STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification surey started on February 1, 2015 and completed on February 4, 2014, the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	F 164 3-16-15 1. All residents will have confidentiality maintained in Emar. All residents will have the right to privacy maintained to their rooms by acknowledging staff knocking before staff enters room is res is able to acknowledge. Confidential roster of sampled residents from survey 2014 was removed from binder at front door. 2. All residents have the potential to be affected by these deficient practices. 3. A. Education to all staff at All Staff Meeting on 2-26-15 regarding residents right to privacy by knocking on residents doors and awaiting acknowledgement from resident before entering.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Guy Lambert | TITLE: Administrator | (X6) DATE: 3-6-15

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident, group, and staff interview, the facility failed to provide privacy for 8 of 12 sampled residents (Resident #1, #2, #4, #6, #7, #8, #9, and #10) interviewed and/or observed during personal cares, and random observations of the electronic medical record and the environment. Failure to provide privacy and confidentiality is an infringement on the residents' rights and may lead to a loss of dignity. Findings include: RESIDENT PRIVACY Review of the facility policy titled "Dignity Issues" occurred on 02/04/15. This policy, dated 05/25/10, stated, "1. Provide privacy, knock before entering room: . . ." During the group interview, on 02/01/15 at 2:00 p.m., four residents indicated staff knock and walk right into their room without waiting for a response. - During an interview on 02/03/15 at 9:00 a.m., Resident #1 indicated staff knocked and entered without announcing themselves and/or waiting for a response. - During observation on 02/03/15 at 10:41 a.m., a Certified Nursing Assistant (CNA) (#10) knocked on Resident #2's door as the resident was in the bathroom. The CNA (#10) entered the resident's	F 164	B. CMA's and CN's will be educated on privacy/confidentiality at CN/CMA meeting on 3-12-15 re matrix "walk away" or screen minimize of E-MAR's when away from med cart. C. Results of most recent Health Survey accessible to the public at HTH will not contain sample residents names. Office staff educated re this procedure on 2-26-15. 4. A. Lap top EMAR med cart QA monitoring will be done on 25% of charge nurses and CMA's by nursing management at varying times of the day bi-weekly x 2; then in one months; then in three months After completion date ongoing monitoring will continue indefinitely by management staff observation with immediate education if deficient practice is observed. B. QA monitoring will be done by nursing management. 25% of staff entering residents rooms will be monitored for maintaining res privacy by	

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F 164	Continued From page 2 bathroom without the resident stating it was okay to enter. - Observations on 02/01/15 at 1:27 p.m., showed two certified nursing assistants (CNAs) (#6 and #7) toileting Resident #4. A third CNA (#8) knocked on the door and entered the resident's room without announcing herself and/or waiting for a response. - Observations on 02/02/15 at 10:20 a.m., showed a CNA (#4) knocked on the door and entered Resident 6's room without announcing herself and/or waiting for a response. - Observation on 02/01/15 at 8:30 a.m. showed a CNA (#13) in Resident #7's room. Another CNA (#23) knocked on the door and entered the room without announcing herself and/or waiting for a response. - During an interview on 02/02/15 at 2:00 p.m., Resident #8 stated staff "do not always knock" before entering her room. - During an interview on 02/03/15 at 3:35 p.m., Resident #9 indicated "some staff" knock and enter without announcing themselves and/or waiting for a response. - During an interview on 02/04/15 at 9:10 a.m., Resident #10 stated staff will "knock and walk in" without waiting for her to respond. - Observation on 02/03/14 at 1:35 p.m. showed a nurse (#12) entered Resident #11's room without knocking or announcing self. During two interviews on the morning of 02/04/15,	F 164	knocking and awaiting response before entering room weekly x 2 weeks; then in one month and at 3 months. Findings will be reported to QA nurse, QA committee and QA Meeting Quarterly Meeting . C. QA will check the 2015 survey result put out to the public after it has been put out by office staff to ensure the sampled resident roster is not in the folder. Findings will be reported to QA Nurse, Committee and QA Quarterly Meeting. 5 . 3-16-15.	

