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 _____	C 02/24/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the unannounced complaint survey conducted February 23-24, 2015, the sample included four sampled residents for complete review.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards/facility policy for 1 of 2 sampled residents (Resident #1) who experienced falls. Failure to complete neurological assessments following a fall has the potential for a head injury to go undetected. Findings include: Review of the facility policy titled "Falls - Resident" occurred on 02/24/15. This policy, revised January 2015, stated ". . . Residents who have hit their head or had an unwitnessed fall will have neuro checks, including vital signs, done as follows: upon initial assessment, 2 hours post fall, then every 8 hours x 3. . . ." Review of Resident #1's medical record occurred on all days of survey. The progress notes identified the following: * 01/07/15 at 4:29 a.m., ". . . Resident ambulating	F 281	**F 281 Professional Standards (Neuro-Checks):** 1. Resident #1 was assessed for neuro checks and vital signs completed with no neurological concerns identified. 2. All residents who fall have the potential to be affected. 3. Education completed on 3/25/15 with licensed nursing staff to ensure facility policy on falls is followed for the completion of neuro checks and vital signs post resident fall. Education will be completed prior to March 27th, 2015. 4. The DON or designee will be responsible to monitor compliance with Fall Protocol according to policy. QA Monitoring will be implemented on 3/25/15. The DON or designee will monitor falls weekly for a month, monthly for three months and then random audits as needed per QA recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 10th April 2015	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tony W. Pontius	Executive Director	3/20/15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 281	Continued From page 1	F 281		

self to bathroom, slid out of wheelchair onto floor. . . . unwitnessed. . . . Neuro's checked. . . ."
* 01/08/15 at 5:43 a.m., ". . . Resident asleep at rounds. 4:45 a.m. staff to room . . . Found sitting on the floor states she fell. [initiated neuro checks] . . . "

Review of the neuro check flow sheet identified neuro checks completed on 01/07/15 at 6:09 a.m. and 2:13 p.m., on 01/08/15 at 12:49 a.m., 6:45 a.m., 6:56 a.m., and 2:21 p.m., and on 01/09/15 at 12:02 a.m., and 5:49 a.m. On 01/07/15, staff assessed Resident #1's vital signs immediately after the fall, and approximately 2 hours, 10 hours, and 20.5 hours post fall. On 01/08/15, staff assessed Resident #1's vital signs immediately after the fall, and approximately 2.25 hours, 2.50 hours, 10 hours, 19.5 hours, and 25.5 hours post fall.

A progress note, dated 01/21/15 at 9:22 p.m., identified, ". . . Sitting on edge of bed and slid off to the floor. . . . neuro checks started. . . . "

Review of the neuro check flow sheet identified neuro checks completed on 01/21/15 at 7:30 p.m. and 8:57 p.m., and on 01/22/15 at 5:52 a.m. and 1:25 p.m. On 01/21/15 the neuro check flow sheet reflected staff began assessing Resident #1's vitals approximately 2 hours and .5 hours prior to the time staff documented her fall, and 8.5 hours and 16 hours post fall.

The progress notes, dated 02/06/15 at 2:21 a.m., identified, ". . . Bruise to left side of the face noted from the fall from the bed this morning at 12:30 a.m." and at 4:20 a.m., ". . . witness stated that pt [patient] was sleeping when she rolled out of bed. . . . Did resident hit head? . . . yes. . . . [initiated

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F 281	Continued From page 2 neuro checks] . . . injury, if any . . . Bruise to left forehead/left face noted. . . . Ice application to the affected side. . . ." Review of the neuro check flow sheet identified neuro checks completed on 02/06/15 at 5:54 a.m. and 11:00 a.m. On 02/06/15, staff assessed Resident #1's vital signs approximately 5.5 hours and 11.5 hours post fall. Facility staff failed to assess Resident #1's vital signs following an unwitnessed fall and/or fall with bruising to her left forehead/face as per facility policy. On 02/24/15 at 12:30 p.m., an administrative staff member (#1) and managerial nurse (#2) confirmed the staff are expected to perform neuro checks as per facility policy.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to consistently implement pressure-relieving interventions for 1	F 314		

