheduled oral medications ordered for administration before or at 10:00 a.m.: *Finasteride 5 milligrams (mg) at 10:00 a.m., one time each day (for urine retention) *Furosemide 20 mg at 10:00 a.m., one time each day (for fluid retention) *Omeprazole 20 mg at 10:00 a.m., one time each day (for stomach upset) *Potassium Chloride 10 milliequivalents at 10:00 a.m., one time each day (mineral supplement) *Acetaminophen ER (extended release) 650 mg at 10:00 a.m. and 8:00 p.m., two times each day (pain reliever) Review of Resident #4's medical record failed to identify a physician's order, an assessment, or care planning for self-administration of medications. During interview, on 12/19/13 at 10:50 a.m., an administrative nursing staff member (#1) confirmed the facility staff failed to obtain a physician's order, complete an assessment, care plan, and monitor Resident #4 for self-administration of medications.	F 176		

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F 176	Continued From page 8 - On 12/19/13 at 1:45 p.m., observation showed two hand held inhalers on Resident #16's bedside stand. The resident stated she takes two puffs of the Symbicort 160/4.5 twice daily and two puffs of the Atrovent four times daily. Review of Resident #16's record occurred on 12/19/13. The current care plan for the Activities of Daily Living (ADL) focus area included the intervention "Meds and inhalers may be left at bedside for resident to administer herself." The physician orders failed to include an order to self-administer the Symbicort or the Atrovent inhaler. Resident #16's record lacked a SAM assessment for the inhalers the resident self-administered. During an interview on 12/19/13 at 1:15 p.m., an administrative nurse (#1) stated staff should have completed a SAM assessment for medications left in a resident's room to self administer.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 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 ensure 1 of 1 sampled resident (Resident #6) who used a chair that prevented her from rising was free of physical restraints not required to treat her medical	F 221		

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F 221	Continued From page 9 symptoms. Failure to assess the chair that prevented rising as the least restrictive option, failure to obtain a physician's order, and failure to obtain the family's consent, placed Resident #6 and any resident using a geriatric wheelchair at risk of injury and loss of mobility. Findings include: Review of the facility policy and procedure, "Restraint Utilization," occurred on 12/19/13. This document, revised in May 2013, stated "PURPOSE: To determine the need for the use of the least restrictive form of physical restraint to improve a resident's safety and to review the continued need for the use of the restraint. POLICY: Physical restraints will be utilized only when other alternatives to prevent falls have been exhausted. . . . Examples of physical restraints: . . . chairs that prevent rising . . . restraints will be included in the resident's care plan . . . PROCEDURE: . . . C. Obtain a practitioner order for the use of the restraint: 1. Order must include statements and determination regarding medical symptoms for deeming medical necessity. . . . D. [Obtain] The resident's or family/guardian's informed consent for the restraint . . ." Review of Resident #6's medical record occurred on December 16-19, 2013. The facility admitted the resident in December 2012. Current diagnoses included Alzheimer's disease, anxiety, and dementia. The resident's quarterly Minimum Data Set (MDS), dated 09/11/13, identified the resident usually understood others and made herself understood by others, demonstrated physical, verbal, and other behaviors up six days during the seven day assessment period, required extensive assistance of two persons for	F 221	F 221: 1. Resident 6 will be reassessed for appropriate seating and follow restraint policy if appropriate. Care Plan will be reviewed and updated as needed. 2. Reassess all residents w/ restraints for orders and following restraint policy. 3. All Nurses were re-educated on the restraint policy and following protocols for appropriate use. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the use of physical restraints. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 221	Continued From page 10 transfers, did not walk, and experienced one fall without injury and two falls with injuries since the prior assessment. Resident #6's current care plan stated the following: *Revised 09/19/13, "Focus, The resident is moderate risk for falls r/t [related to] unaware of safety needs. . . . Interventions . . . The resident needs a safe environment . . . the bed in a low position . . . personal items in reach . . . Allow res. [resident] to crawl on her beds [mattresses] or floor if desired." *Revised 12/09/13, "Focus, The resident has an ADL [Activities of Daily Living] Self Care Performance deficit . . . Interventions . . . TRANSFER/AMBULATES: . . . I use a flowered rocker w/c [wheelchair] for positioning. . . ." Resident #6's nurse's notes stated the following: *09/25/13, 6:52 p.m. - "Noted today res. does not keep her feet on foot rests and begins to lean forward in w/c. Note put in for a geri chair [geriatric wheelchair] after discussion with [staff name] reguarding [sic] fall follow-up on 09/24/13." *09/26/13, 6:49 p.m. - "Geri-chair in place. . . ." *09/27/13, 11:01 a.m. - "Resident was in geri chair for about 30 minutes and did have some attempts to stand up. Geri chair reclined after eating but made resident very anxious and continued to attempt to stand. . . ." Observation on all days of survey showed Resident #6 seated in an adjustable reclining rocking wheelchair. The resident did not attempt to stand from the current wheelchair. Staff members reported Resident #6 used the geri wheelchair until approximately one week earlier when the facility staff began using the reclining	F 221		

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F 221	Continued From page 11 rocking wheelchair. Staff members reported the resident seemed more relaxed in the current wheelchair. Resident #6's medical record lacked evidence the facility considered the geri chair as a restraint. During interview, on 12/19/13 at 9:05 a.m., two supervisory nursing staff members (#1) and (#2) confirmed the facility did not consider the geri chair as a chair that prevented Resident #6 from rising. Failure to assess the chair that prevented rising as a restraint, obtain a physician's order, obtain the family/guardian's consent, and care plan it as an intervention, placed Resident #6 and all facility residents using this type of wheelchair at risk of injury and limited mobility.	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and resident and family interview, the facility failed to provide care for 5 of 19 sampled residents (Resident #7, #10, #12, #13, #14) and for 1 confidential resident (Resident C) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to ensure privacy when putting on Resident #7's stockings, failure to clean Resident #10's fingernails, failure to ensure Resident #10 and #14 wore clean clothes, failure	F 241		

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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F 241	Continued From page 12 to ensure Resident #12 was clean shaven, failure to maintain Resident #13's confidentiality, and failure to make Resident C's bed in a timely manner did not recognize the residents' individuality or provide care in a dignified manner. Findings include: Review of the facility policy titled "Standards of Care" occurred on 12/19/13. This policy, revised July 2013, stated, ". . . Procedure: PERSONAL CARE: . . . 4. Faces are to be kept free of facial hair (unless a male resident has a beard or mustache). . . . DIGNITY: 1. Privacy curtain/door to be closed with cares . . ." - Observation on 12/16/13 at 4:30 p.m. identified Resident #14 sitting in her wheelchair in the corridor by the nurse's station. Observation showed an orange stain approximately the size of a fifty cent piece on the front of her blouse. The unidentified CNA who transported the resident to supper failed to change the resident's blouse before she assisted her to the dining room. - During an interview on the morning of 12/16/13, Resident C stated she required staff assistance to make her bed and stressed the importance of having her bed made in the morning. Resident C stated staff either make her bed later in the day or not at all. Observation of Resident C's bed during the week of survey identified the following: *12/16/13 at 11:15 a.m. - bed unmade (unknown when staff made the bed) *12/17/13 - bed made at approximately 11:30 a.m. *12/18/13 - bed made at approximately 1:30 p.m.	F 241	F 241: 1. Resident 7, 10, 12, 13 & 14 the facility will promote care for residents in a manner and in an environment that maintains or enhances the resident's dignity and respect. Resident 13 discharged from the facility. All residents were checked and areas noted were corrected. 2. All residents of the facility have the potential to be affected. All residents assessed and checked for no cares being done in common areas, clean and clipped nails, clean clothing, clean shave, beds made timely and no eye matter. 3. All CNA's & Nurses were re-educated on promoting dignity and respect to all residents including items listed. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor resident dignity and respect. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 241	Continued From page 13 - During an interview on 12/17/13 at 3:50 p.m., Resident #12 stated a staff member shaved him earlier in the day, but failed to do a thorough job. Observation showed a significant amount of facial hair still present on the resident's face. The resident stated it is important to him to be clean shaven. Observation on 12/18/13 at 10:20 a.m. identified Resident #12 in his wheelchair getting ready to leave the facility on an outing. Observation showed a significant amount of facial hair visible on the resident's face. - During observation in another resident's room on 12/18/13 at 10:33 a.m., a nurse (#10) verbalized the CNAs would assist the resident once they finished assisting "[Resident #13]." - Observation on 12/18/13 at 7:45 a.m. identified Resident #7 dressed in a robe in a recliner with the foot rest elevated in the resident lounge area of the special care unit. A male resident was seated next to Resident #7 and three other residents were seated at a table approximately ten feet away. A CNA (#20) removed Resident #7's cotton socks, lifted the resident's robe above her knees, applied lotion to Resident #7's legs from her feet to above her knees, and applied knee high elastic support stockings to both legs. The male resident seated next to Resident #7 observed this process. Review of Resident #7's medical record occurred on December 16-19, 2013. The facility admitted the resident in September 2011. Current diagnoses included dementia. The resident's annual Minimum Data Set (MDS), dated 09/26/13, identified the resident made herself	F 241		

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F 241	Continued From page 14 understood and usually understood others, cognition was severely impaired, and required extensive assistance of two persons for dressing and transfers. During interview, on 12/18/13 at 9:05 a.m., two management staff members (#1) and (#2) confirmed applying Resident #7's stockings in the lounge in front of other residents did not recognize the resident's dignity or individuality and facility staff should have waited until the resident was in her private room. - An interview with two members of Resident #10's family occurred on the morning of 12/18/13. The family members (#2 and #3) stated they have concerns about their mother's grooming, and that they have observed "dirty fingernails," "matter around her eyes," and "food stains" on her shirt. The family members stated that in the past their mother was always very particular about her grooming and appearance. The family members stated they have expressed their concerns to the staff about their mother's hygiene.	F 241		
F 246 SS=E	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:	F 246		

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F 246	Continued From page 15 Based on observation, record review, and group and resident interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 3 of 19 sampled residents (Resident #11, #13, #19) and 12 supplemental residents (Resident A, B, C, D, E, F, G, H, I, J, K, M); and failed to ensure adequate lower extremity support for 1 of 1 sampled resident seated in a reclined rocking wheelchair (Resident #6). Failure to answer call lights in a timely manner and ensure accessibility of call lights may result in falls, avoidable incontinence, increased behaviors, and a decreased quality of life. Failure to ensure adequate lower extremity support while seated in the wheelchairs may result in reduced range of motion and pain. Findings include: - The initial tour of the facility occurred on 12/16/13 at 10:15 a.m. Residents made the following statements regarding call lights: *Resident D stated she has concerns with staff answering call lights. Stated that she has had to wait "20 minutes or more" for staff to answer the call light. Resident D stated she waits longer for staff in the evenings. *Resident E stated staff do not answer call lights promptly. She stated she has to wait "20 minutes" for staff to answer the call light. Resident E stated she once had an incontinent episode while waiting for staff to answer the call light. *Resident A stated her concern is that she has to wait for staff to answer the call light. States that the amount of time she has to wait "varies." *Resident B stated that one of her concerns is that she has to "wait for staff to answer the call light."	F 246	F 246 – 1. For Resident 11 & 19 facility will ensure that call lights are answered timely. Resident 13 discharged from the facility. Resident 6 was reassessed for adequate lower extremity support and leg support was installed on her chair to better accommodate the resident's needs. 2. All the residents of the facility have the potential to be affected. Multiple call light audits will be performed to monitor call light response time, access to the call light and response to resident's requests. Audits are also being completed to make sure that resident's lower extremities are being supported. 3. All CNA's & Nurses were re-educated on prompt call light response, call lights always available and responding to the resident's requests are being met. Re-education was also provided about making sure that residents have the correct lower extremity equipment to support their needs. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor resident dignity and respect. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 246	Continued From page 16 *Resident F stated staff will come to her room when she puts the call light on and tell her to "wait," but "then they don't come back in" to help. *Resident C stated she often waits up to 30 minutes for staff to answer her bathroom call light and assist her from the toilet. *Resident G stated he often waits up to 30 minutes for staff to answer his call light and identified he waits the longest during the evening shift. - A group interview conducted with six residents (Resident B, E, G, H, I, J, and K) (identified by the facility as interviewable) occurred on 12/16/13 at 2 p.m. and identified resident concerns regarding the amount of time for staff to answer/respond to resident call lights. Residents attending this group interview stated the amount of time for staff to respond to their call light ranges from 15-30 minutes. - During an interview on 12/16/13 at 5:00 p.m., Resident #13 (intact cognition and identified by facility as interviewable) stated staff do not check on him very much and it "scares him" since he has a tracheostomy and can quickly experience respiratory distress. Resident #13 stated staff do not always put his call light within reach and when he does put on his call light, it usually takes staff 30 minutes to answer his light. The resident stated he waits the longest period of time for staff assistance during the evening shift and has waited up to one hour and 15 minutes for staff assistance. - Observation on 12/17/13 at 7:35 a.m. showed a certified nursing assistant (CNA) (#13) exited Resident #13's room to find another staff member to assist her to reposition the resident. Prior to	F 246		

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F 246	Continued From page 17 leaving the room, the CNA (#13) failed to place the soft touch call light within the resident's reach. Resident #13 was without his call light for approximately 10 minutes before the CNA (#13) returned. Resident #13 required a tracheostomy tube to breathe. - Observation on 12/18/13 identified Resident #11 turned on his call light for staff assistance at the following times: *8:12 a.m. (on for 6 minutes) *8:19 a.m. (on for 7 minutes) *8:36 a.m. (duration unknown) *9:26 a.m. (on for 15 minutes) *9:58 a.m. (on for 4 minutes) *10:20 a.m. (on for 10 minutes) On the morning of 12/18/13, Resident #11 stated he asked for his breakfast room tray at 8:12 a.m. and did not receive it until 10:05 a.m. Resident #11 stated he rang his call light numerous times, staff answered the call light to see what he needed, but then shut the call light off and did not bring his breakfast (stated this practice commonly occurred when he turned on his call light for other things, as well). - Observation on 12/18/13 at 9:49 a.m. identified Room 419's call light on. Staff answered the call light at 10:05 a.m. (16 minutes later). - During an interview on 12/18/13 at 9:30 a.m., Resident C (interviewable) stated she finished in the bathroom "about 10 minutes ago" after waiting 20-25 minutes for staff to answer her bathroom call light to assist her. - An interview occurred with Resident M at 4:50 p.m. on 12/18/13. Resident M stated staff take "a	F 246		

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F 246	Continued From page 18	F 246		

long time" to answer call lights. Resident M expressed concerns that "if we have an emergency and put the (call) light on, I don't know what might happen." Review of Resident M's medical record, on 12/19/13, identified diagnosis of insulin dependent diabetes mellitus, hypertension, and chronic obstructive asthma.

- During the initial facility tour, on 12/16/13 at approximately 11:40 a.m., Resident #19 reported two nights before (on 12/14/13) she did not have her call light. The resident reported she telephoned her daughter who told the resident she would call the facility and if the facility staff did not respond in "ten minutes" the resident should call the daughter again. The resident reported she called her daughter three times (total of 30 minutes wait) before facility staff responded by ensuring she had her call light. Resident #19 reported she did not have any negative outcome because she did not have her call light, but felt she should have the call light. A licensed nurse (#10) present during the tour overheard Resident #19's comments and reported she was aware of this incident.