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F 164	Continued From page 3 an administrative nurse (#5) confirmed staff are are expected to knock and wait for a response prior to entering a resident's room. CONFIDENTIALITY - Observation on 02/02/15 at 7:15 a.m. showed a Certified Medication Aide (CMA) (#22) left the electronic medication administration record (E-MAR) open on top of the medication cart while she walked down the hall to a resident's room. The E-MAR identified resident names. - Observation on 02/02/15 at 11:39 a.m., showed two E-MARs on two different medication carts opened to resident's names, while a CMA (#11) and a licensed practical nurse (LPN) (#12) were in the dining room away from the E-MARs. - Observation on 02/02/15 at 12:04 p.m., showed a lap top on top of a medication cart was opened to Resident #16's E-MAR. The LPN (#12) left the medication cart unattended for approximately 12 minutes after she walked down the hallway out of sight. - Observation on 02/04/15 at 7:06 a.m., showed a medication cart in the Spring Creek Road hallway with an E-MAR opened and identified a resident's medical information including medications received. The staff administrating medications was not near the medication cart. During an interview on 02/04/15 at 8:25 a.m., with administrative nurse managers (#5, #21 and #26) they stated staff are expected to keep E-MAR's confidential by using the walk away button or minimizing the screen.	F 164		

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F 164	Continued From page 4 Observation on 02/01/15 at 3:05 p.m. showed the results of the most recent health survey in a binder near the front door. The results included a copy of the confidential roster of the sampled residents that stated, "Roster - Confidential Information Do Not Disclose to the Public" During an interview on 02/01/15 at 3:05 p.m. an administrative staff member (#25) confirmed the survey results should not contain the roster of the sampled residents.	F 164		
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, record review, review of facility policy, and staff interview, the facility failed to accurately assess and implement the self-administer medication (SAM) assessment for 2 of 2 sampled residents (Resident #2 and #3) self administering medications. Failure to discontinue the practice and allow these residents to SAM placed the residents at risk of harm. Findings include: Review of the facility policy titled "Self Administration of Medications" occurred on 02/04/15. This policy dated, 10/20/99, stated, "Conditions for resident self administration of medication: 1. Interdisciplinary team determines if	F 176	F176 3-16-15 1. Resident # 2 and #3 has had the self administration of medication order discontinued and all portions of residents' records reflect the accurate information. 2. Residents that have a self administration of medication order have the potential to be affected. 3. All residents will be evaluated and accurately assessed quarterly and PRN by nursing management for safety and compliance of self administration of medications. Self administration of medication policy revised. Self administration evaluation/reevaluation form will be revised to ensure changes are implemented to all necessary portions of resident's records including	

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F 176	Continued From page 5 the practice would be safe. . . . 4. . . . Residents self administering medications in their rooms will have medications left at bedside only if awake. 5. The nurse or CMA [Certified Medication Assistant] will check back with resident to ensure the mediation was taken. 6. Resident is subject to periodic and quarterly re-evaluations. . . . 8. . . . If the resident is unable to monitor medication prior to ingestion, the self administration order will be discontinued." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia without behaviors. The current care plan dated 05/31/14, stated, "Problem . . . Medication . . . Resident has . . . diagnosis the [sic] requires assist: . . . Approaches: . . . 3. Nursing staff to provide medications . . ." A Minimum Data Set (MDS), dated 11/30/14, identified moderate cognitive impairment. Resident #2's Electronic Medication Administration Record (E-MAR) indicated that Resident #2 could self-administer medications after setup by the charge nurse. The quarterly status report, dated 11/30/2014, stated ". . . the resident does not self-administer medications . . . resident is not appropriate to continue with self-administration . . ." The quarterly status report indicated Resident #2 was not appropriate to self-administer medications however the E-MAR incorrectly identified the resident could self-administer medications. Interview with an administrative nurse (#1) on 02/03/14 at 4:35 p.m., verified the discrepancy with Resident #2's E-MAR and the quarterly status report.	F 176	care plan, EMAR, Quarterly Status Report and PO sheet. Education will be provided to CMA's and Charge nurses regarding the self administration of medication. Self administration of medication evaluation audits will be completed on 5 residents biweekly x 4 weeks and 5 residents monthly x 5 months. Self administration evaluations with continue to be completed and PRN. 1. Medication administration audits will be completed by nursing management on 25% of licensed personnel (RN, LPN and CMA's). Medication pass audits will be done on 25% of residents weekly x 2 weeks, and at 1 and 3 months. Findings will be reported to the QA nurse and to the QA committee at the quarterly meeting. 5. 3-16-15	

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F 176	Continued From page 6 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included depressive disorder and decreased vision. The care plan stated, " . . . Problem: . . . Category: Cognitive Loss/Dementia. Resident has a memory/recall problem; BIMs score indicates severe cognitive impairment. . . ." Resident #3's Assessment For Self-Administration Of Medications identified Resident #3 as unable to self administer medications due to cognitive status. Observation on 02/02/15 at 08:15 a.m. showed Resident #3 at the breakfast table eating independently. The CMA (#22) approached Resident #3, stated she had the resident's medications, placed the medication cup near the resident, and left the dinning area. Resident #3 took the medications one at a time without supervision. During an interview on 02/04/15 at 8:25 a.m., administrative nurse managers (#5, #21 and #26) confirmed Resident #3 is unable to self administer medications.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225	F225 3-16-15 1. Res #7 is free from abuse or neglect. 2. All residents a have the potential to be affected by this deficient practice.	