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F 314	Continued From page 3 of 4 sampled resident (Resident #2) dependent on staff. Failure to apply the resident's heel protectors as ordered may result in the development of avoidable, facility-acquired pressure ulcers. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included severe cognitive deficits, infantile cerebral palsy, quadriplegia, and potential for skin breakdown due to immobility. The quarterly Minimum Data Set (MDS), dated 02/13/15, identified severely impaired cognitive skills and total assistance required for Activities of Daily Living (ADLs). The current care plan stated, ". . . Focus . . . potential for skin breakdown due to immobility . . . Interventions . . . I am totally dependent on 2 staff for repositioning and turning in bed. Turned and Repositioned per schedule. Blue heelers [heel protectors] on in bed. . . ." Observations showed the following: * On 02/23/15 at 3:22 p.m., 4:05 p.m., and 5:06 p.m., Resident #2 laid in bed with no heel protectors on his feet. * On 02/24/15 at 8:20 a.m., two certified nursing assistants (CNAs) (#6 and #7) removed Resident #2's bedding, positioning devices, and heel protectors in order to provide personal cares. While preparing the area, one of the CNAs (#6) stated, "These [heel protectors] are on the wrong feet." Facility staff failed to apply heel protectors as care planned.	F 314	**F 314 Treatment/Services to Prevent/Heel Pressure Sores (Heel-boots/Plan of Care):** 1. Resident # 2's heels were assessed and no skin breakdown was noted. 2. All residents who are identified as high risk for pressure areas have the potential to be affected. 3. Education will be completed on the proper application of heel protectors as care planned on 3/18/15 & 3/25/15. Education will be completed prior to March 27th, 2015 regarding following the Individualized careplans for each resident. 4. The DON or designee will be responsible to monitor compliance with application of heel protectors. QA Monitoring was implemented on 3/18/15. The DON or designee will monitor weekly for a month, monthly for three months and then random audits as needed per QA recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 10th April 2015	

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F 314	Continued From page 4 On 02/24/15 at 12:30 p.m., an administrative staff member (#1) and managerial nurse (#2) confirmed staff should apply heel protectors as per the resident's care plan.	F 314	**F 323 Accident Hazards/Supervision/Devices (Side-rails/Transferring):** 1. Resident #2 was assessed for the need of padded side rails. It was determined that resident #2 has been placed in a low bed with safety mats on either side. 2. All residents who have a need for side rails and/or transferred to a wheelchair have the potential to be affected. The facility will ensure staff are following the individualized care plan, assessing the need for side rails as well as making sure wheelchair brakes are locked prior to transfer. 3. Nursing staff will be educated on following the individualized careplan, safe use of side rails and application of brakes on wheelchair's before transferring on 3/18/15 and 3/25/15 prior to March 27th, 2015 4. The DON or designee will be responsible to monitor compliance with Side Rails assessments, wheelchair breaks and following careplan. QA Monitoring was implemented on 3/18/15. The DON or designee will monitor weekly for a month, monthly for three months and then random audits as needed per QA recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: 10th April 2015	
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 staff interviews, the facility failed to recognize safety hazards and failed to provide adequate supervision/assistance for 2 of 4 sampled residents (Resident #2 and #3) who spent most of their time in bed and/or required staff assistance to reposition and transfer. Failure of staff to recognize safety hazards and ensure adequate assistance has the potential to cause residents unnecessary pain and places them at risk of accident and/or injury. Findings include: BED MOBILITY/SIDERAILS Review of Resident #2's medical record occurred on all days of survey. Diagnoses included severe cognitive deficits, infantile cerebral palsy, quadriplegia, epilepsy, osteopenia, and fractured	F 323		

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F 323	Continued From page 5	F 323		

femur (01/29/15). The quarterly Minimum Data Set (MDS), dated 02/13/15, identified severely impaired cognitive skills and total assistance required for Activities of Daily Living (ADLs).