Review of Resident #19's medical record occurred on December 18-19, 2013. The resident's admission MDS, dated 12/11/13, identified intact cognition, required extensive assistance of two persons with toileting and transfers. The facility identified the resident as interviewable.

Failure to ensure accessibility of Resident #19's call light and after repeated telephone calls from a family member placed the resident at risk of incontinence and falls.

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F 246	Continued From page 19 - Observation, on 12/16/13 at 4:20 p.m., identified Resident #6 positioned in a reclined rocking wheelchair with a pillow between her feet and the foot rests. During interview, a licensed nurse (#25) reported the resident's feet did not reach the wheelchair foot rests and facility staff used the pillow to provide support for the resident's feet. The staff member (#25) reported Resident #6 recently started using the reclined rocking wheelchair and the staff did request a therapy evaluation of the wheelchair and leg rests. Observations on 12/17/13 showed Resident #6 transferred to and seated in the reclined rocking wheelchair without the pillows for foot support during the following time periods: *7:45 a.m. to 9:50 a.m. (2 hours, 5 minutes) *11:00 a.m. to 1:45 p.m. (3 hours, 45 minutes) *3:25 p.m. to 4:50 p.m. (1 hour, 25 minutes) Observation on 12/17/13 at 5:10 p.m. and random observations on 12/18/13 showed a blue foam block approximately three inches thick positioned between Resident #6's feet and the wheelchair foot rests. The medical record contained an occupational therapy wheelchair assessment completed on 12/17/13. The facility staff identified the need for a positioning device for Resident #6's lower extremities and used pillows as a temporary solution. Failure to continue to support the resident's lower extremities placed Resident #6 at risk of reduced range of motion and pain.	F 246		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 20 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, family interview, and staff interview, the facility failed to review and revise the plan of care for 4 of 19 sampled residents (Resident #2, #3, #5, and #6).and 1 of 3 closed resident records (Resident #22). Failure to update the care plan related to adaptive equipment (Resident #2), fall prevention measures (Resident #3), depression (Resident #5), meal plan (Resident #6), and pain (Resident #22) as each resident's status changed limited the staff's ability to provide care in a consistent and coordinated manner. Findings include:	F 280	F 280 – 1. Resident 2, 3, 5 and 6 were all reassessed and care plans we updated for the following corresponding areas; dietary needs, fall prevention measures, depression, adaptive equipment and pain. Resident 22 discharged from the facility. 2. All care plans will be checked, verified as correct or updated as needed. Changes will be made when they are identified. 3. All CNA's & Nurses were re-educated on making sure that the residents needs are accurately reflected in the care plan and care plan is current. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor resident care plans. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 280	Continued From page 21 Review of the facility policy and procedure, "Care Plans," occurred on 12/19/13. This document, revised on 05/20/13, stated "Purpose: To develop a care plan as a workable tool that reflects the actual care and condition of each resident. Policy: . . . The Master Care Plan (MCP) . . . will be reviewed and updated monthly and as needed. Pertinent information from the care plan will be added to the NAR/CNA [Nursing Assistant R /Certified Nursing Assistant] care plan for continuity of care. . . . Procedure: . . . C . . . Documentation, 1. Each discipline is responsible to address their individual needs . . . 2. Care plans will be updated and changes will be made as they occur to ensure the most current plan for the resident. 3. Care plans will be reviewed at least monthly by each discipline . . . 4. Any changes made to the MCP will also be updated in the NAR/CNA care plan for accuracy." - Observation on all days of survey showed Resident #2 utilized a covered cup with a straw and two handles to drink from, with staff providing assistance. Review of Resident #2's dietary ticket, dated 12/19/13, indicated "Sipper cup for liquids." Review of Resident #2's current care plan showed staff failed to include the intervention of a covered cup with straw/sipper cup. - Review of Resident #5's medical record occurred on December 16-18, 2013. Diagnoses included depression. Physician orders included Zoloft (an antidepressant), ordered 06/03/11, and Hospice care, ordered 04/18/13.	F 280	F 280 – Revised 1. Resident 2, 3, 5 and 6 were all reassessed and care plans we updated for the following corresponding areas; dietary needs, fall prevention measures, depression, adaptive equipment and pain. Resident 22 discharged from the facility. 2. All care plans will be checked, verified as correct or updated as needed. Changes will be made when they are identified. 3. All CNA's & Nurses were re-educated on making sure that the residents needs are accurately reflected in the care plan and care plan is current. Have Interdisciplinary Team approach is being used to develop and maintain care plans. Nursing staff updates and maintains current and accurate information 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor resident care plans. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 280	Continued From page 22 A physician note, dated 06/06/13, declined to reduce Resident #5's Zoloft dose, noting to do so would "likely worsen symptoms - chronic depression . . ." A Hospice note, dated 11/27/13, noted the resident "feeling low." Review of Resident #5's current care plan showed the focus area of "difficulty with sleep" with the intervention "See Mood Intervention Plan." Staff failed to identify depression as a focus area or develop interventions for depression. During an interview on 12/19/13 at 8:45 a.m., an administrative nurse (#1) stated the Mood Intervention Plan is no longer used, and when staff discontinued the plan, individual interventions were not added to Resident #5's care plan. - Review of Resident #22's medical record occurred on 12/19/13. Diagnoses included unspecified backache, gastritis, and closed fracture of lumbar vertebra. Medications included acetaminophen 500 milligrams (mg) three times daily (TID), Fentanyl 12 micrograms per hour (mcg/hr) patch changed every 72 hours, and oxycodone 10 mg every four hours as needed for mild pain, which the resident used on multiple occasions. Resident #22's nurse's note, dated 11/15/13, noted, ". . . Tells staff how to hold her back to increase comfort. . . ." The pain assessment, dated 11/26/13, indicated a back ache of "5" daily; with pain medication, repositioning, and activity helpful; scheduled Tylenol	F 280		

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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F 280	Continued From page 23 (acetaminophen) effective, and resident requested oxycodone if increased pain intensity. Resident #22's admission Minimum Data Set (MDS), dated 11/20/13, indicated frequent pain affecting her activity involvement, and of high intensity of "9" on a scale of 0-10. The MDS Care Area Assessment (CAA) summary triggered the care area of pain with the decision to care plan as "yes." Review of Resident #22's current care plan showed staff failed to develop a focus area (care area) and interventions related to pain. During an interview on 12/19/13 at 1:05 p.m., an administrative nurse stated Resident #22 should have had a care plan related to pain. - Review of Resident #3's medical record occurred on December 16-19, 2013. The facility admitted the resident in September 2011, transferred the resident to an acute hospital on 09/23/13 for surgical repair of a fractured hip after a fall, and re-admitted the resident to the facility on 10/02/13. Resident #3's current care plan, revised on 12/17/13, stated "Focus, I am at risk for falls r/t [related to] unaware of safety needs, confusion, gait/balance problems & [and] h/o [history of] fall, muscle weakness, hx [history] of hip fx [fracture]. . . . Interventions . . . Maintain clear pathways in room if able. MSL [Medi Stand Lift (sit to stand lift)] with assist of 2 for all transfers . . . Blue mat [mattress] by bed at all times when resident in bed. 30 minute checks during the night when resident in bed. . . . Will use drop seat in wheelchair. [Aids in self propulsion of wheelchair.]	F 280		

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F 280	Continued From page 24 . . ." and, created on 12/17/13, "Focus, I have an ADL [Activities of Daily Living] Self Performance Deficit r/t Alzheimer's Disease. . . . My ambulation and transfer ability fluctuates and I become increasingly agitated with staffs' attempts to assist me. . . . Interventions, Locomotion . . . w/c [wheelchair] with assist of 1 to propel long & short distances. Limited assist x [times] 2 with fww [front wheeled walker] and gait belt. . . . Special Equipment . . . hoyer [full body] lift for all transfers . . . medistand for all transfers . . . Transfers: extensive assist 2 with medistand. May use assist x 2 with gait belt. . . ." Observation on all days of survey showed the staff transferred the resident with a sit to stand lift with assistance of one or two persons (care plan states two assist with all transfers) or pivot transfer with a gait belt and two persons. The staff positioned the resident in a standard wheelchair with foot rests, without a drop seat. During interview, on 12/19/13 at 9:05 a.m., two nursing management staff members (#1) and (#2) confirmed Resident #3's current care plan was inconsistent and did not reflect the resident's current care. - Review of Resident #6's medical record occurred on all days of survey. The facility admitted the resident in December 2012. Current diagnoses included esophageal reflux and dementia. Resident #6's current care plan stated "Focus, The resident has an ADL Self Care Performance Deficit r/t Disease Process Alzheimers Dementia . . . Interventions . . . Eating [revised 07/23/13]: The resident requires meal set up with	F 280		

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F 280	Continued From page 25 extensive-total assist of 1. . . . Focus, The resident has an alteration in gastrointestinal status r/t esophageal reflux . . . Interventions [Initiated 10/07/13] . . . The resident should avoid overeating. Provide small frequent meals rather than 3 large ones. . . ." Observation throughout the survey showed Resident #6 receiving assistance from staff at established meal times with other residents, approximately 7:30 a.m., 11:30 a.m., and 5:30 p.m. During interview, on 12/18/13 at approximately 1:45 p.m., Resident #6's family member (#1) reported the resident ate three regular meals each day without problem before entering the facility. The family member (#1) was unaware of why the resident's care plan included frequent small meals. During interview, on 12/19/13 at 9:05 a.m., two nursing management staff members (#1) and (#2) reported they were unaware of why Resident #6's care plan included frequent small meals. During interviews, on 12/19/13 at 11:15 a.m. and 11:45 a.m., a consultant dietary staff member (#3) reported frequent small meals may be appropriate for Resident #6's diagnosis of esophageal reflux. This staff member (#3) could not determine why Resident #6's care plan included frequent small meals since the resident had no difficulty and did not receive the frequent small meals.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 26 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, facility policy, record review, and staff interview, the facility failed to ensure a qualified professional completed dressing changes for 1 of 1 sampled resident (Resident #13) with a gastrostomy (a tube inserted through the abdomen that delivers nutrition directly to the stomach) and tracheostomy tube (a breathing tube inserted into the windpipe). Allowing the practice of unqualified professionals to perform dressing changes to Resident #13's gastrostomy and tracheostomy tubes may result in the spread of bacteria and harm to the resident. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1294, states, ". . . Administering a Gastrostomy or Jejunostomy Feeding . . . 2. Perform hand hygiene and observe other appropriate infection control procedures (e.g., clean gloves) . . . 5. . . . Wearing gloves, remove the dressing. Then discard the dressing and gloves in the moisture-proof bag. Perform hand hygiene and apply new clean gloves . . . 7. Administer the feeding . . . 8. Ensure client comfort and safety . . . Assess status of peristomal skin. Rationale: Gastric or jejunal drainage contains digestive enzymes that can irritate the skin. Document any redness and broken skin areas. Check orders about cleaning the peristomal skin, applying a	F 281	F 281 – 1. Resident 13 discharged from the facility. 2. All residents who have a gastrostomy or tracheostomy tube have the potential to be affected. All dressing changes and trach cares will be completed by nurse. 3. All CNA's & Nurses were re-educated on only licensed nurse staff doing dressing and trach cares and using the proper technique in caring for the site the dressing is being applied. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the dressing changes of facility residents. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 281	Continued From page 27 skin protectant, and applying appropriate dressings. Generally, the peristomal skin is washed with mild soap and water at least once daily. The tube may be rotated between thumb and forefinger to release any sticking and promote tract formation. Petrolatum, zinc oxide treatment, or other skin protectant may be applied around the stoma, and precut 4 X 4 gauze squares may be placed around the tube . . ." Review of the facility policy titled "Tracheostomy - Insertion, Care, and Suctioning" occurred on 12/19/13. This policy, revised May 2013, stated, "Policy: Tracheostomy insertion, care, and suctioning will be done by nurses per practitioner orders. Purpose: . . . and maintain a clean site that is free of infection. . . ." Review of the facility policy titled "Dressing Changes/Bandages" occurred on 12/19/13. This policy, revised May 2013, stated, "Policy: All dressing changes will be completed in a clean and/or sterile technique as appropriate for wound care. Purpose: To avoid cross-contamination of wounds. . . ." Review of Resident #13's medical record occurred on all days of survey and identified a tracheostomy and gastrostomy tube and history of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteria (October 2013) and Proud Flesh (current) (an excess of granulation tissue - red, often shiny, soft appearance above the level of the surrounding skin) around the resident's gastrostomy tube. Review of the resident's progress notes identified the following: *12/16/13 at 9:23 p.m. - ". . . Silver Nitrate Sticks	F 281		

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F 281	Continued From page 28 (chemical compound used to cauterize/stop the growth of granulation tissue) to proud flesh on g-stoma [gastrostomy stoma]. . . ." *12/17/13 at 5:02 a.m. - ". . . Silver Nitrate Sticks to proud flesh on g-stoma: Proud flesh silver and shrinking." Observation on 12/17/13 at 2:30 p.m. identified a certified nursing assistant (CNA) (#9) washed her hands, donned gloves, placed a new gauze dressing around Resident #13's gastrostomy tube, and then placed a new gauze dressing around the resident's tracheostomy tube. The CNA (#9) failed to perform hand hygiene and change gloves between the two dressing changes. Observation showed the skin surrounding the gastrostomy tube appeared red and "shiny/wet." During an interview on the afternoon of 12/18/13, a nurse (#10) stated the CNAs cleaned around Resident #13's gastrostomy tube when doing cares and changed the dressing, but "I was in the room, too." During an interview on 12/19/13 at 11:00 a.m., two administrative nurses (#1 and #2) stated only nurses should change the dressing on a tracheostomy tube, and stated CNAs can change the dressing around a gastrostomy tube, but only nurses should perform treatments or apply creams, ointments, etc.	F 281		
F 309 SS=E	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,	F 309		