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F 225	Continued From page 7 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/20/14. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to immediately report an incident of alleged abuse and the results of the investigation to the State survey and certification agency for 1 of 1	F 225	3. The Abuse and Neglect Prohibition Policy was reviewed and education given to all staff at 2-26-15 All Staff Meeting. Any reportable or suspected case of abuse and neglect will be investigated internally by SSD and other appropriate administration staff. Incidents will be reported to ND State Health Dept. per policy. 4. SSD will audit all alleged violations involving mistreatment, neglect or abuse or misappropriation ofproperty to ensure policy is being followed for reporting and investigation at one month, at 2 months and at 3 months. Findings will be reported to the QA nurse ,QA Committee and at Quarterly QA meeting. 5. 3-16-15	

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sampled resident (Resident #7). Failure to report violations involving alleged abuse has the potential to place all residents at risk of abuse.

Findings include:

Review of facility policy, "Abuse and Neglect Prohibition Policy" occurred on 02/04/15. This policy, dated March 2014, stated, ". . . . Hill Top Home of Comfort, Inc. respects the right of each resident to be free from abuse . . . and realizes its responsibilities to reasonably prevent not only abuse, but also those practices and omissions, neglect, . . . which, if left unchecked, lead to abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . . . staff of other agencies serving the individual . . . Any alleged violations should be recorded and reported immediately to the facility Administrator or his designated representative and to other officials through established procedures and in accordance with State law (including to the State survey and certification agency). The Administrator or his designee shall report the results of all investigations to the State survey and certification agency no later than five (5) working days following initial report to the Administrator. . . ."

Review of the "Abuse Investigation" policy occurred on 02/04/15. This policy, dated January 2002, stated, "1. Allegations of mistreatment, neglect abuse, . . . will be thoroughly investigated and documented using established procedures. . . . 2. All alleged violations will be investigated thoroughly by a committee including the Administrator, Social service designee, Director of Nursing Department Supervisor and others deemed necessary . . . The Resident Abuse

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F 225	Continued From page 9 Report Form and any documents relative to the incident will become a part of the investigation. . . . 3. The investigation shall consist of: a. A review of the completed Resident Abuse Report Form and any other documents relative to the incident; b. An interview with any person(s) reporting the incident, . . . c. Interviews with any witnesses to the incident; d. An interview with the resident; . . . f. An interview with staff members (on all shifts) having contact with the resident during the period of the alleged incident . . ." Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses included dementia. Resident #7's quarterly Minimum Data Set (MDS), dated 01/10/15, identified a BIMS (brief interview for mental status) score of 13, indicating cognitively intact, with fluctuating delirium behaviors. Resident #7's current care plan identified, "Cognitive Loss/Dementia - Resident has a memory/recall problem which can vary from day to day. He does not always understand communication with him. He has hx [history] of hallucination/delusions. . . ." Review of Resident #7's progress notes identified the following: * 05/04/14 at 10:00 a.m. [Recorded as Late Entry on 05/04/2014 at 7:04 PM] - "This nurse was approached by [name of family member], stating he needed to talk to me. [Family member] informed me [Resident #7] stated he 'was beat up by a [derogatory term for African American] last noc [night] and he threw me into bed!' I then informed [family member] I would call my supervisor and visit with this res. Upon interview [Resident #7], he did state 'the [derogatory term	F 225		

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for African American] hit me on the chest and threw me into the bed, I did not want to go to bed yet!' When questioned if he could identify the black man he said 'No!' Res was unable to give this nurse a name either. I then called the Nurse Manager and informed her of the proposed incident. I assessed [Resident #7] for bruises on the upper extremities, chest/back and wrists. No immediate bruising was found."