The current care plan stated, ". . . Focus: ADL Self Care Performance Deficit . . . Seizure Disorder . . . Intervention: . . . 3/4 padded side rails x 2 . . . I am totally dependent on 2 staff for repositioning and turning in bed. . . . assist of 2 and hoyer [lift] . . ."

A progress note, dated 01/29/15 at 2:00 a.m., stated, ". . . Res [resident's] R [right] upper thigh is edematous, and middle thigh is indented. R leg turned inward. R knee is reddened/bruising . . . ambulance here for resident at 2:15 a.m. . . . Er [emergency room] . . ." At 8:03 a.m., "[Physician] called at 3:30 a.m. and stated leg is fractured . . ."

The radiology report, dated 01/29/15, identified, ". . . Comminuted fracture of the distal femoral diaphyseal fracture with segmental fragment. . . . Osteopenic osseous structures. . . ."

The facility interviewed 15 staff members between January 29 and February 2, 2015 regarding Resident #2's femur fracture. Two of four (#11 and #12) admitted repositioning him without assistance. One of the CNAs (#12) also stated, "I've seen him almost hanging off the bed," and stated it was possible for his leg to get caught in a side rail. Two CNAs failed to provide the level of assistance Resident #2 required the evening of 01/29/15.

Observations on 02/23/15 at 2:17 p.m., 3:22 p.m., 4:05 p.m., and 5:06 p.m., and 02/24/15 at 8:07 a.m., showed Resident #2 lying in bed, with the

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F 323	Continued From page 6	F 323		

bed raised to waist level and two 3/4 padded side rails raised on both sides of the bed. Observation on 02/24/15 at 8:07 a.m. showed the side rail not fully covered and a section of the rail exposed; large enough for a limb to slip through.

During an interview on 02/24/15 at 7:55 a.m., an orthopedic staff member (A) reported the distal section of the femur is often weak in residents diagnosed with disuse osteopenia. He also explained this type of fracture could be caused by a seizure, by a resident thrashing about in bed, by a side rail, if the resident's foot caught in the side rail, and/or by torque (a force producing rotary motion).

Facility staff failed to provide assistance according to Resident #2's care plan and failed to recognize the side rails as a safety hazard.

On 02/24/15 at 12:30 p.m., an administrative staff member (#1) and managerial nurse (#2) confirmed staff are expected to reposition residents according to their care plan. The administrative staff member (#1) and managerial nurse (#2) reported the padded 3/4 length side rails were in place to keep Resident #2 safe, as he has a history of tonic/clonic seizures (loss of consciousness with uncontrolled jerking of muscles throughout the body.)

WHEELCHAIR BREAKS

Observation on 02/24/15 at 8:20 a.m. showed two CNAs (#6 and #7) transferring Resident #2 from bed to his wheelchair with a full body lift. As the CNA (#7) lowered the resident into his wheelchair, the other CNA grabbed the wheelchair when it began to roll to the side during

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F 323	Continued From page 7 the transfer. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . Focus: ADL Self Care Performance Deficit . . . Limited Mobility . . . Intervention: . . . assist of 1 with gait belt and . . . walker . . ." Observation on 02/23/15 at 4:13 p.m. showed two CNAs (#3 and #4) assisting Resident #3's with cares. One CNA (#3) assisted Resident #3 to stand using a gait belt, while the other CNA (#4) grabbed for the wheelchair when it began to roll backwards during the transfer. Facility staff failed to lock wheelchair brakes prior to transferring residents into and/or out of their wheelchairs. On 02/24/15 at 12:30 p.m., an administrative staff member (#1) and managerial nurse (#2) confirmed the staff are expected to lock the wheelchair breaks prior to assisting residents with transfers.	F 323		
F9999	FINAL OBSERVATIONS The concerns regarding possible abuse/neglect and falls were unsubstantiated.	F9999		