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F 309	Continued From page 29 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, review of professional reference, record review, and resident and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for 1 of 1 sampled resident (Resident #2) without a bowel movement for six days, for 1 of 1 sampled resident (Resident #2) care planned to keep her heels off the bed, for 1 of 1 sampled resident (Resident #5) who received another resident's medication, for 2 of 2 sampled residents residing in the facility's secured unit (Resident #6 and #7) with inaccurate weights, and for 1 of 1 sampled resident (#11) who self-administers insulin. Failure to implement a bowel protocol to ensure regular bowel evacuation, failure to provide pressure relieving measures, failure to investigate a medication error and institute corrective action, failure to reweigh residents with inaccurate weights, and failure to deliver a meal tray to a resident in a timely manner after receiving insulin did not ensure residents receive the highest quality of care possible, and may lead to unnecessary pain or adverse drug reaction. Findings include: An administrative nurse (#2) provided the form "BM Interventions" when asked for the facility bowel movement (BM) protocol. The form, revised 05/31/11, stated, "Residents with NO	F 309	F 309 – 1. Resident 2 reassessed bowel plan and revise as appropriate, reassessed heels and follow skin policy as applicable to keep off bed. Resident 5 reassessed if family and physician notified and follow proper procedure if a medication error occurs. Residents 6 & 7 reassessed current weights. Reassessed resident 11, receives insulin in accordance with meal times. 2. Reassess all residents for bowel plans, pressure areas on heels, weights, follow-up w/ medication errors and insulin administration in accordance with meal times. 3. All CNA's & Nurses were re-educated on proper bowel protocol, care plans are followed to prevent skin break down, medication error procedure is followed, staff understand correct protocol to obtain an accurate weight and lastly that diabetics receive their meals timely. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor proper bowel protocol, skin care interventions, medication error procedure, reweighing process and timely meal delivery. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 309	Continued From page 30 recorded BM for two (2) days: (Give Prune Juice or Fruit Ball). Residents with NO recorded BM for three (3) days: (Give Laxative). Residents with NO recorded BM for four (4) days: (Give suppository or Enema). This nurse indicated the night nurse makes a list of residents with no BM for two days, and the day nurse gives those residents prune juice or a fruit ball, but this intervention is not documented. This nurse stated the BM Interventions of a laxative, suppository, or enema are addressed in physician standing orders. The undated standing orders included "Bowel Management," and listed fruit balls, Milk of Magnesia, bisacodyl (a stimulant laxative) tablet and suppository, and enemas. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included constipation. Medications included bisacodyl 5 milligrams (mg) 1-2 tablets daily PRN (as needed) for bowel management, bisacodyl laxative 10 mg suppository daily PRN for bowel assist, and lactulose 30 cubic centimeters (cc) twice daily for constipation. Resident #2's diet ticket (printed with each meal) listed "offer prune juice daily." Observation showed staff failed to provide prune juice with breakfast or lunch on December 17-18, and breakfast on December 19. Resident #2's BM record showed the following length of time without a BM and the resident's Medication Administration Record (MAR) showed laxatives given: * 09/27/13 - four days (no bisacodyl tablets given on day 3, suppository given on day 4) * 11/22/13 - six days (no bisacodyl tablet given on day 3, no suppository or enema given on day 4 or 5, suppository given on day 6)	F 309		

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F 309	Continued From page 31 * 12/11/13 - six days (no bisacodyl tablet given on day 3, no suppository or enema given on day 4 or 5, two bisacodyl tablets given on day 5) Failure to follow the BM protocol and failure to implement/document dietary interventions to treat constipation has the potential to cause Resident #2 unnecessary pain and discomfort. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included muscle weakness and history of ankle fracture. A physician order, dated 09/27/13, stated, "Elevate (L) LE [left lower extremity]." The current care plan stated, "Focus: ADL [Activities of Daily Living]: Self-care performance deficit r/t [related to] diagnosis of generalized muscle weakness . . . Potential for skin breakdown. . . . High risk for pressure ulcers due to refusing repositioning at times. . . . Interventions: . . . Bed Mobility: I require extensive assist of 2 . . . May be dependent x [times] 2 assist at times. I use pillows to keep my heels off the bed and to keep the sheets off my toes as I refuse to use foot cradle . . . Focus: The resident has potential/actual impairment to skin integrity r/t edema and immobility. . . . Interventions: . . . pillows under bilateral feet at all times when in bed to keep heels off of bed . . ." Resident #2's current Daily Care Guide (instructions for certified nurse aides [CNAs]) stated, "Equipment: . . . pillow underneath feet to keep heels off of bed, pillows along side feet to keep pressure off of toes . . ." Resident #2's nurse's note, dated 09/5/13, stated, "ulcer healed [right] great toe . . ."	F 309		

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F 309	Continued From page 32 Observation at the following times showed Resident #2 in bed with no pillow to keep her heels off the bed and no pillows along side her feet to keep pressure off her toes. * 12/17/13 from 7:40 a.m. to 9:39 a.m. * 12/17/13 from 10:30 a.m. to 5:30 p.m. (In bed as not feeling well) * 12/18/13 from 7:32 a.m. to 1:40 p.m. During an interview on 12/18/13 at 1:40 p.m., a CNA (#16) stated, "Nights [night staff] put her feet up [heels off the bed], usually she is up most of the day, she likes to be up." Failure to elevate Resident #2's heels off the bed and place pillows to keep pressure off her toes has the potential for the toe ulcer to reoccur and may result in the development of heel ulcers. - Review of Resident #5's medical record occurred on all days of survey. Physician orders included Ativan (lorazepam) (anti-anxiety medication) 0.25 mg every 3 hours PRN for restlessness/anxiety. A fax to the resident's physician, dated 09/11/13, stated, "Resident received another resident's HS [bed time] pills. Res [resident] spit out all the pills except a lorazepam 0.5 mg. Res does have a prn dose of lorazepam and has received without S/E [side effects] or ill effects. Will monitor." The record lacked any further information or follow-up to this incident. During an interview the morning of 12/19/13, an administrative nurse (#2) stated she was unaware of this incident, but would expect follow-up to it. The facility was unable to provide additional information before the end of the survey.	F 309		

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Lack of immediate reporting and follow-up regarding Resident #5 receiving incorrect medications could lead to undetected adverse effects, and prevented the facility from instituting corrective action to prevent similar incidents in the future.

- The Nursing 2011 Drug Handbook, pages 1064-1065, stated, ". . . NovoLog . . . ADMINISTRATION . . . Give NovoLog 5 to 10 minutes before the start of a meal. . . . ACTION . . . Onset . . . 15 min [minutes] . . . Peak . . . 1-3 hr [hours] . . . Duration . . . 3-5 hr . . ." Page 1069 stated, ". . . Lantus . . . ACTION . . . Onset . . . 1 hr . . . Peak . . . None . . . Duration . . . 24 hr. . . ."

Review of Resident #11's medical record occurred on all days of survey and diagnoses included type II diabetes. The record identified the resident as able to self-administer insulin. The quarterly Minimum Data Set (MDS), dated 11/09/13, identified the resident with intact cognition.

The resident's current diabetic medications included Lantus insulin (long-acting insulin) 50 units twice daily and NovoLog sliding scale insulin (short-acting insulin) with blood sugar checks three times a day.

Review of the Medication Administration Record (MAR) for the morning of 12/18/13 identified Resident #11 received 50 units of Lantus insulin and 22 units of NovoLog sliding scale insulin for a blood sugar of 142.

During an interview at 10:33 a.m. on 12/18/13, Resident #11 stated the nurse brought both

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F 309	Continued From page 34 insulin pens, primed them, dialed the doses, and left them on his bedside table for him to self-administer before he ate. The resident stated he administered his Lantus and NovoLog insulins between 9:20 and 9:30 a.m., anticipating staff would deliver his breakfast tray within 10-15 minutes. Observation and resident interview identified Resident #11 turned on his call light at 9:26 a.m. to order his breakfast (answered by staff at 9:41 a.m.) and did not receive his meal until 10:05 a.m. (35-45 minutes after the resident injected his insulins). The resident identified he started "to feel lightheadedness [sic] while waiting for meal, now I feel fine [after eating breakfast]." - Review of the facility policy and procedure, "Vital Signs and Weights," occurred on 12/19/13. This document, revised May 2013, stated "Policy: . . . weights will be done weekly and prn unless ordered differently by the physician/practitioner. . . . Procedure: . . . A weight will be obtained on admission. After that weights will be obtained weekly and prn. . . ." Review of Resident #6's medical record occurred on December 16-19, 2013. The facility admitted the resident to the secured unit in January 2013. Current diagnoses included Alzheimer's disease and dementia. Resident #6's Nutritional Care Area Assessment (CAA), dated 05/31/13, identified the facility would weigh the resident weekly. Resident #6's current care plan, revised on 09/27/13, stated ". . . Weigh resident as ordered. Monitor for wt. changes and address prn." Resident #6's Nutrition Progress Notes stated the	F 309		

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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

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F 309	Continued From page 35 following: *09/27/13, 4:07 p.m. - "WEIGHT WARNING . . . 117.1 [pounds] . . . -7.5% change over 90 days . . . -10.0% change over 180 days . . . weight was at 121.7# [pounds] one month ago and at 122# five weeks ago. Usually this resident is weighed on wing 1 scale which is broken. This weight obtained using the scale on wing 4. The difference maybe relate [sic] to scale discrepancy. Will be assessing next weight." Resident #6's Weight Summary identified the following dates and weights in pounds: *11/17/13 - "115.2" *11/24/13 - "84.0" *12/01/13 - "120.8" *12/08/13 - "110.8" Resident #6's medical record failed to show the facility staff identified the weights on 11/24/13, 12/01/13, and 12/08/13 as possible errors and implement corrective action including re-weighing the resident. - Review of Resident #7's medical record occurred on December 16-19, 2013. The facility admitted the resident to the secured unit in July 2013. Current diagnoses included Alzheimer's disease and gastritis. Resident #7's current care plan, revised 09/26/13, stated "Focus, Alteration in nutrition. Potential for wt. [weight] loss d/t [due to] her dementia and intake inconsistent. . . . Interventions . . . Monitor weights weekly. . . ." Resident #7's Weight Summary identified the following dates and weights in pounds:	F 309		

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F 309	Continued From page 36 *11/24/13 - "127.6" *12/01/13 - "122.6" *12/08/13 - "135.4" *12/15/13 - "130.8" Resident #7's medical record failed to show the facility staff identified the weights on 12/01/13, 12/08/13, and 12/15/13 as possible errors and implement corrective action including re-weighing the resident. During interview, on 12/19/13 at 11:45 a.m., a consultant licensed dietary staff member (#3), reported she expected that facility staff would re-weigh the residents when possible errors are identified. This staff member (#3) reported re-weighing the residents at this time, Resident #6 - 116.2 pounds and Resident #7 - 122.8 pounds. Failure to re-weigh residents when inaccurate weights were present placed the residents at risk of unidentified weight loss. This limited the facility's ability to accurately determine the benefits of its interventions for these residents and placed all residents at risk of unidentified weight loss.	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	F 312		

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F 312	Continued From page 37 by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/10/13. Based on observation, record review, policy and procedure review, and resident, family, and staff interview, the facility failed to ensure 3 of 19 sampled residents (Resident #3, #9, and #10) and 1 of 1 confidential resident (Resident C) received the necessary assistance for good nutrition, grooming, and personal hygiene. Failure to provide complete personal hygiene resulted in body odor and a strong urine odor in the resident's room (Resident #3), perineal rash (Resident C), and incomplete personal hygiene (Resident #10). Failure to provide Resident #9 with toileting for five hours did not meet the resident's needs for personal hygiene. Failure to provide assistance in the dining room has the potential to result in poor nutrition and/or weight loss (Resident #10). Findings include: - Observation during the initial facility tour on 12/16/13 at approximately 10:20 a.m. identified Resident #3 in her room and an odor in the room. The resident was the sole occupant of the room. Review of the facility policy, "Standards of Care" occurred on 12/19/13. This policy, dated July 2013, stated, "Purpose: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. Policy: The following standards of care will be followed in providing care to the residents of Eventide. . . . PERSONAL CARE: 1. Oral cares are given a minimum of AM [morning] and PM [evening] (teeth/dentures cleansed; mouth rinsed or swabbed).	F 312	F 312 – 1. Resident 3 reassessed for odor of resident & room as well as appropriate bath schedules. Resident 10 reassessed dining assistance needed, oral care, odor and overall cleanliness. Resident 9 expired on 1/8/14. 2. Reassess all residents for personal or room odor, appropriate bath schedules, needs w/ dining assistance, oral cares and overall cleanliness. 3. All CNA's & Nurses were Re-educated on the need to provide grooming and personal hygiene care, odor concerns, dining assistance, bath schedules and overall cleanliness. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor proper ADL care related to grooming, personal hygiene and toileting. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 312	Continued From page 38 2. Peri [Perineal] cares are given after each toileting or brief change and prn [as needed] - soap and water will be used in the am and pm; disposable incontinent wipes may be used in between am/pm cares . . . 4. Faces are to be kept free of facial hair (unless a male resident has a beard or mustache) 5. Nail care done weekly and prn . . ." - Observation on 12/17/13 at 8:05 a.m. showed a CNA (certified nursing assistant) (#7) assisting Resident #10 in the bathroom. Observation showed soft brown stool in Resident #10's brief. The CNA raised the resident to a standing position with a mechanical lift and wiped the rectal area using disposable wipes. The CNA did not provide frontal perineal cares, or check to see if the area was completely clean of the soft stool. The CNA (#7) did not use soap and water for perineal cares in the am, as indicated by the Standards of Care policy. The CNA placed the resident's dentures in her mouth, without providing any oral cares. Review of Resident #10's care plan identified, "Self care deficit related to dementia . . . Interventions: . . . Eating: I am able to feed myself after my tray is set up. At times I may need supervision with reminders when eating . . ." Observation of Resident #10 in the dining room occurred on 12/17/13 at 8:45 a.m. when she received her breakfast meal. At 9:05 a.m., Resident #10 had not eaten any of her food, and was leaning forward in her chair, with her eyes closed. No staff members encouraged or assisted her to eat during this time period. At 9:10 a.m., Resident #10 leaned forward and laid her face on her plate of food. A dietary staff member	F 312		

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F 312	Continued From page 39 went to the nurses station to alert the nurse the resident's "face is on her plate" of food. The staff nurse immediately moved Resident #10 to a table with a CNA who assisted/encouraged her to eat. An interview with two members of Resident #10's family occurred on the morning of 12/18/13. The family members (#2 and #3) stated they have concerns about their mother's grooming, and that they have observed "dirty fingernails," "matter around her eyes," and "food stains" on her shirt. The family members stated that in the past their mother was always very particular about her grooming and appearance. The family members stated they have expressed their concerns to the staff about their mother's hygiene. Resident #10's family members also stated they were told "two to three weeks ago" by staff their mother would be moved to an assisted table and this had not occurred yet. The family members stated they have concerns with "communication" within the facility. They stated they will ask/tell a staff member about a concern or issue, but it does not get communicated to other staff. - Review of Resident #9's medical record occurred on all days of survey. Medical diagnoses included lymphedema, congestive heart failure, chronic kidney disease, and fluid overload. Resident #9's current medications included two diuretic medications and a topical ointment for her reddened skin on the right inner thigh, groin, and skin folds. Resident #9's Minimum Data Set (MDS), dated 11/03/13, identified extensive assistance required for toileting and personal hygiene. Resident #9's current care plan identified, "Focus: I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] dementia, obesity . . . I am incontinent	F 312		

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F 312	Continued From page 40 of bladder and bowel. . . Interventions: . . . Toilet Use: I am checked and changed every 2 hours. I wear incontinent product. . . ." Observation on 12/17/13 from 7:40 a.m. to 12:00 noon identified staff failed to check or change Resident #9's brief. During an interview on 12/17/13 at 1:45 p.m., a CNA (#27) stated she and another staff member checked and changed Resident #9's brief after lunch. When asked if she or any other staff checked or changed Resident #9's brief this morning or before lunch, the CNA (#27) stated she "didn't have time, because the resident went to devotions at church." - Review of Resident #3's medical record occurred on December 16-19, 2013. The facility re-admitted the resident in October 2013 after surgical repair of a fractured hip. The resident's quarterly MDS, dated 11/27/13, identified the resident understood others, made herself understood, required total assistance of two or more persons for toileting, and frequently incontinent of bowel and bladder. Resident #3's current care plan, revised on 12/02/13, stated "Focus, I have an ADL Self Care Performance Deficit r/t Alzheimer's disease. . . . Interventions . . . PERSONAL HYGIENE: I require limited to extensive assist of one for all hygiene cares. May be dependent at times depending on current cognitive status. . . . TOILET USE: Occasionally incontinent of bowel and bladder. Am not able to always make my toileting needs known, staff to anticipate needs prn. Extensive assist for toileting and dependent for peri cares. . . ." Observation, on 12/16/13 at 4:30 p.m., identified	F 312		