* 05/04/14 at 3:00 p.m. [Recorded as Late Entry on 05/04/2014 at 7:51 PM] - "Phone call received from CN [charge nurse] on duty to inform of incident that occurred today. Incident explained in earlier documentation . . . Writer contacted [Resident #7's family member] regarding the conversation with [Resident #7] and his comments toward a Male CNA [certified nursing assistant]. [Family member] did express that [Resident #7] has a HX [history] of making rude raciest [sic] comments in the past and does have the tenancy to be raciest [sic] towards people of color. [Family member] did also state that [Resident #7] has a HX of Hallucinations and Delusions when he was living at home. [Resident #7] was on Risperdal for hallucinations which has recently been discontinued. He was having no hallucinations while on the Risperdal. Skin assessment was completed by CN with no obvious bruising noted. Also instructed CN for the time being to have no colored caregivers care for [Resident #7]. [Family member] expressed understanding of the situation and did not feel that [Resident #7] was at any danger. [Family member] did question if risperdal needed to be adjusted as he was concerned that he could be hallunicating [sic] again. Social services . . . Admin [administrator] . . . and DON [Director of Nurses] . . . were all notified of the incident that

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F 225	Continued From page 11 occurred today." *05/04/14 at 11:13 a.m. - "VSS [vital signs stable] . . . Res. alert and pleasant when spoken to; converses and answers questions in a timely manner. Res does not indicate feeling vertigo, having a H/A [headache], or hallucinations/delusion." * 05/05/14 at 1:20 p.m. - "SSD [social services designee] visited with res. at 8:30 a.m. following breakfast. Res. in good mood & [and] said that he ate a good breakfast. Discussed his wk.[week] end with him, & he said that he had a visit from his [family member] which he enjoyed. During the visit, SSD asked him if he had any concerns, & res. said that he was upset with two 'workers' who put him into bed, 'making me go to bed.' He said that this happened night before last, & could not say what time. Res. said that they did not hurt him, 'just his pride.' He told SSD that he does not want 'black people' working with him. He was unable to explain why. 'I just don't like them.' SSD explained to res. that his wish would be honored as much as possible. SSD assured res. that his concern has been addressed. Res expressed understanding." During interview, the afternoon of 02/03/15, an administrative nursing staff member (#20) stated the facility did not report the above incident to the State agency because they felt Resident #7 was hallucinating after recent discontinuation of Risperdal. (The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual defines a hallucination as the perception of the presence of something that is not actually there.) When asked about the investigation of the	F 225		

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F 225	Continued From page 12 incident, the staff member (#20) failed to provide documentation of the investigation.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument	F 278	F278 3-16-15 1. The facility will make modification/corrections to most recent MDS of resident #5 and any other affected residents MDS. Resident # 6 is a closed record; Resident # 4 had scheduled MDS with ARD 02/06/2015 that is correctly identifying residents' current behaviors. The facility will ensure that documentation is included on each scheduled MDS, Section E for all residents subsequently being triggered for behaviors. 2. All residents have potential to be affected. 3. In-services and educating nursing, and CNA staff at March 2015 staff meetings regarding documentation and reporting behaviors. Educate social service designee appropriate documentation and validation required to identify behaviors in section E of the MDS. Review Section E definitions of	

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F 278	Continued From page 13 (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 3 of 3 sampled residents (Resident #4, #5, and #6) coded on the MDS as having delusions. Failure to accurately assess and code the MDS may affect the level of care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), May 2013, page E-2 stated, ". . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. . . . A delusion is a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . ." - Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 11/06/14, identified Resident #4 as having delusions. Resident #4's progress notes failed to show he exhibited delusional behaviors in November 2014. - Review of Resident #5's medical record occurred on all days of survey. The significant change MDS, dated 12/31/14, identified Resident #5 as having delusions. Resident #5's progress notes failed to show he exhibited delusional behaviors in December 2014. - Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 01/17/15, identified Resident #6 as having delusions. Resident #6's progress notes failed to show he exhibited delusional behaviors	F 278	mood/behavior symptoms with nurses and social service designee. 4. Five audits of MDS section E monthly x 3 months and then five audits of MDS section E at 6 months. Findings to be reported to QA nurse and to the QA committee at the quarterly meeting. 5. 3-16-15	

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F 278	Continued From page 14 in January 2015. During an interview on 02/04/15 at 9:35 a.m., both a managerial nurse (#1) and a social services staff member (#2) confirmed the residents' medical records failed to show they exhibited delusional behaviors during the seven day look-back periods.	F 278		
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 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 02/20/14.	F 280	F#280 3-16-15 1. Resident's #2, 3, 4, 5, 6, 8 and #12 careplan's were reviewed and revised by nursing management and now reflect the resident's current status. a. Resident #4's Care plan now reflects that he requires a plate riser and built up silverware for all meals. Education will be provided to staff on upcoming dietary and nursing meetings in March. Will continue with wander guard and it will remain on care plan even though resident resides in the locked special care unit because resident comes out of unit frequently for activities, special events and therapy.	

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F 280	Continued From page 15 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 7 of 12 sampled residents (Resident #2, #3, #4, #5, #6, #8, and #12). Failure to revise the care plans limited staffs' ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 02/04/15. This policy, dated 10/20/99, stated, ". . . 2. Plan must identify problems/needs, list goals (measurable, behavior-oriented, time limited and achievable . . . approaches and evaluation . . . 4. Care plans will be updated and reviewed every ninety (90) days thereafter, or more frequently if needed. 5. Care Plans are to be updated as problems/needs change or new problems/needs arise . . ." - Observation in the Special Care Unit on 02/02/15 at 8:50 a.m., showed Resident #4 fed himself using built-up silverware. He spilt pureed foods on his clothing protector throughout the meal. At 12:00 p.m., Resident #4 fed himself using a plate riser and built-up silverware. He spilt approximately one third the amount of food when utilizing the plate riser. Resident #4's current care plan identified, ". . . Approach: . . . Provide resident with safety device/appliance as indicated appropriate. See Resident Care Information for current fall/safety interventions in place. . . ." Resident #4's resident care information sheet identified, ". . . Safety Devices: . . . Wanderguard . . ."	F 280	b. Resident #5 Care Plan dated 12/31/14 states "Resident is non-weight bearing to his right lower extremity. He requires a full lift for transfers." On 12/29/14 Orthopedic doctor was called and orders received for "ROM upper body and left leg, transfer to chair, non weight bearing. Up in chair for meals." Approach stating "Resident is able to transfer from bed to chair. He uses a w/c for all mobility throughout the facility." Approach changed to clarify any conflicting information and now states. "Resident is able to get up for all meals with the use of full lift." Will continue order with wandergaurd and continue on care plan even though resident	

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F 280	Continued From page 16 Resident #4's current care plan/resident care information sheet failed to identify the specific types of "adaptive equipment" he required during meals. The current care plan/resident care information sheet also identified the need for a Wanderguard bracelet even though he resides in a locked Special Care Unit. - Resident #5's hospital discharge summary, dated, 12/22/14, identified, ". . . Patient is suspected to have sustained a fall but unfortunately nobody witnessed it. . . . Imaging studies done in the emergency room revealed that patient has a right subcapital fracture of the right hip. . . . Patient was scheduled for surgery the next day but unfortunately was unable to withstand the stress. . . . patient transferred back to the nursing home. . . ." The current physician orders identified, ". . . non wt [weight[bearing . . ." Observation in the Special Care Unit on 02/02/15 at 10:10 a.m., showed two certified nursing assistants (CNAs) (#3 and #4) transferred Resident #5 from his wheelchair to the bed using a full body lift. At 11:39 a.m., two CNAs (#3 and #4) transferred Resident #5 from his bed to the wheelchair using a full body lift. Resident #5's current care plan identified, ". . . Approach: . . . [Resident #5] is able to transfer from bed to chair. . . . [Resident #5] is nonweightbearing to his right lower extremity. He requires full lift for all transfers." The care plan also identified, ". . . Approach: . . . Apply and maintain wander guard alarm bracelet. . . ." Resident #5's current care plan contained	F 280	resides in special care unit because resident comes out of unit frequently for activities and special events. c. Resident #6 Has been discharged from our Facility as of 2/4/2015 d. Resident # 3 Care plan now reflects that resident will wander at times and that wanderguard is in place. Resident was also moved to a private room on 2/24/15 to an area close to a nurses station with more monitoring from staff members. e. Resident #12 Care plan was revised. Wanderguard and bed alarm have been	