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F 312	Continued From page 41 two CNAs (#30 and #31) changed Resident #3's brief and provided perineal care. Observation identified an odor of urine and a body odor. When asked, CNA (#30) stated Resident #3's "urine has a strong smell." The CNAs bagged and removed the soiled brief from the room and moved the resident in her wheelchair to the nurse's station. The CNAs (#30) and (#31) did not provide additional hygiene for Resident #3. Observation of Resident #3's morning cares occurred on 12/17/13 at 8:10 a.m. and on 12/18/13 at 7:55 a.m. During both observations, a CNA (#29) dressed Resident #3's lower body while she assisted the resident with toileting; dressed the resident's upper body; completed oral cares; and, wheeled the resident to the nurse's station to wait for breakfast. During both observations, the CNA (#29) failed to wash Resident #3's perineal area with soap and water as indicated by the Standards of Care policy. On 12/18/13, before wheeling the resident from her room, the CNA sprayed Resident #3 with perfume. During interview, on 12/17/13 at 7:05 p.m., Resident #3' family member (#5) reported a concern regarding the resident's cleanliness. The family member (#5) stated Resident #3 wears briefs and she feels the facility staff do not change the brief often enough. The family member (#5) stated she and other family members have noted Resident #4 has a body odor and an odor in her room and have had to request staff change her soiled brief, most recently on 12/15/13. During interview, on 12/19/13 at 9:05 a.m., two supervisory nursing staff members (#1) and (#2)	F 312		

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F 312	Continued From page 42 stated they expected facility staff to wash Resident #3's trunk, underarms, and perineal area before dressing. - During a confidential interview on the morning of 12/18/13, Resident C stated staff do not always wipe her properly after toileting and she feels "itchy" in her perineal area.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure that a resident with a pressure ulcer received the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 1 sampled resident (Resident #10) with deteriorating pressure ulcer requiring hospitalization. Failure to protect Resident #10's left heel during transport in the wheel chair had the potential to cause injury, pain, or worsening of the pressure ulcer; failure to apply the protective heel boot to the right foot as ordered had the potential for new ulcers to develop; failure to identify a worsening pressure	F 314	F 314 – 1. Resident 10 reassessed for pressure ulcer and wheelchair positioning. 2. All residents who have a history of skin breakdown or currently has pressure ulcers have the potential to be affected. Assess all residents with pressure ulcers, document appropriate care and positioning as well as pain management. 3. All CNA's & Nurses were re-educated on the need to be aware of proper care of pressure areas and appropriate wheelchair positioning 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the care of skin areas to ensure that areas do not worsen. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 314	Continued From page 43 ulcer, as evidenced by increased pain, redness and swelling of the leg, and foul smelling drainage and failure to notify the physician of the worsening pressure ulcer resulted in Resident #10's hospitalization for surgical intervention of the pressure ulcer. Findings include: Review of the policy "Skin Assessment" occurred on 12/19/13. This policy, dated May 2013, stated, "Purpose: The purpose is to inspect and assess all areas of the resident's skin to identify current and potential problems. A resident who is admitted to the facility will receive the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from occurring. It is Eventide's goal that residents who enter the facility without pressure ulcers do not develop them unless the clinical condition demonstrates the pressure sore was unavoidable. . . . Policy: . . . The nurse is responsible for: . . . Identifying and evaluating risk factors and changes in residents' conditions. . . ." Review of Resident #10's medical record occurred on all days of survey. Resident #10's medical diagnoses included dementia, diabetes mellitus type II, and unstageable pressure ulcers to the left heel. Review of Resident #10's care plan identified a Focus area of "Hx [history] of Stage 2 pressure ulcer to coccyx. I have un-stageable pressure ulcers to left heel. . . . Interventions: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing weekly and prn. . . . Assess and document status of wound perimeter, wound bed	F 314	F 314 – Revised 1. Resident 10 reassessed for pressure ulcer and wheelchair positioning. 2. All residents who have a history of skin breakdown or currently has pressure ulcers have the potential to be affected. Assess all residents with pressure ulcers, document appropriate care and positioning as well as pain management. 3. All CNA's & Nurses were re-educated on the proper care of pressure areas, wounds and appropriate wheelchair positioning. Policy was reviewed and is deemed acceptable. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the care of skin areas to ensure that areas do not worsen. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 314	Continued From page 44 and healing progress. Report improvement and declines to the MD." Review of Resident #10's Nursing Progress Notes identified the following: *11/30/13 - "Resident has a 4.8 by 3.6 cm [centimeter] fluid filled area to outer left heel. Heelers are now in place, MD [medical doctor] notified. . . ." NOTE: This is the first time staff identified the blister area on the left heel in the medical record. *12/02/13 - "Skin asst [assessment] done and has left heel fluid like filled area and is on TX [treatment] to check. . . ." *12/03/13 - 8:49 a.m. - ". . . note still a fluid lilled [sic] area present and skin dark. 1:15 p.m. - To wlak [sic] - in clinic via bus and dtr [daughter] met her there to have left heel checked. . . . Culture obtained after opening blister. No puss noted. Will await culture results before starting antibiotics. Suspect pressure ulcer, to keep moist with aquaphor and non-adherent dressing. Change BID [twice a day] Continue with heel protectors." NOTE: Physician's Progress note dated 12/03/13 stated, ". . . There is a handwritten note stating that on November 30 they noticed a blister on her left heel. It was 4.8 x 3.6 cm in size. . . . Plan: . . . I would like them to keep this area moist and covered with a nonadherent dressing. It should be changed twice a day to make sure the area is examined. . . . It is important to use heel protectors as I feel this is most likely a pressure ulcer. We will prescribe appropriate antibiotics based upon culture results." *12/08/13 - ". . . note small amt [amount] of dry blood on old drsg [dressing]. " *12/10/13 - ". . . some areas dark and another fluid filled area present and intact. . . . Dr. . . .	F 314		

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F 314	Continued From page 45 faxed an update on current pressure areas and status of healing. . . . Final culture results returned and faxed it to Dr. . . ." *12/11/13 - ". . . note the 1 area still open where Dr. opened up and the other area still fluid filled. Heel is odorous. . . ." *12/12/13 - ". . . Area on left heel has loose skin where Dr. opened up it up and has another loosely fluid filled pockt [sic]. Tx done as per order." *12/13/12 at 4:01 p.m. - "Tylenol with Codeine #3 . . . complaints of left foot pain." 10:02 p.m. - "Tylenol with Codeine #3 . . . left heel" *12/14/13 - "Tylenol with Codeine #3 . . . pain in left foot. resident states that it hurts really bad." *12/15/13 - "Tylenol with Codeine #3 pain in left foot. resident states it hurts real bad." *12/16/13 - "Tylenol with Codeine #3 . . . resident crying out asked if she was having pain stated yes unable to give me a number." *12/17/13 - "Tylenol with Codeine #3 . . . pain in back/heel unable to say number but resident crying. . . . Cleansed with normal saline and telfa applied and wrapped with Kling. Did not apply aquaphor as too moist and has a very foul odor to it . . . " 4:25 p.m. - "Dr. . . . faxed at 6:40 am this am re: left heel wound and update. 9:40 am. very sleepy probably from pain pill earlier . . . This afternoon received fax Dr . . . to send to walk-in clinic. . . . resident went via bus . . ." 5:33 p.m. - "Nurse on wing 3 notified at approximately 1625 [4:25 p.m.] that [name of resident] was being admitted to [name of local hospital] . . . ." Review of the Medication Administration Record (MAR) showed Resident #10 received Tylenol with Codeine #3 on December 6, 11, 13 (twice) 14, 15, 16, and 17, 2013. The nurses notes identify the resident complained of foot pain.	F 314		

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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F 314	Continued From page 46 Review of Resident #10's Wound Care Flow Sheets identified the following: *11/30/13 - "Site: Left heel . . . Type: blister . . . Units of Measure: Length 4.8 cm Width 3.6 cm . . . Stage: N/A" *12/02/13 - "Site: Left inner heel . . . Type: pressure . . . . Length 3.5 cm Width 4.0 cm . . . Stage: Unstageable . . .Wound Bed Tissue: Raised, dark fluid filled blister" *12/03/13 - "Site: Left heel outer . . . Type: pressure. . . Length 3.1 cm Width 3.1 . . . Stage: Unstageable. . . Drainage: none - raised fluid filled blister" *12/09/13 - "Site: Left heel. . . Type: Blister . . . Length 4.8 cm Width 4.0 cm. . . . Stage: N/A" *12/10/13 - "Site: L inner heel . . . Type: Pressure . . . Length 3.1 cm Width 3.5 cm . . . Stage: Unstageable . . . Site: L outer heel . . . Type: Pressure. . . Length 4.0 cm Width 6.5 . . . Drainage: Left inner heel has small amount of bloody drainage. Left outer heel continues to have a fluid filled blister. . . . Odor: Foul odor present . . . Wound Bed Tissue: Left inner heel with dark red area, difficult to determine tissue bed d/t [due to] scab beginning to form. Left outer heel continues to have a blister intact." *12/16/13 - "Site: Left inner heel . . . Length 3.5 cm Width 4.1cm . . . Site: Left outer heel . . . Type: Pressure . . . Length 7.5 cm Width 6.0 cm . . . Drainage: Left inner heel area has mod [moderate] amt of bloody tinged drainage from it this am and area that is open is large then (sic) last week as more of the skin as (sic) come off. Area is very dark. Left outer heel has a fluid filled area intact the size of 7.5 by 6 which is larger area then (sic) last week. . . . Odor: foul smell to wound . . . Wound Bed Tissue: slough present"	F 314		

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F 314	Continued From page 47 Observation of two staff members (CNA #5 and CNA #6) assisting Resident #10 out of bed occurred on 12/16/13 at 4:35 p.m. The resident stated "don't touch my leg" and complained of pain when the CNAs lifted the resident's leg. Observation showed the gauze dressing around the heel saturated with a dark colored drainage, and a very foul odor permeated throughout the room. Resident #10's left lower leg was reddened, swollen, and approximately twice the size of the right lower leg. The CNA (#5) stated "her leg is really swollen." The CNAs stated they would notify the nurse about the resident's leg and the saturated dressing. Observation showed Resident #10 wearing a soft protective booty on her left heel while in bed and in the wheelchair, but not on the right heel. While transporting the resident in the wheelchair down the hall, the left foot (the foot with the heel ulcers) repeatedly fell or slipped back off the foot pedal, towards the wheel of the chair. The CNA notified the nurse about the resident's leg pain and of the foot slipping off the chair and the nurse placed a work order for a support board. At 5:00 p.m., Resident #10 stated "I don't know if I can sit up anymore." Observation showed the resident's left foot slipped off the back of the foot pedal towards the floor and wheel during transport back to her room. Observation on 12/17/13 at 7:50 a.m. showed Resident #10 in bed with a blue protective booty on her left heel, but not on her right heel. Observation showed a nursing staff member (#4) changed the dressing on Resident #10's left heel. During the dressing change, Resident #10 moaned out in pain. The nurse (#4) stated she had given the resident Tylenol with Codeine #3	F 314		

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F 314	Continued From page 48 one hour prior to the dressing change. Observation showed a large area of black tissue over the inner heal and a large fluid filled blister on the outer heal. The heel had a strong, foul odor which permeated the room. Observation showed Resident #10's left leg was reddened and swollen. At 8:05 a.m., a CNA (#7) assisted Resident #10 from the bed to the bathroom with a mechanical standing lift. Observation showed a soft, protective booty on the left heel, but not on the right heel. The resident moaned and cried of pain in her leg when the CNA moved the resident to the side of the bed for placement in the lift. After using the bathroom, the CNA transferred the resident to her wheelchair with the mechanical lift. Observation showed the resident's left foot falling backward off the foot pedal when transported down the hall to the dining room. Observation on 12/17/13 at 9:30 a.m., showed a staff member (#8) transported Resident #10 back to her room in her wheelchair after breakfast. Observation showed the resident's left foot falling off the back of the foot pedal. The resident stated "My shoe came off, I lost my shoe" and the CNA placed her foot back on the pedal. After using the standing lift to transfer Resident #10 to the recliner, the CNA (#8) removed the shoe from the resident's right foot. The CNA stated "she is supposed to have another booty for her right foot." The CNA looked around the room, and then found the booty in the bag on the back of the wheelchair. The CNA then placed the protective booty on the right heel. Facility nursing staff faxed the physician on 12/10/13 the following information: "[Name of	F 314		

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F 314	Continued From page 49	F 314		

resident] went to walk-in clinic on 12-3-13 and she opened up a blister on (L) heel and this is the culture results. Also has another large blister on same heel noted yesterday. Is this a significant culture result? Please fax back." The Physician's responded, "Likely not significant."

Facility staff notified the physician regarding the culture result and the development of a new blister area on the heel on 12/10/13, however did not describe the size, appearance, or the foul odor as identified on the Wound Care Flow Sheet dated 12/10/13. The next day, 12/11/13, the nurses notes again identified the heel as odorous. The Wound Care Flow Sheet, dated 12/16/13, identified the foul odor to the wound and the enlargement of the pressure areas on the heel. Resident #10 began to complain of foot pain on December 13-17, requiring administration of Tylenol with Codeine #3. Observations on 12/16/13 identified redness and swelling of Resident #10's left leg, pain in the left leg, and a strong, foul odor in the resident's room, yet the facility did not notify the physician until the following day, 12/17/13.

On 12/17/13, facility nursing staff faxed the physician the following information: "Re: L heel wound (s) - went to walk-in clinic on 12-3-13 with large fluid filled area on L heel. Seen Dr. [name of physician] . . . opened the area with small slit and did C&S [culture and sensitivity] of drainage. Results came back negative. . . . ordered aquaphor and dressing change BID. Then on 12-11-13 another lg [large] fluid filled area next to the open one. As of yesterday noted the 1st area most of top layer of skin gone and now has very dark (necrotic area?) present and very, very foul odor to it. Redness around wound(s), having a lot

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F 314	Continued From page 50 of pain with some warmth around area also needs it looked at at clinic? Please fax back." Physician Response: "Take to walk in clinic today." Facility staff transported Resident #10 to the clinic the afternoon of 12/17/13, and nurses notes later identified Resident #10's admission to the Jamestown Regional Medical Center. On the morning of 12/18/13, a staff nurse stated Resident #10 would be having surgery for debridement of the pressure ulcer. The facility failed to: * Recognize and identify Resident #10's deteriorating pressure ulcer as evidenced by increased pain, redness and swelling of the leg, and the development of a foul smelling drainage. * Promptly notify/consult the physician when Resident #10's heel ulcer began to deteriorate. * Identify the pressure ulcer until it was a 4.8 cm by 3.6 cm fluid filled area. * Promptly protect Resident #10's left heel/pressure ulcer area when staff identified her foot continued to fall off the back of the foot pedal. * Implement the heel protector booty on Resident #10's right foot.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, the facility failed to ensure that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 2 of 2 sampled residents (Resident #12 and #13) who utilized hand splints and for 1 of 1 sampled resident (Resident #13) who required passive range of motion exercises. Staff failure to apply the hand splints to Resident #12 and #13, as ordered by the physician, and failure to complete Resident #13's passive range of motion as ordered may result in both residents experiencing discomfort and new or worsening contractures. Findings include: Review of the facility policy titled "Range of Motion" occurred on 12/19/13. This policy, revised May 2013, stated, ". . . Purpose: Providing range of motion assists in maintaining joint mobility which in turn assists in preventing joint pain and improves the ease of providing personal cares. Residents with limited range of motion will receive appropriate treatment and services to increase range of motion and prevent further decrease in range of motion . . . Procedure: The occupational or physical therapist or nursing will determine whether range of motion (ROM) is indicated for a resident . . . The Rehab Aide/CNA [certified nursing assistant]/nurse will be instructed in the range of motion program for the resident and will be responsible for providing it as scheduled. . . ."	F 318	F 318 – 1. Resident 12 reassessed for use of hand splint. Resident 13 discharged from the facility. 2. Reassess all resident with hand splints and ROM who have the potential to be affected. 3. All CNA's & Nurses were re-educated on the need to properly apply splints and complete range of motion exercises. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the use of braces and residents that need range of motion exercises. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 318	Continued From page 52 - Review of Resident #13's medical record occurred on all days of survey and diagnoses included quadriplegia, muscle spasms, and bilateral upper extremity contractures. The quarterly Minimum Data Set (MDS), dated 10/11/13, identified intact cognition, extensive assistance of two or more staff members for bed mobility, and limited range of motion to both upper and lower extremities. The current care plan stated, "... Focus: The resident has an ADL [activities daily living] Self Care Performance Deficit r/t [related to] quadriplegia ... Goals: ... The resident will maintain current level of function ... Interventions: ... I am bedfast most of the time per my choice. CNAs to perform PROM [passive range of motion] to LE [lower extremities] bid [twice a day]. ..." A form identifying an occupational therapist's recommendations to Resident #13's caregivers, dated 08/29/13, stated, "... Problem: Prevention of contractures to left upper extremity ... Tasks: Please complete gentle PROM to [left] shoulder daily. If resident's wife is here ask if she would like to do it that day first ... Approaches: Slow gentle range. If you have questions please come and find me in therapy and I will help teach you again ... Equipment: Left hand splint - if wife is here she can put it on. Otherwise needs to go on daily. Can be put on anytime b/w [between] 11 am- 1 pm and then he will request when he wants it off at night. Please see picture, if you need a refresher on how to put it on please find me in therapy and I will show you ... Please look at pictures and read directions on back of picture page. ..."	F 318	F 318 – Revised 1. Resident 12 reassessed for use of hand splint. Resident 13 discharged from the facility. 2. Reassess all resident with hand splints and ROM who have the potential to be affected. 3. All CNA's & Nurses were re-educated on properly applying splints and complete range of motion exercises as care planned. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the use of braces and residents that need range of motion exercises. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 318	Continued From page 53 During an interview on 12/16/13 at 5:00 p.m., Resident #13 stated he required range of motion exercises to his lower extremities twice a day, however, staff sometimes just completed them once a day or not at all. The resident stated staff often completed his exercises late in the day. Resident #13 identified he never wore his left hand splint because the CNAs did not know how to put it on; "they just don't do it." He stated if staff put the hand splint on wrong, it causes him pain and he asks them to remove it. Resident #13 stated staff do not perform range of motion exercises on his left arm/shoulder so he attempted this independently. On December 17-19, 2013, observations, resident interview, and staff interview identified Resident #13 received passive range of motion exercises to his lower extremities at the following times: *12/17/13 at 2:40 p.m. (observation - leg spasms during exercises) and 8:45 p.m. (resident interview) *12/18/13 at 1:50 p.m. (staff interview) and 7:45 p.m. (resident interview) *12/19/13 at 1:30 p.m. (observation) Observations on all days of survey identified staff failed to apply Resident #13's left hand splint and failed to perform range of motion exercises to his left arm/shoulder daily. During an interview on the afternoon of 12/17/13, Resident #13 stated the staff member who completed his lower extremity range of motion exercises on the evening of 12/16/13 "did not know what she was doing," which resulted in ankle discomfort still present at the time of the	F 318		

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F 318	Continued From page 54 interview on 12/17/13. Observation on 12/17/13 at 11:45 a.m. showed Resident #13 asked a CNA (#13) if she could complete his range of motion exercises before his bath as "it gets so close to the second time in the evening otherwise [when the resident is to receive additional range of motion exercises]." The CNA (#13) responded and stated the exercises would probably be done in the afternoon after his bath due to staff being needed in the dining room. Facility staff failed to complete Resident #13's passive range of motion exercises to his left arm/shoulder daily, his bilateral lower extremities twice daily as ordered, with appropriate time between to allow the resident's muscles to relax, and failed to apply his left hand splint daily as per the resident's care plan and direction from an occupational therapist. - Review of Resident #12's medical record occurred on all days of survey and diagnoses included Multiple Sclerosis (MS), bilateral hand contractures, and muscle spasms. The quarterly MDS, dated 09/08/13, identified intact cognition, extensive assistance of two or more staff for bed mobility, and limited range of motion to both upper and lower extremities. The current care plan stated, ". . . Focus: The resident has an ADL Self Care Performance Deficit r/t Advanced MS . . . Goals . . . I will maintain current level of function . . . Interventions: . . . Hand braces to be put on 2 hours in AM and 2 hours in PM. . . ." (Frequency inconsistent with current CNA task documentation.)	F 318		

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F 318	Continued From page 55 Observations on December 16-18, 2013 showed staff failed to apply Resident #12's bilateral hand braces. During an interview on 12/17/13 at 11:30 a.m., Resident #12 stated if he wore the bilateral hand braces, it is usually at night. The resident confirmed he required staff assistance to put the braces on and take them off. Review of the CNA task documentation for December 16-18, 2013 identified the task "Bilateral hand braces, On at 8 AM and off at 8 PM." (Frequency inconsistent with current care plan.) This documentation showed staff initialed off each day, indicating they placed Resident #12's bilateral hand braces each morning during survey. (This documentation conflicts with observation and resident interview.) Facility staff failed to apply Resident #12's bilateral hand braces every morning as identified in the resident's care plan and CNA task documentation.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate	F 322		

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F 322	Continued From page 56 treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, record review, and staff interview, the facility failed to provide the appropriate treatment and services for 1 of 1 sampled resident (Resident #13) fed by a gastrostomy tube. Failure to keep Resident #13's head of bed at a minimum of 30 degrees while receiving continuous tube feedings may result in aspiration pneumonia. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1292, states, ". . . Administering a Tube Feeding . . . Assist the client to a Fowler's position (at least 30 degrees elevation) in bed or a sitting position in a chair, the normal position for eating. If a sitting position is contraindicated, a slightly elevated right side-lying position is acceptable. Rationale: These positions enhance the gravitational flow of the solution and prevent aspiration of fluid into the lungs. . . ." Review of Resident #13's medical record	F 322	F 322 – 1. Resident 13 discharged from the facility. 2. All residents who are fed by a gastrostomy tube have the potential to be affected. 3. All Nurses and CNA's were re-educated on the need to keep the head of the bed at a minimum of 30 degrees while receiving tube feeding. Feeding will be paused when resident is flat for repositioning. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the positioning while a resident is receiving tube feeding. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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 322	Continued From page 57 occurred on all days of survey and identified diagnoses of quadriplegia, chronic respiratory failure, and dysphagia. A physician's order, dated 07/11/13, identified Osmolite tube feeding at 75 milliliters per hour continuous. Resident #13's current care plan stated, ". . . Resident has potential for complications r/t [related to] tube feedings (. . . aspiration . . .) . . . Interventions . . . HOB [head of bed] needs to be elevated at least 30 degrees. . . ." Observation of personal cares and repositioning occurred on December 17-18, 2013 and identified staff failed to pause Resident #13's continuous tube feeding when lowering the head of the bed less than 30 degrees. During an interview on 12/19/13 at 11:00 a.m., an administrative nurse (#2) stated she expected staff to pause Resident #13's tube feeding when lowering the head of the bed for cares and repositioning.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review	F 323		

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F 323	Continued From page 58 of facility policy and procedure, the facility failed to ensure the environment remained as free of accident hazards as possible for 1 of 10 sampled residents (Resident #3) transferred with a stand lift. Failure to ensure transfers with assistance of two persons as identified in Resident #3's care plan and failure to properly use the gait belt during transfers placed the resident and staff at risk of injury. Findings include: Review of the facility policy and procedure, "Standards of Care," occurred on 12/19/13. This document, revised in May 2013, stated "Purpose: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. Policy: The following standards of care will be followed in providing care to the residents of Eventide. Each staff member providing direct nursing care will have in their possession throughout their shift the written plan of care for each resident and will perform specific cares as directed according to this form. . . . Procedure: SAFETY: . . . 4. Hoyer lifts [full body lifts] require the attendance of 2 staff. . . ." Review of Resident #3's medical record occurred on December 16-19, 2013. The facility re-admitted the resident in October 2013 following surgical repair of a fractured right hip. The resident's quarterly Minimum Data Set (MDS), dated 11/27/13, identified the resident demonstrated physical behaviors one to three days during the seven day assessment period and required extensive assistance of two or more persons with transfers.	F 323	F 323 – 1. Resident 3 was reassessed for proper transfer device and technique. 2. All residents who are required to use a lift or transfer with a gait belt have the potential to be affected. 3. All CNA and Nursing staff were re-educated about following the care plan for transfers as well as the proper use the gait belt to make sure that the resident and staff are safe. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the use of following the care plan with transferring with lifts as well as the proper use of a gait belt when transferring residents. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 59 Resident #3's current care plan included the following: *dated 12/17/13, "Focus, I am at risk for falls r/t [related to] unaware of safety needs . . . Interventions . . . MSL [MediStand Lift (sit to stand lift)] with assist of 2 for all transfers. . . ." *dated 12/17/13, "Focus, I have an ADL [Activities of Daily Living] Self Care Performance deficit r/t Alzheimer's disease. . . . My ambulation and transfer ability fluctuates and I become increasingly agitated with staffs' [sic] attempts to assist me. . . . Interventions . . . SPECIAL EQUIPMENT: . . . hoyer lift for all transfers . . . medistand for all transfers . . . TRANSFERS: extensive assist [of] 2 with medistand. May use assist x [times] 2 with gait belt. . . ." Observations of one certified nursing assistant (CNA) (#29) assisting Resident #3 to transfer from her bed to the toilet; and from the toilet to a wheelchair with a sit to stand lift occurred on 12/17/13 at 7:35 a.m. and 10:03 a.m.; and, on 12/18/13 at 7:55 a.m. On 12/18/13 at 9:40 a.m. observation showed one CNA (#29) transferred the resident from the wheelchair to the toilet using a sit to stand lift. Observation of a gait belt transfer occurred on 12/17/13 at 3:55 p.m. when two CNAs (#30 and #31) assisted the resident from her bed to a wheelchair with a gait belt loosely applied around the resident's waist. The CNAs grasped the gait belt, lifted, and as the gait belt slid up, the CNAs lifted under the resident's arms, pulling on the resident's shoulders. Resident #3's care plan requires the use of two persons for transfers with the full body lift and the sit to stand lift. Treansferring Resident #3 with	F 323		

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F 323	Continued From page 60 only one staff person may result in injury to the resident. Loosely applying the gait belt and lifting on Resident #3's shoulders may result in pain and injury to the resident.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, facility staff failed to offer fluids to 3 of 7 sampled residents (Resident #2, #3, and #12) dependent on staff for fluid intake. Failure to offer fluids during cares increased the residents' risk of dehydration, constipation, urinary tract infections (UTIs), and may delay the healing process. Findings include: Review of the facility policy, "Standards of Care" occurred on 12/19/13. This policy, dated July 2013, stated, "Purpose: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. Policy: The following standards of care will be followed in providing care to the residents of Eventide. . . . NUTRITION: . . . 4. Offer fluids when completing scheduled cares (toileting, turning, etc.). . . ." - Review of Resident #12's medical record occurred on all days of survey and diagnoses included Multiple Sclerosis (MS), bilateral hand	F 327	F 327 – 1. Resident 2, 3 and 12 reassessed and staff re-educated to offer fluids with cares. 2. All residents who are dependent on staff for fluid intake have the potential to be affected. 3. All CNA and Nursing staff were re-educated on the importance of offering fluids to residents during cares. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor fluid intake during cares. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 327	Continued From page 61 contractures, history of UTIs, and a current pressure ulcer. The quarterly Minimum Data Set (MDS), dated 09/08/13, identified intact cognition, extensive assistance for eating, and a Stage II pressure ulcer. A nutrition assessment, dated 09/04/13, identified the resident required 1500 cc [cubic centimeters] of fluids daily. The current care plan stated, ". . . The resident has potential for swallowing problems due to advanced MS. Potential for wt. [weight] loss as resident [sic] not always eats 100% . . . encourage fluids. . . ." During an interview on 12/19/13 at 9:00 a.m., Resident #12 stated he completely relied on staff for food and fluid intake. Observations of Resident #12's cares identified the following: *12/17/13 at 9:35 a.m. - Two certified nursing assistants (CNAs) (#13 and #14) performed morning cares and repositioned the resident. The staff (#13 and #14) failed to offer Resident #12 fluids during cares. *12/17/13 at 11:35 a.m. - Two CNAs (#13 and #14) transferred the resident from bed to his wheelchair. The CNAs (#13 and #14) did not offer fluids at this time. Observation showed Resident #12 received his noon meal/hydration at 12:25 p.m. During an interview on the afternoon of 12/18/13, an administrative nurse (#1) stated the facility does not record residents' fluid intakes. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included muscle weakness, other malaise and	F 327		

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F 327	Continued From page 62 fatigue, and history of UTIs. Medication included the antibiotic ciprofloxacin, started on 12/16/13 for a UTI. The quarterly MDS, dated 09/08/13, indicated moderate cognitive impairment, extensive assistance with bed mobility and locomotion, limited assistance with eating, a current stage 2 pressure ulcer, and on an antibiotic. Resident #2's current care plan stated, "Focus: Alteration in Nutrition: . . . hx [history] of inconsistent intake . . . hx of refuses some meals. . . . Interventions: . . . Encourage adequate fluids . . . Focus: ADL [activity of daily living] . . . Self-care performance deficit r/t [related to] diagnosis of generalized muscle weakness . . . Interventions: EATING: set-up assist for all meals, may require limited-ext [extensive] assist at times when more lethargic. . . . Focus: The resident has potential/actual impairment to skin integrity r/t edema and immobility. . . . Focus: Encourage good nutrition and hydration in order to promote healthier skin. . . . Focus dated 12/17/13: I am receiving antibiotic therapy r/t possible UTI, . . . *elevated temp [temperature], increase in hallucinations . . . Interventions: Enc. [encourage] increased fluid intake . . ." Observation showed the following: * 12/17/13 at 8:04 a.m., two CNAs (#21 and #22) performed morning cares for Resident #2. A CNA (#22) stated the resident usually washes up in the bathroom, but hasn't been feeling well the last few days so stayed in bed to wash up. The CNAs failed to offer the resident fluids before leaving the room. * 12/17/13 at 9:11 a.m., a CNA (#22) brought a cup of milk, as the resident requested, for breakfast, and the resident drank all of it while the	F 327		