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F 280	Continued From page 17 conflicting information regarding his mobility status and identified the need for a Wanderguard bracelet even though he resides in a locked Special Care Unit. - Resident #6's current care plan identified, ". . . Problem: . . . Res [resident] moved into Special Care Unit due to dementia. . . . Approach: . . . Ask him to visit with SSD [Social Service Designee] if he has a point to make when in a group, rather than take over the meeting. Resident Council [meetings - an opportunity for residents to voice concerns] where he is often disruptive. . . ." Resident #6's current care plan identified the resident as disruptive during Resident Council meetings even though he resides in a locked Special Care Unit. During an interview on 02/02/15 at 5:00 p.m., an administrative nurse (#5) confirmed Resident #4, #5, and #6's care plans need to be updated. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included depressive disorder. The care plan stated, " . . . Problem: . . . Category: Cognitive Loss/Dementia. Resident has a memory/recall problem; BIMs [brief interview for mental status] score indicates severe cognitive impairment. . . ." The facility identified Resident #3 as a wandering resident. Observation on all days of survey showed Resident #3 wearing a wanderguard bracelet. Resident #3's care plan failed to identify Resident #3 as a wandering resident and wearing a wanderguard bracelet.	F 280	discontinued from the Care Plan. f. Resident #2 Care plan revised and under mood state resident is listed as being at risk for depression. Resident and his family declines the use anti-depressant therapy at this time. g. Resident #8 Care plan revised and monitor roommate relationship approach has been removed as resident is in a private room. 2. All Resident's careplans have the potential to be affected. 3. All Care Plans are now being brought to interdisciplinary team report when held so changes can be placed on all resident's care plans immediately. Care plan education will be given at Charge nurse meeting in March. The Care plans will continue to	

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F 280	Continued From page 18 During an interview on 02/04/15 at 8:25 a.m., with administrative nurse managers (#5, #21 and #26) they confirmed Resident #3 care plan needed to be updated. - Review of Resident #12's medical record occurred on February 03-04, 2015. Resident #12's current comprehensive care plan, dated 04/12/14, stated ". . . Problem . . . Cognitive loss/ Dementia . . . Approach . . . Wanderguard bracelet; bed alarm . . . " During an interview on 02/03/15 at 3:35 p.m., an administrative nurse (#1) confirmed Resident #12 does not wear a Wanderguard bracelet or use a bed alarm. This administrative nurse confirmed Resident #12's care plan needs to be updated. Observation of Resident #12 on 02/04/15 at 09:30 a.m., showed Resident #12 did not have a wanderguard bracelet on either wrist, and showed no bed alarm system in place on the Resident #12's bed. The facility failed to revise care plan approach to remove the Wanderguard bracelet and bed alarm from this care plan. - Review of Resident #2's medical record occurred on February 01-03, 2015. The quarterly MDS, dated 11/30/14, identified an increase in depression level. Resident #2's current comprehensive care plan, dated 05/31/14, stated ". . . Problem . . . Mood State . . . Res's mood is generally good . . . He is occasionally emotional, and easily tears up . . . Res. denies depression . . . Approach . . . Anti-depressant therapy . . . Observe for s/s [signs and symptoms] of depression; increased tearfulness, negative statement, sad expression . . ."	F 280	be reviewed and revised by all disciplines(MDS Coordinator/Assistant, Social Services, Dietary, Activities) with all Admission, Quarterly, Annual and Significant Change MDS that are completed. 4. The MDS Coordinator and/or Assistant will monitor resident care plans reviewing 5 resident care plans bi weekly x 4 weeks and 5 resident's care plans monthly x 5 months. Findings will be reported to the QA nurse and to the QA committee at the quarterly QA meeting. 5. Completion date 03/16/2015	

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F 280	Continued From page 19 During an interview on 02/03/15 at 12:45 p.m., a licensed social worker (#12) stated she expected staff to update the care plan to reflect Resident #2's change in mood state to "at risk for depression." - Review of Resident #8's medical record occurred on all days of survey. Resident #8's care plan stated, "Mood state . . . Monitor roommate relationship (concern with her being rude at times, & [and] listening to her radio at high volume.) Remind res. to turn radio down, esp. [especially] towards evening. Report concerns to SSD [social service designee] or CN [charge nurse]. . . ." Observations during all days of survey showed Resident #8 in a private room. During interview, the morning of 02/04/15, an administrative nurse (#20) confirmed staff should update the care plan to reflect Resident #8 no longer had a roommate.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	F315 3-16-15 1. Residents # 2, # 3, # 9 and # 12 will have pericares provided per policy. 2. Residents requiring assistance with toileting have the potential to be affected. 3. The CNA's have reviewed the revised ADL policy and procedure for pericare at	