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F 327	Continued From page 63 CNA held the cup. The CNA failed to encourage the resident to eat or drink anything else for breakfast. * 12/17/13 at 12:28 p.m., staff raised up the head of the bed for Resident #2 and set up her tray, and over 20 minutes the resident took a few small bites of food and most of her pop. Resident #2 closed her eyes occasionally during the meal. The CNAs offered no assistance to eat/drink more. * 12/17/13 at 2:55 p.m., a CNA (#22) stated at the nurse's request she checked Resident #2's temperature - 100.6 [degrees Fahrenheit]. * 12/18/13 at 11:35 a.m., Resident #2, still in bed said "come get me." When asked if she had breakfast yet, the resident replied "didn't want any, only milk." Noted one empty cup on the bedside stand, a half cup of water, and three-fourths cup of pop. * 12/18/13 at 1:40 p.m., a CNA (#16) stated the resident had water with her medications, and refused lunch. * 12/18/13 at 5:35 p.m., Resident #2, in bed all day sleeping on and off, stated when asked "hasn't had anything to eat today and is hungry," then closed her eyes. Has same amount of pop left in cup as earlier, one empty cup, and less than one-fourth cup of water on her bedside stand. At 5:40 p.m., a CNA (#21) asked the resident if she wanted anything other than the milk she requested, and resident said "no." The CNA stated the resident had about 240 cc [cubic centimeters] total of milk and water today, with no pop today. Observation showed Resident #2's mouth and tongue were dry. When asked the resident if her mouth feels dry, she stated "yes, can I have a wet cloth for my mouth." * 12/19/13 at 9:03 a.m., observed Resident #2 in bed, had not received breakfast yet, and her	F 327		

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F 327	Continued From page 64 tongue was dry. Failure to offer and encourage fluids consistently, with cares and meals, may contribute to dehydration and UTIs, and delay the healing process. - Review of Resident #3's medical record occurred on December 16-19, 2013. The resident's current diagnoses included dementia, dysphagia, and constipation. The resident's quarterly MDS, dated 11/27/13, identified the resident required extensive assistance of one person for eating. Resident #3's current care plan, revised 12/16/13, stated "Focus, Alteration in nutrition. . . . Diagnosis of dysphagia, on altered diet . . . Interventions . . . pureed texture with thin liquids. Encourage adequate fluids. . . ." Observations of resident cares identified the following: *12/16/13, 4:30 p.m. - Two CNAs (#30 and #31) provided check and change of her brief and assisted the resident from her bed to a wheelchair. The CNAs (#30 and #31) failed to offer fluids to the resident. Resident #3 received her evening meal one hour later. *12/17/13, 10:03 a.m. - A CNA (#29) provided toileting assistance for the resident. The resident remained in her wheelchair in her room. The CNA (#29) failed to offer fluids to the resident. During interview, on 12/19/13 at 9:05 a.m., two supervisory nursing staff members (#1) and (#2) stated they expected staff to offer residents fluids during cares.	F 327		

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F 353	Continued From page 65	F 353		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation; record review; professional reference review; and group, resident, family, and staff interview; the facility failed to ensure availability of qualified nursing staff on a daily basis to meet the needs of residents for 6 of 6 resident neighborhoods (Special Care Unit, 100, 200, 300, 400, and 500 wings). Failure to ensure availability of staff may have contributed to concerns regarding dignity (Refer to F241); call lights (Refer to F246); inaccurate weights, medication errors, and late	F 353	F 353 - 1. Facility has sufficient staffing on a per patient day basis. Nursing and CNA categories were re-organized to facilitate better work flow. 2. All residents of the facility have the potential to be affected. 3. Job duties of the nursing staff have been reorganized to be able to meet the needs of the residents of the facilities. Education has been provided to the staff on the reorganization to best meet the needs identified in resident care plans. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that resident's needs are being met. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 353	Continued From page 66 meal tray for a diabetic resident (Refer to F309); personal cares and meal assistance (Refer to 312); range of motion and hand splints (Refer to F318); accidents and supervision (Refer to F323); and food temperatures/food service (Refer to F363 and F364). In addition, the lack of available staff resulted in failure to ensure residents received morning snacks (Resident #16 and Resident #26), breakfast in a timely manner (Resident #11, Resident #15, and Resident C), and timely assistance from the dining room after meals (Resident #9). Findings include: The Centers for Medicare and Medicaid Services has defined "staff" as "licensed nurses (RNs and/or LPNs/LVNs), and nurse aides." - During an interview on the morning of 12/16/13, Resident C stated the facility was short-staffed and she "was always waiting." - During an interview on the afternoon of 12/16/13, Resident #11 stated the facility lacked enough staff. - During an interview on 12/16/13 at 4:45 p.m., Resident #12 stated the facility was short-staffed. - During an interview on 12/16/13 at 5:00 p.m., Resident #13 stated the facility did not have enough staff and some of the current staff did not seem to care. The resident stated he often feels like just a "body in a bed." Resident #13 stated the facility never seemed to resolve his concerns and the communication was poor amongst all staff members and between various disciplines.	F 353	F 353 – Revised 1. Facility has sufficient staffing on a per patient day basis. Nursing and CNA categories were re-organized to facilitate better work flow. 2. All residents of the facility have the potential to be affected. 3. Job duties of the nursing staff have been reorganized to be able to meet the needs of the residents of the facilities. Education has been provided to the staff on the reorganization to best meet the needs identified in resident care plans. The re-alignment of bath aides and the elimination of the Paid Feeding Assistant Program helps by moving those hours to better care for all the needs of the residents. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that resident's needs are being met. Items in the tag are being audited in F241, F246, F309, F312, F318, F323, F363 and F364. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 353	Continued From page 67 - During an interview on 12/18/13 at 9:30 a.m., Resident C stated staff delivered her breakfast late that morning and she received it 20 minutes after requesting her room tray. - Observation on 12/18/13 at 10:20 a.m. identified a dietary staff member (#11) came to the nurse's station and told a nurse (#10) Resident #15 did not eat breakfast. The nurse (#10) went to Resident #15's room and told the resident the time and reminded her she didn't eat breakfast yet. Resident #15 stated she would wait until lunch (11:00 a.m.). Observation at 10:30 a.m. showed Resident #15 dressed in a night gown and sitting in her wheelchair in the corridor, requesting assistance to get dressed. At 10:55 a.m., Resident #15 was dressed and sitting in her wheelchair in the corridor by the nurse's station, stating she was hungry. Staff brought the resident some coffee but nothing to eat. Observation showed the resident received her first meal of the day at 11:40 a.m. in the dining room. During an interview on 12/18/13 at 12:25 p.m., an unidentified dietary staff member identified Resident #15 ate 25 percent of her noon meal and stated "she usually eats more for breakfast and not much for lunch." - On 12/18/13 at 10:33 a.m., Resident #11 stated he first put his call light on and asked for his breakfast meal tray at 8:12 a.m. Resident #11 stated he rang his call light numerous times, staff answered the call light to see what he needed, but then shut the call light off and no one brought his breakfast until 10:05 a.m. (1 hour and 53 minutes later). - On 12/18/13 at 11:00 a.m., a CNA (#13)	F 353		

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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 353	Continued From page 68 confirmed staff failed to pass Resident #16 and Resident #26's morning snacks; "they were missed." The CNA (#13) stated they were the only two residents who received morning snacks on the 400 nursing unit. - Review of Resident #9's medical record occurred on all days of survey. Resident #9's Minimum Data Set (MDS), dated 11/03/13, identified total dependence on staff for locomotion on the unit. Observation on 12/17/13 at 7:40 a.m. showed Resident #9 in the dining room eating breakfast. At 8:30 a.m., Resident #9 remained in the dining room, sitting in her chair by the table. Observation at 8:50 a.m. showed Resident #9 remained in the dining room by the table. At 9:05 a.m., observation showed Resident #9 with her eyes closed as she sat by the table. At 9:15 a.m., a Certified Nursing Assistant (CNA #19) asked the resident "Can I move you out of the dining room?" to which the resident replied, "Yes, I have been sitting here for ages." - An interview with two members of Resident #10's family occurred on the morning of 12/18/13. The family members (#2 and #3) stated they have concerns that the facility needs more staff, "they are absolutely short-staffed." - During interview on 12/18/13 at 4:50 p.m., Resident M, who eats meals in her room, stated she has to "wait a long time for meals," sometimes "longer than half an hour." - During an interview on 12/19/13 at 9:10 a.m., Resident N stated, "I was done with breakfast a	F 353		

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F 353	Continued From page 69 long time ago. I don't want to ring for someone to take my [breakfast] tray out [of the resident's room] as I know they are busy. They work so hard here, and do good. They are overworked."	F 353		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily menus, review of residents' tray cards, resident interview, and staff interview, the facility failed to meet the nutritional needs of residents by not serving items requested on the resident tray cards for 3 of 3 days of observed meal service (December 16-18, 2013) and serving incorrect portion sizes for 2 of 3 observations (lunch and supper on 12/18/13) of tray line service. Failure to follow recommended portion sizes and failure to serve items on the menu and items requested by residents as outlined in the facility's menus may result in dissatisfaction with meal service, inadequate nutritional intake, and potential weight loss. Findings include: - During an interview on the morning of 12/16/13, Resident C stated staff often do not provide her the specific meal items she requested on her meal tickets.	F 363	F 363 – 1. Residents 38, 39, 40, 41, 42, 43 all tray tickets will be corrected with the correct scoop sizes used. 2. All residents of the facility have the potential to be affected. 3. All staff were re-educated to make sure that resident food requests are fulfilled. Resident tray tickets were reviewed and corrected to make sure that the portion sizes are appropriate. New scoops have been purchased to make sure that the right portion sizes are served to the residents. Education to the Dietary staff was done to ensure that the right portions are used when serving the residents as well as making sure the all the items on the meal tickets are available for the residents. 4. Date of Correction: 14th February 2014 5. The Director of Nutrition & Culinary Services or designee will be responsible to monitor that resident's needs are being met. QA monitoring was implemented. The Director of Nutrition & Culinary Services or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition & Culinary Services or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 363	Continued From page 70 - Review of Resident #1's medical record occurred on December 16-18, 2013. The current care plan stated, "Focus: Alteration in Nutrition: . . . Refuses meals when angry, resulting in wt. [weight] loss. . . ." During an interview on 12/16/13 at 7:58 a.m., Resident #1 stated, "[name of staff] gave me skim milk, and I asked for 2% milk." The resident added this staff member always gives him the wrong milk. Review of Resident #1's diet tray card on his breakfast tray included "diabetic diet/prefers 2% milk." At 11:45 a.m. on 12/16/13, Resident #1 informed a CNA (#22) of his lunch choice, and stated, "Make sure I get 2% milk." Failure to provide Resident #1 his preference of 2% milk (which is noted on his tray card) may lead to decreased intake, contribute to weight loss, and does not respect his rights. - Observation of the dinner meal occurred on 12/16/13 at 5:15 p.m. Resident #37's meal ticket showed sweet cherries as a requested item. Observation throughout the meal service showed staff did not serve the resident sweet cherries. Resident #38's meal ticket showed ice cream with strawberries as a requested item. Observation throughout the meal service showed staff did not serve Resident #38 the ice cream with strawberries. During an interview on 12/16/13 at 5:20 p.m., a dietary staff member (#28) stated staff serve the meal first, and then serve the desserts after they have eaten their meal. Observation during the evening meal showed some staff members brought desserts out with	F 363	F 363 – Revised 1. Residents 38, 39, 40, 41, 42, 43 all tray tickets will be corrected with the correct scoop sizes used. Updated Resident 1 with the request for preference in type of milk. 2. All residents of the facility have the potential to be affected. 3. All staff were re-educated to make sure that resident food requests are fulfilled. Resident tray tickets were reviewed and corrected to make sure that the portion sizes are appropriate. New scoops have been purchased to make sure that the right portion sizes are served to the residents. Education to the Dietary staff was done to ensure that the right portions are used when serving the residents as well as making sure the all the items on the meal tickets are available for the residents. 4. Date of Correction: 14th February 2014 5. The Director of Nutrition & Culinary Services or designee will be responsible to monitor that resident's needs are being met. QA monitoring was implemented. The Director of Nutrition & Culinary Services or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition & Culinary Services or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 363	Continued From page 71 the meal, and some brought the desserts after the meal. Staff failed to serve the sweet cherries and the strawberry ice cream to the above residents. - Observation of the lunch meal occurred on 12/17/13 at 11:30 a.m. Resident #38 and Resident #39's tray cards showed steak fries as a requested menu item. Observation showed tater tots on their plates instead of steak fries. Observations of several random meal trays showed peas as a meal item, although the tray card identified cauliflower as the requested vegetable. When asked about the discrepancies with the tray cards, a dietary staff member (#11) talked with kitchen staff; and at 12:00 p.m., observation showed staff prepared steak fries and cauliflower and served those items as requested to the remainder of the residents in the dining room. Observation of a room tray for Resident #40 showed staff did not serve the requested yogurt as identified on the tray card. - Observation of the evening meal on 12/17/13 at 5:30 showed Resident #43 did not receive tomato and rice soup as requested on her tray card. Observation at 5:50 p.m. showed meal trays on a cart in the hall, ready to be delivered to resident rooms. Staff did not serve the requested tropical fruit and cookie for Resident #41 and #42 respectively. Observation from 5:20 p.m. to 5:55 p.m. showed Resident #3 assisted by an unidentified staff member. The resident ate all of her meal items and did not receive her fruit dessert as requested on her tray card. - Observation of lunch tray line service occurred on 12/18/13 at 11:15 a.m. A dietary staff member used a 4 ounce scoop (1/2 cup) for the pureed	F 363		

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F 363	Continued From page 72 Seafood Newberg, and the menu identified a #6 (2/3 cup) scoop as the serving size for this item. A dietary staff member used a 3 ounce serving spoon for the green beans, and the menu identified 4 ounces as the portion for the regular diets and 2 ounces for the small portion diets. Observation showed staff used one serving utensil/scoop in each food item and filled the utensil/scoop approximately half full for small portion diets. - Observation of supper tray line service occurred on 12/18/13 at 5:40 p.m. Observation showed staff used half of a 3 ounce scoop as the serving size for the mixed vegetables for a small portion diet, and the menu identified 2 ounces as the serving size for this item. Observation showed staff used one serving utensil/scoop in each food item and filled the utensil/scoop approximately half full for small portion diets. When asked about small portion diets, the dietary staff member (#32) serving the food stated he/she uses "about half" the utensil. During interview the morning of 12/19/13, the consultant dietitian (#3) and a dietary staff member (#11) confirmed staff should serve the food items residents request on the tray cards, if it is allowed on their diet. The consultant dietitian (#3) confirmed staff should follow the portions outlined on the menus.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364		