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F 315	Continued From page 20 by: Based on observation, review of facility policy, medical record review, and staff interview, the facility failed to provide proper perineal care for 4 of 11 sampled residents (Resident #2, #3, #9, and #12) dependent on staff for perineal care and incontinent of bladder and/or bowel. Failure to cleanse appropriately after incontinence/voiding placed residents at risk for skin irritation/breakdown and urinary tract infections. Findings include: Review of the facility policy titled "Toileting & Providing Perineal Care" occurred on 02/04/15. This policy, dated 02/22/10, stated, ". . . Staff members will be required to wash hands prior to getting additional supplies from clean areas . . . after hands/gloves have been contaminated . . . Cleanse perineal area. Always wash front to back towards anus. Female: separate labia and wash downward on each side using different parts of the washcloth or wipe. Male: Retract foreskin. Wash penis from urethral opening down, then scrotum. Wash and replace foreskin. . . . remove and discard gloves . . . wash hands with soap and water . . ." - Review of Resident #2's medical record occurred on February 01-03, 2015. A quarterly Minimum Data Set (MDS), dated 11/30/14, identified Resident #2 required extensive assistance with toileting, personal hygiene, always incontinent of urine, and frequently incontinent of bowel. The record identified a history of chronic urinary tract infections, and penile skin irritation. Resident #2's current comprehensive care plan, dated 05/31/14, stated, ". . . Problem . . . Urinary Incontinence . . . is	F 315	the 3/10/15 CNA meeting. A copy was provided for each CNA and additional instruction was provided. Reminders have been placed in the CNA log books. Management will monitor for compliance (see below). 4. The QA Coordinator and/or nursing management will audit 25% of CNA's who are providing pericares for appropriate technique bi-weekly x2 and at 2 and 3 months. Findings will be reported to the QA Committee. 5. 3-16-15	

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frequently incontinent of bladder and of bowel . . . Approach . . . Nursing staff to assist and encourage correct toileting hygiene . . . staff to provide incontinence care after each incontinent episode . . ."

Observation on 02/01/15 at 2:15 p.m. showed a certified nursing assistant (CNA) (#9) assisted Resident #2 to the bathroom. The CNA (#9) applied gloves, removed the wet brief, removed gloves, and applied new gloves. After Resident #2 voided, CNA (#9) provided perineal cares, wiped the rectal area with a wash cloth then washed frontal area with the same washcloth. The CNA (#9) failed to wash the frontal perineal area before washing the back perineal area.

Observation on 02/02/15 at 7:18 a.m. showed a CNA (#17) assisted Resident #2 to the bathroom. The CNA (#17) applied gloves and removed Resident #2's brief before he sat on the toilet. When Resident #2 finished, he stood up with assistance from CNA (#17). The CNA (#17) used a wet washcloth to wipe Resident #2's left and right groin area without washing the penis area, and proceeded to wipe the back anal area. The CNA (#17) failed to provide the necessary frontal perineal cares.

Observation on 02/02/15 at 4:17 p.m. showed a certified nursing assistant CNA (#18) assisted Resident #2 to the bathroom. The CNA (#18) applied gloves and removed Resident #2's brief. When Resident #2 was finished on the toilet, the CNA (#18) assisted Resident #2 to stand up and wiped the right and then left groin with a washcloth. The CNA (#18) did not wipe the penis area. The CNA (#18) wiped the anal area. The CNA (#18) failed to provide the necessary frontal

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F 315	Continued From page 22 perineal cares. Observation on 02/03/15 at 10:41 a.m. showed a CNA (#9) assisted Resident #2 into the bathroom. The CNA (#9) removed the wet brief and Resident #2 sat on the toilet. Resident #2 stated he finished voiding, and CNA (#9) assisted him to stand. Urine was dribbling from the penis. The CNA (#9) placed a wipe over the penis and left it in place, took another wipe and cleansed the back perineal area and discarded the wipe. The CNA (#9) took the wipe that was left on the penis to catch the dribbling urine and used this same wipe to clean the penis. The CNA (#9) applied a new brief. The CNA (#9) failed to clean the frontal perineal area with a clean wipe. - Review of Resident #12's medical record occurred on February 03-04, 2015. The record identified Resident #12 with urinary incontinence. A quarterly MDS, dated 01/12/15, identified Resident #12 required extensive assistance with toileting, personal hygiene, always incontinent of urine and bowel. Resident #12's current comprehensive care plan, dated 04/12/14, stated, ". . . problem of Urinary Incontinence . . . Approach . . . staff to assist and encourage correct toileting hygiene . . ." Observation on 02/03/15 at 4:32 p.m. showed two CNAs (#3 and #19)provided perineal cares to Resident #12 in bed. The CNA (#3) cleansed the perineal area from front to back. Without changing gloves, the CNA (#3) applied protective barrier cream to Resident #12's anal area and then the penis area. The CNA (#3) failed to apply protective skin barrier to the frontal perineal area with clean gloves.	F 315		