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F 364	Continued From page 73 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, sampled test tray, resident interview, review of resident group minutes, and staff interview, the facility failed to serve food at palatable temperatures for 4 confidential residents on initial tour (Resident A, B, C and G), 7 confidential residents during the group interview (Resident B, E, G, H, I, J, and K), and 1 confidential resident (Resident M). Failure to provide food at palatable temperatures has the potential to result in refusal of food, weight loss and can affect the overall well-being of all residents. Findings include: The initial tour of the facility occurred on 12/16/13 at 10:15 a.m. Residents made the following statements regarding food temperatures: *Resident A stated she eats her meals in her room and the "food is cold, the potatoes are cold" The resident stated she has "told them" about the cold food, but it has not improved. *Resident B stated there is a "problem with cold food" and that she has had to send the food back. The resident stated she has "brought it up at the meetings." *Resident C stated food received both in the dining room and in her room often tasted "cold" and unpalatable. *Resident G stated food received both in the dining room and in his room often tasted "cold" and unpalatable. - Review of the Resident Council Meeting Minutes	F 364	F 364 – 1. N/A 2. All residents of the facility have the potential to be affected. 3. Facility has focused on streamlining processes to address the issue of having cold food. Facility has installed a plate warmer to make sure that the plates are warm when food is being served. Facility also are now using insulated covers for residents that eat meals in there room. Dietary staff have been trained on monitoring food temperatures. Dietary staff are auditing food temperatures to ensure the palatable temperatures of food. Dining Room was rearranged to enhance the environment to better meet the needs of the residents. On 1/29/14 no issues about cold food was brought up at the monthly resident council meeting. 4. Date of Correction: 14th February 2014 5. The Director of Nutrition & Culinary services or designee will be responsible to monitor that resident's needs are being met. QA monitoring was implemented. The Director of Nutrition & Culinary Services or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition & Culinary Services or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 364	Continued From page 74 from July-October 2013 occurred on December 16-17, 2013. These minutes stated: *09/30/13 - ". . . NEW BUSINESS . . . There were some concerns for Dietary . . . [name] Director of Nutrition and Culinary was out of her office. There is a [sic] Action Team plan in place and will be reviewed at the next Resident Council meeting in October . . . ." *10/28/13 - ". . . OLD BUSINESS . . . [name] Director of Nutrition and Culinary was not available at this time to go over the Action team plan from dietary . . . ." On 12/16/13 at 4 p.m., a staff member (#15) provided a copy of the Action Team Plan, dated 10/02/13 for review. This plan, stated, "1. Concern 1. Food has been coming cold (not as warm as they like it). . . . 2. Goal: It was discussed with staff no more than five plates in the window. Second service will go out and pass trays if not moving. . . . Staff will be monitored more closely if resident is not happy, needs to return food item. 3. Findings A meeting has been held. Staff are being trained to watch more closely for food going out. A check has been done and resident [sic] were asked how their service was and if the meal was to there [sic] expectations. No complaints. Food tasting good and food is hot. In some situations, please ask your server not to put the ticket in until apitizer [sic] is finished. " A group interview conducted with six residents (Resident B, E, G, H, I, J, and K) (identified by the facility as interviewable) occurred on 12/16/13 at 2:00 p.m. The interview identified resident concerns with the temperature the facility served the food. These residents stated they informed the facility of the their concerns previously during	F 364		

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F 364	Continued From page 75 the monthly Resident Council Meetings and the problem continues to persist. During an interview on 12/16/13 at 4 p.m., a staff member (#15) stated the Resident Council Meeting minutes from 11/25/13 have not been typed at this time. This staff member stated the dietary Action Plan, dated 10/02/13, was reviewed with residents during the November meeting. Observation on 12/17/13 at 5:50 a.m. showed a cart in the hall outside the dining room containing two resident meal trays. The plates where covered with a clear, hard plastic cover with a hole in the top of the cover. Ten minutes later, at 6:00 p.m., a staff member wheeled the cart down the hall to deliver the trays to the rooms. Observation on 12/18/13 at 12:00 noon showed three room trays on the counter for 10 minutes prior to staff taking them to resident rooms. Observation of another room tray showed the clear plastic cover did not completely fit over the top of the plate, potentially allowing the food to cool more quickly. On 12/18/13 at 12:15 p.m., the surveyors obtained a test tray at the end of meal service. Kitchen staff covered the plate with a clear, hard plastic cover that had a hole in the top of the cover. The meal included Seafood Newburg, mashed potatoes, pureed squash, beef noodle soup, and green beans. The surveyors confirmed the Seafood Newburg, mashed potatoes and pureed squash tasted lukewarm and the green beans cool. During interview on 12/18/13 at 4:50 p.m., Resident M stated she prefers to eat meals in her	F 364		

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F 364	Continued From page 76 room. Resident M stated the food is "lukewarm" when staff bring the tray to her room. During interview, the morning of 12/19/13, the consultant dietitian (#3) and a dietary staff member (#11) stated the facility had recently purchased the clear plate covers with the holes on top and stopped using the insulated covers they had previously. The staff members confirmed food temperatures have been a problem and stated the new cover may lose more heat due to the hole on the top.	F 364		
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: Based on observation and staff interview, the facility failed to ensure sanitation of dishware in 1 of 1 mechanical dishwashing room and failed to ensure a sanitary environment for storage of dishware in 1 of 1 kitchen. Failure to follow proper sanitation practices has the potential to result in a foodborne illness. Findings include:	F 371	F 371 – 1. N/A 2. All residents of the facility have the potential to be affected. 3. Education to Dietary Staff on the proper testing of the dish machine was completed. A new tracking form was implemented to ensure that the dish machine is operating under the required specifications. Fans placed in the Kitchen areas have been cleaned. The fans are monitored and cleaned on a weekly basis by maintenance staff 4. Date of Correction: 14th February 2014 5. The Director of Nutrition & Culinary Services or designee will be responsible to monitor the dish machine levels as well as the cleanliness of the fans in the kitchen areas. QA monitoring was implemented. The Director of Nutrition & Culinary Services or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition and Culinary Services or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 371	Continued From page 77 Observation of the mechanical dishwashing room occurred on 12/19/13 at 9:30 a.m. with a consultant dietitian (#3) and a dietary staff member (#11). The dietary staff member identified the dishmachine used Chlorine cycle for sanitization of dishes. When asked to check the chemical concentration level, a dietary staff member operating the dishmachine (#17) stated she does not check the levels, as another member of the staff usually checks the chemical concentration once a day at the noon meal. The dietary staff member (#11) retrieved a bottle of Chlorine test strips to test the concentration. The staff member (#11) stated the concentration of the Chlorine should be 50 parts per million (ppm), as listed on the Dishmachine Concentration log. The result showed a very small area on the test strip matched the color indicator on the bottle between 25-50 ppm, but the majority color on the strip did not match any other of the colors on the indicator. After checking 2-3 more times, the results remained inconclusive. The dietary staff members (#3 and #11) asked the administrative maintenance staff member (#12) to check the machine, and he made adjustments on the machine to change the concentration. The results on the facility's test strips remained inconclusive, however when the surveyor used his/her own supply of Chlorine test strips, the concentration was 200 ppm. The staff members (#3 and #12) confirmed the test results from the facility test strips were inconclusive and stated they would check with the dishmachine company regarding the chemical dispenser and the accuracy of the test strips. The facility used paper plates and utensils for the noon meal while staff performed maintenance/testing of the dishmachine. Failure to ensure accurate chemical levels has the potential to result in either too little or too much	F 371		

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F 371	Continued From page 78 chemical concentration. Observation of the kitchen on 12/18/13 at 9:30 a.m., showed two fans with a build-up of dust/debris on the fan blade and cage. One fan located in the mechanical dishmachine room above the clean dishes, and the other fan in the room by the three compartment sink. The dietary staff members (#3 and #11) confirmed staff should clean the fans. During an interview at 10:00 a.m., an administrative maintenance staff member (#12) stated he cleans the kitchen fans quarterly.	F 371		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung	F 373	F 373 – 1. For resident 27 CNA staff will assist resident as care planned. 2. All residents that are at risk for aspiration have the potential to be affected. 3. Facility has eliminated the Paid Feeding Assistant program so not to compromise the care of the residents. 4. Date of Correction: 10th January 2014 5. N/A as the program has been eliminated.	

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

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F 373	Continued From page 79 aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to ensure 1 of 5 supplemental residents	F 373		

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F 373	Continued From page 80 (Resident #27) observed coughing while being fed by a paid feeding assistant (PFA) (staff member #18) was appropriate to be fed by a PFA. Failure to ensure a PFA feeds only residents with no complicated feeding problems has the potential to place residents at risk for choking and aspiration. Findings include: Review of the facility policy titled "Feeding Assistants- Paid" occurred on 12/18/13. This policy, with a revision date of May 2013, stated, ". . . PROCEDURE: . . . 3. Residents who are assessed to be safe for a feeding assistant to feed will have documentation on the resident's plan of care . . . ." During the entrance conference on the morning of 12/16/13, an administrative nurse (#2) confirmed the facility utilizes PFAs in the dining room to feed residents. On the afternoon of 12/16/13, an administrative nurse (#2) provided a list of eleven resident names with a hand-written note stating ". . . CNA [certified nurse aide] must feed." This list included Resident #27's name. Observation on 12/17/13 at 5 p.m. identified three PFAs in the dining room feeding residents. At 5:25 p.m. observation showed a PFA (#18) delivered Resident #27 her plate of food, provided meal set-up assistance, and verbally encouraged the resident to begin to eat. This PFA (#18) proceeded to feed Resident #27's table mate and continued to provide verbal encouragement on/off to Resident #27 for approximately five minutes. When Resident #27	F 373		

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F 373	Continued From page 81 failed to start to eat on her own, the PFA (#18) picked up a glass of water, lifted the glass to the resident's lips, and Resident #27 took a swallow. Observation showed Resident #27 coughed after drinking this liquid. Observation from 5:25 p.m.-5:45 p.m. showed the PFA (#18) fed Resident #27 her supper meal. Review of Resident #27's current care plan, with a revised date of 03/11/13, identified "Self care deficit" with "Interventions" of " . . . EATING . . . I require assist of one with eating. I often refuse to eat. I can not be fed by a feeding assistant . . . ." Resident #27's "Feeding Assessment" dated 12/07/13, identified a PFA could feed this resident. Review of Resident #27's quarterly Minimum Data Set (Section K Swallowing/Nutritional Status), dated 12/08/13, failed to document any signs and symptoms of a possible swallowing disorder. Review of the list of names provided by the facility identified Resident #27 should be fed by a CNA. Observation on 12/17/13 showed a PFA fed Resident #27. Resident #27's current care plan identified only CNAs should feed this resident. Resident #27's current Feeding Assessment identified a PFA could assist the resident. Facility staff failed to clearly identify which staff member(s) (whether a PFA or CNA) should feed Resident #27.	F 373		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425		

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F 425	Continued From page 82 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable well-being for 3 of 3 sampled residents (Resident #3, #13, and #18) who did not receive all scheduled medications. Failure to ensure the availability of all residents' medications may result in residents experiencing increased pain, anxiety, and/or behaviors. Findings include: - Review of Resident #13's medical record occurred on all days of survey and diagnoses included quadriplegia, muscle spasms, contractures, chronic pain, and adjustment	F 425	F 425 – 1. For resident 3 & 18 staff were educated on making sure that medications are available. 2. All residents that received medications have the potential to be affected. 3. All nursing staff re-educated to ensure that the medications that are ordered by the physician are available to administer in a timely basis. Contact has been made with the pharmacist to ensure that medications are available. Follow-up calls will be made to pharmacy as needed to ensure delivery. Emergency care pharmacy phone numbers are available for 24 hour service. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that resident medications are available. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 425	Continued From page 83 disorder with anxiety and depression. Resident #13's care plan identified the following: "Focus: I have chronic pain *I request prn [as needed] pain meds frequently . . . Goals: I will voice a level of comfort . . . Interventions: . . . Administer analgesia as per orders . . . Evaluate the effectiveness of pain interventions PRN . . . Focus: I have mood issues r/t [related to] my Adjustment Disorder w/[with] noted anxiety and inability to cope at times . . . Interventions: . . . Administer medications as ordered. . . ." The resident's current medications included oxycodone hydrochloride (HCl) (used for moderate to severe pain) 15 milligrams (mg) every four hours (midnight, 4:00 a.m., 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m.) and Ativan (used for anxiety) 1 mg fives times per day (midnight, 4:00 a.m., 8:00 a.m., noon, 4:00 p.m.), both given per gastrostomy tube (g-tube). Review of Resident #13's Medication Administration Record (MAR) identified Resident #13 did not receive oxycodone HCl 15 mg on 12/16/13 at 4:00 a.m. and 8:00 a.m.; and, Ativan 1 mg on 12/16/13 at noon and 4:00 p.m. Review of Resident #13's nursing Progress Notes identified the following: *12/16/13 at 4:20 a.m. - ". . . OxyCODONE HCl - give per g-tube: med unavailable, gave prn ibuprofen (used for mild to moderate pain) instead." *12/16/13 at 7:48 a.m. - ". . . OxyCODONE HCl - give per g-tube: med unavailable." *12/16/13 at 12:06 p.m. - ". . . Ativan - five times daily : . . med unavailable." *12/16/13 at 3:58 p.m. - ". . . Ativan - five times daily . . . med unavailable."	F 425		

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F 425	Continued From page 84 During an interview on the afternoon of 12/18/13, an administrative nurse (#1) stated a staff member faxed the pharmacy on 12/13/13 to reorder Resident #13's oxycodone HCl and Ativan, however, the pharmacy did not deliver the medications that day. The nurse (#1) stated the facility received the resident's medications after a staff member contacted the pharmacy again on 12/16/13. - Review of Resident #18's medical record occurred on December 18-19, 2013. Medical diagnoses included osteoarthrosis, myalgia, and myositis. Resident #18's care plan identified the following: "Focus: I have chronic pain r/t [related to] myalgia and myositis. . . Goals: I will not have an interruption in normal activities due to pain. Interventions: . . . Medications as ordered . . ." Resident #18's current medications included Duragesic transdermal patch (narcotic pain medication) 12 micrograms/hour every 72 hours. Review of Resident #18's nursing Progress Notes identified the following: *11/11/13 - "Duragesic-12 . . . med unavailable." *11/27/13 - "check duragesic patch every shift no patch to be found so new 1 put on." Review of Resident #18's MAR identified Resident #18 did not receive a new Duragesic patch until 11/13/13. During an interview on the afternoon of 12/19/13, an administrative nursing staff member (#1) confirmed staff had not completed an investigation or follow-up regarding unavailability of the Duragesic patch on November 11-12,	F 425		

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F 425	Continued From page 85 2013, or the missing Duragesic patch on November 27, 2013. - Nursing 2011 Drug Handbook, pages 1097-1099, states "Prednisone . . . NURSING CONSIDERATIONS . . . For better results . . . give a once-daily dose in the morning. . . ." Review of Resident #3's medical record occurred on December 16-19, 2013. The facility admitted the resident in September 2011. Current diagnoses included psychosis and behaviors. Resident #3's current medications included Lexapro 20 mg every day at 4:00 p.m., Seroquel 25 mg every day at 10:00 a.m., Seroquel 50 mg every day at 8:00 p.m., and Prednisone 7.5 mg every day at 10:00 a.m. Resident #3's current care plan, revised on 09/13/13, stated "Focus, I have mood/behavior issues r/t [related to] my dx [diagnosis] of Alzheimer's disease w/ [with] memory and communication issues noted by anxiety and agitation . . . I will yell out/scream causing disruption to others. I have depression. . . . Interventions . . . Medications as ordered. . . . Focus, I have acute pain r/t dx Osteopenia, Arthritis & [and] Gout . . . Interventions . . . Administer medications as ordered. . . ." Resident #3's Nurse's Notes identified the following: *12/05/13, 4:32 p.m. - "Lexapro - Take one tablet daily: u/a [unavailable]." Lexapro is an anti-depressant. *12/05/13, 7:15 p.m. - "Seroquel - 50 mg every HS: unavailable." Seroquel is an anti-psychotic. *12/06/13, 7:52 a.m. - "Prednisone - Take 1 tab	F 425		

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F 425	Continued From page 86 [tablet] daily: Not available." Prednisone is a steroid anti-inflammatory. *12/06/13, 7:53 a.m. - "Seroquel - 25 mg daily: Not available" Resident #3's MAR for December 05-06, 2013 identified the resident did not receive the following medications: *Lexapro 20 mg, on 12/05/13 at 4:00 p.m. *Seroquel 50 mg, on 12/05/13 at 8:00 p.m. at bedtime *Seroquel 25 mg, on 12/06/13 at 10:00 a.m. *Prednisone 7.5 mg, on 12/06/13 at 10:00 a.m. The facility's Pharmacy Communication Forms, dated 12/05/13, stated "[Resident #3], Lexapro 20 mg, pm [afternoon] (Did not get during med [medication] exchange.)" and "We didn't get [Resident #3]'s HS Seroquel 50 mg." These forms were untimed and were identified as "Faxed." It is unknown when or to whom the forms were faxed. During interview, on 12/19/13 at 10:50 a.m., a supervisory nursing staff member (#1) confirmed the facility failed to provide prescribed medications to Resident #3 on 12/05/13 and 12/06/13. This staff member (#1) reported the facility failed to complete an investigation or contact the resident's physician regarding these medications. This staff member (#1) reported her expectation that the facility staff would have contacted the on-call pharmacy for medications until they were available from the resident's regular pharmacy. Failure to ensure Resident #3 received medications as prescribed placed her at risk of experiencing increased pain, depression, and	F 425		

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F 425	Continued From page 87 demonstrating increased behaviors.	F 425		
F 431 SS=E	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 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.	F 431	F 431 – 1. N/A 2. All residents that use insulin pens have the potential to be affected. 3. All nursing staff re-educated on importance that insulin pens are dated appropriately upon opening. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that all insulin pens are dated appropriately. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 431	Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's product instruction's, the facility failed to date in-use insulin pens (a small pen shaped device prefilled with insulin) in 4 of 6 medication carts/storage rooms (located in the Special Care Unit and the 200, 300, and 400 wings) affecting six supplemental residents (Resident #25, #28, #29, #30, #31, and #32). Failure to identify an open date on insulin pens may result in-use exceeding the manufacturer's recommendations and affect the potency and efficacy of the medication. Findings include: Manufacturer's instructions stated, - Levemir, dated 2009, ". . . PenFill cartridges, FlexPen or InnoLet After initial use, a cartridge or a prefilled syringe . . . may be used for up to 42 days if it is kept at room temperature . . . ." - Lantus, dated April 2010, " . . . The opened (in-use) cartridge system must be discarded in 28 days after being opened . . . ." - NovoLog, dated 2011, " . . . How should I store NovoLog? . . . PenFill Cartridges or NovoLog FlexPen. Keep at room temperature . . . for up to 28 days . . . ." A tour of the 200 wing medication cart occurred on 12/17/13 at 2:45 p.m. with a staff nurse (#23) and identified two in-use and undated insulin pens (one NovoLog and one Lantus) belonging to Resident #29, two in-use and undated insulin pens (one NovoLog and one Lantus) belonging to Resident #30, and one in-use and undated insulin pen (NovoLog) belonging to Resident #31. This staff nurse confirmed the above opened insulin	F 431	F 431 – Revised 1. Current pens for residents 25, 28, 29, 30, 31 & 32 were discarded and new pens were obtained and dated. 2. All residents that use insulin pens have the potential to be affected. 3. All nursing staff re-educated that insulin pens are dated appropriately upon opening. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor that all insulin pens are dated appropriately. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 431	Continued From page 89 pens lacked a date of when the pen was first opened/used. A tour of the 300 wing medication cart and medication room occurred on 12/17/13 at 3:15 p.m. with a certified medication assistant (#19) and identified one in-use and undated Lantus insulin pen belonging to Resident #32. A tour of the 400 wing medication room occurred on 12/17/13 at 4:15 p.m. with an agency nurse (#24) and identified one in-use and undated NovoLog insulin pen belonging to Resident #25. A tour of the Special Care Unit medication room occurred on 12/17/13 at 4:45 p.m. with an unidentified licensed nurse and identified one in-use Levemir insulin pen belonging to Resident #28.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 90 (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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 1/10/13. Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standard infection control practices for 3 of 4 sampled residents (Resident #11, #12, and #13) observed during perineal cares with an indwelling catheter, and for 2 of 3 sampled residents (Resident #10 and Resident #13) observed during a dressing change. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include:	F 441	F 441 – 1. Resident 11 & 12 reassessed for peri care and catheter care appropriately done. Resident 13 discharged from the facility. Resident 10 nurse staff have been educated on the proper hand hygiene when changing dressings. 2. All residents that have indwelling catheter or require dressing changes have the potential to be affected. 3. All nursing and cna staff re-educated on the proper infection control process. This education included the following: caring for indwelling catheters, hand hygiene in dealing with dressing changes, proper procedure in taking care of soiled linen & hand hygiene in providing peri-cares. 4. Date of Correction: 14th February 2014 5. The Director of Nursing or designee will be responsible to monitor the care for indwelling catheters, hand hygiene in dealing with dressing changes, proper procedure in taking care of soiled linen & hand hygiene in providing peri-cares. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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	355078	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 91 Review of the facility policy, "Standards of Care" occurred on 12/19/13. This policy, dated July 2013, stated, "Purpose: These standards will help guide the staff at Eventide in providing quality, safe care to our residents. Policy: The following standards of care will be followed in providing care to the residents of Eventide. . . . INFECTION CONTROL: 1. Soiled linen must be placed in appropriate barrels. Do not place soiled linen on the floor in either the resident rooms or the bathing areas 2. All staff must use hand hygiene per hand washing policy . . ." Review of the facility policy titled "Catheters - Indwelling" occurred on 12/19/13. This policy, revised May 2013, stated, ". . . Procedure: The following steps are to be taken to help prevent urinary tract infections and to keep the catheter draining freely: . . . 1. Always wash your hands before and after touching the catheter, tubing, or bag . . . 2. Keep the drainage tubing/catheter junction closed except when changing to leg bag/urinary drainage bag. Use proper aseptic technique when you must disconnect tubing. Use an alcohol wipe to cleanse the junction. . . ." Review of the facility policy titled "Dressing Changes/Bandages" occurred on 12/19/13. This policy, revised May 2013, stated, "Policy: All dressing changes will be completed in a clean and/or sterile technique as appropriate for wound care. Purpose: To avoid cross-contamination of wounds. . . ." Review of the facility policy titled "Perineal Care" occurred on 12/19/13. This policy, revised May 2013, stated, "Policy: It is the policy of Eventide to	F 441		

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F 441	Continued From page 92 complete perineal care with bath/shower, after each toileting/brief change, and prn [as needed] . . . Procedure . . . Staff must wash hands with soap and water after removing gloves following pericares (alcohol based hand cleanser not appropriate to use). . . ." Review of the facility policy titled "Hand Hygiene" occurred on 12/19/13. This policy, revised 11/20/13, stated, "Policy: It is the policy of Eventide that the proper hand hygiene procedure will be followed. Hand hygiene will be done: a. Before and after resident contact (before you leave the room) b. before every clean procedure c. after every dirty procedure d. as needed. Purpose: Hand Hygiene is a general term that applies to either hand washing or antiseptic hand rub. The purpose is to prevent the spread of infection. Procedure: A. Alcohol based product . . . 4. Exception to this is when: a. Doing any personal resident cares. . . ." Review of the facility policy titled "Linens soiled with Blood/Body Fluids" occurred on 12/19/13. This policy, revised December 2013, stated, ". . . Procedure: 1. Wearing gloves, carefully roll linen enclosing soiled areas into center of linen. Use care to avoid agitation of linen, place in plastic bag to carry to Soiled Utility Room for rinsing. . . ." - Review of Resident #13's medical record occurred on all days of survey and diagnoses included quadriplegia and urinary retention. The record identified a tracheostomy and gastrostomy tube, an indwelling urinary catheter, history of Methicillin resistant staphylococcus aureus (MRSA) bacteria (October 2013- drainage around gastrostomy tube and 12/17/13- buttock pressure ulcer), urinary tract infections (UTIs) (current UTI	F 441		

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F 441	Continued From page 93 at time of survey - MRSA positive), and Proud Flesh (current at time of survey) (an excess of granulation tissue - red, often shiny, soft appearance above the level of the surrounding skin) around the resident's gastrostomy tube. Observation on 12/17/13 at 2:30 p.m. identified a certified nursing assistant (CNA) (#9) washed her hands, donned gloves, placed a new gauze dressing around Resident #13's gastrostomy tube, and then placed a new gauze dressing around the resident's tracheostomy tube. The CNA (#9) failed to perform hand hygiene and change gloves between dressing changes. Observation showed the skin surrounding the gastrostomy tube reddened and "shiny/wet." During an interview on 12/19/13 at 11:00 a.m., an administrative nurse (#2) agreed staff should have washed their hands and changed their gloves prior to applying a new dressing around Resident #13's tracheostomy. Observation on 12/17/13 at 7:35 a.m. showed two CNAs (#13 and #14) assisted Resident #13 with morning cares. After completing perineal cares, one CNA (#13) changed her gloves, applied barrier cream to the resident's buttocks, changed her gloves, and assisted the other CNA (#14) to turn and reposition the resident. At this time, one CNA (#14) left Resident #13's room to get a new draw sheet (soiled from buttock wound drainage). The CNA (#14) failed to perform hand hygiene prior to exiting the resident's room. Upon returning, the CNAs (#13 and #14) continued to boost the resident, positioned pillows, applied bilateral leg braces, and placed the call light within reach. The CNA (#13) failed to perform hand hygiene immediately after perineal cares	F 441		

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F 441	Continued From page 94 and prior to completing other tasks. The CNAs (#13 and #14) placed the soiled linen on Resident #13's recliner during cares and upon completion, one CNA (#13) carried the soiled linen to the soiled utility room without placing it in a plastic bag. On 12/17/13 at 2:30 p.m., three CNAs (#5, #9, and #13) assisted Resident #13 from his wheelchair to his bed. The staff members placed the wet linen from the bath on the resident's recliner. Observation showed stool on one of the wet blankets. After transferring Resident #13, one of the CNAs (#9) carried the soiled linen from the resident's room to the soiled utility room without placing the linen in a plastic bag. Observations on 12/17/13 at 8:05 a.m. and 1:35 p.m. showed a CNA (#13) emptied Resident #13's catheter bag. On both occasions, the CNA (#13) failed to cleanse the urine drainage port with an alcohol pad after draining the urine from the bag. - Review of Resident #12's medical record occurred on all days of survey and diagnoses included Multiple Sclerosis, neurogenic bladder, and history of UTIs. The medical record identified a suprapubic catheter (a catheter placed directly into the bladder through the abdomen). During observation on 12/17/13 at 9:35 a.m., two CNAs (#13 and #14) assisted Resident #12 with morning cares. After the CNA (#14) performed perineal cares, she removed her gloves, finished dressing the resident, repositioned the resident, placed pillows to elevate his extremities, placed bilateral heel protectors, placed his call light within reach, washed the resident's face, and	F 441		

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F 441	Continued From page 95 then washed her hands. The CNA (#14) failed to perform hand hygiene immediately after completing perineal cares. Observation on 12/17/13 at 9:45 a.m. showed a CNA (#14) emptied Resident #12's catheter bag. The CNA (#14) failed to cleanse the urine drainage port with an alcohol pad after draining the urine from the bag. - Review of Resident #11's medical record occurred on all days of survey and diagnoses included neurogenic bladder, chronic UTIs, and history of MRSA in the urine. The medical record identified a suprapubic catheter. Observation on 12/16/13 at 4:20 p.m. showed a CNA (#26) emptied Resident #11's catheter bag. The CNA (#26) failed to cleanse the urine drainage port with an alcohol pad after draining the urine from the bag. Observation on 12/17/13 at 8:50 a.m. showed a CNA (#13) assisted Resident #11 with morning cares. The CNA (#13) emptied the resident's catheter bag but failed to cleanse the urine drainage port with an alcohol pad after draining the urine from the bag. After emptying Resident #11's catheter, the CNA (#13) washed her hands, cleansed the resident's perineal area, changed her gloves, applied barrier cream to his abdominal folds, changed her gloves, applied zinc oxide to his scrotum, and removed her gloves. Without performing hand hygiene, the CNA (#13) proceeded to wash and dry the resident's upper body and applied deodorant. During this time, the resident had a bowel movement so the CNA (#13) donned gloves, cleansed the resident's buttocks, changed her	F 441		

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F 441	Continued From page 96 gloves, applied barrier cream to his buttocks, removed her gloves, and washed her hands. The CNA (#13) failed to perform hand hygiene after completing perineal cares and prior to washing other areas of the resident's body. During this observation, the CNA (#13) placed the soiled linen on Resident #11's bedside table, and once finished with cares, she carried the soiled linen against her body to the soiled utility room. The CNA failed to place the soiled linen in a plastic bag and failed to disinfect the resident's bedside table, which the resident used for meals, after contaminating the area with the soiled linen. During an interview on 12/19/13 at 11:00 a.m., an administrative nurse (#2) stated she expected staff to cleanse the urine drainage port of an indwelling catheter after emptying the bag, perform hand hygiene after completing perineal cares and after removing their gloves, and place soiled linen in a bag to avoid contact with staffs' clothes and residents' bedding/furniture. - Observation on 12/17/13 at 7:50 a.m. showed a nursing staff member (#4) changed the dressing on Resident #10's pressure ulcer. Observation showed the nurse applied gloves and removed the gauze and dressing from the left heel. The dressing contained a moderate amount of reddish-brown drainage, which had a strong, foul odor. After the nurse removed the wet, soiled dressing, she removed her gloves and immediately donned a new pair of gloves, without performing hand hygiene. The nurse then gathered clean supplies and proceeded with the dressing change.	F 441		