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F 315	Continued From page 23 During an interview on 02/04/14 at 8:25 a.m., three administrative nursing managers (#1, #20, and #21) stated they expected staff to follow the facility's policy and procedure regarding perineal cares to "always wash front to back, towards there anal area." - Review of Resident #9's medical record occurred on February 3-4, 2015. Medical diagnoses included included catheter placement and history of urinary tract infections (UTIs). The quarterly MDS, dated 11/30/14, identified intact cognitive skills and extensive assistance of one person for toileting. Observation on 02/03/15 at 3:25 p.m., showed a CNA (#13) assisting Resident #9 with perineal cares, after an incontinent episode of a large loose bowel movement. The CNA (#13) gloved, cleansed feces from Resident #9's rectal area and removed his gloves. The CNA (#13) regloved, cleansed the resident's buttocks with a wet cloth, and removed his gloves. The CNA (#13) regloved, placed a new brief, adjusted the resident's clothing, and removed his gloves. The CNA failed to cleanse Resident #9's frontal perineal area or check for possible feces residue. During an interview on the morning of 02/04/15., an administrative nurse (#5) confirmed staff should cleanse a resident from front to back. - Observation on 02/01/15 at 01:40 p.m. showed Resident #3 on the toilet. The resident voided and had a bowel movement. The CNA (#9) donned gloves, assisted the resident off the toilet, cleansed the rectal area and without changing gloves, the CNA (#9) cleansed the frontal perineal	F 315		

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F 315	Continued From page 24 area. During an interview on 02/04/15 at 8:25 a.m., three administrative nurse managers (#5, #21 and #26) stated staff need to cleanse "clean to dirty," and they expect staff to change gloves after cleansing the rectal area.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of facility policy, review of manufacturers recommendations, and staff interview, the facility failed to provide adequate supervision and assistive devices for 7 of 12 sampled residents (Resident #2, #3, #4, #5, #9, #10, and #11) and 2 of 2 supplemental residents (Resident #14 and #15) during transfers/transport, and review of 1 discharged resident record (Resident #13). Failure of the staff to ensure proper use of assistive devices (gait belts, stand lifts, wheelchair breaks and foot pedals) has the potential to cause residents unnecessary pain and places them at risk for possible accident and/or injury. Findings include:	F 323	F323 3-16-15 1. A. Gait belt will be used on residents #3,4, 10 and all residents if weight bearing assistance is required for transfer or ambulation. Res #'s 14, 15, 9 and 2 were assessed by management staff with decision made at Cares Meeting on 3-4-15 to have w/c peddle use during transport by staff and may have off if they want to maneuver selves in w/c. W/C peddles will be kept in bag on back of w/c. Resident # 9 was assessed by OT on 2-27-15 and will have use of full lift for all transfers. Res #11 was assessed by OT and will have use of stand lift for all transfers. Res #5 is now in a	

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F 323	Continued From page 25 GAIT BELTS Review of the facility policy titled "Resident Transfers" occurred on 02/05/15. This policy, dated 06/21/2004, stated, ". . . 3. Gait belts will be used by staff with residents requiring weight bearing assistance or assistance with balance and stability during ambulation or transfers. . ." - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 12/27/14, identified severely impaired cognitive skills and limited assistance of one person for transfers. Observation on 02/01/15 at 1:40 p.m. showed a CNA (#9) assisted Resident #3 off the toilet by lifting under the resident's left arm. After completing perineal cares, the CNA (#9) wheeled the resident into his room. The CNA (#9) assisted Resident #3 into the recliner by lifting under the resident's left arm. - Review of Resident #4's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/06/14, identified severely impaired cognitive skills and extensive assistance of one person for transfers. The current care plan stated, "Focus: Decreased ADL [Activities of Daily Living] function . . . Intervention: . . . Observe and offer [Resident #4] assistance when ambulating. . . ." Observations showed the following: * On 02/01/15 at 1:50 p.m. a certified nursing assistant (CNA) (#15) cued Resident #4 to "stand and walk towards the bathroom." Because	F 323	geri chair at all times. All residents will have w/c breaks on when transferring to or from a w/c. B. Chemicals used at HTH will always be kept in locked cabinets unless in possession of a staff member. The keys to the locked cabinet will be kept in closed drawers away from the locks or in possession of a staff member. Keys will not remain in the locks at any time. Tools at HTH will not be kept in utility rooms. 2. A. All residents requiring assist with transfers and w/c transport could be affected by this deficient practice Regarding gait belts, w/c peddles and mechanical lifts. B. All residents could be affected by deficient practice of unlocked chemicals and accessibility to tools.	

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F 323	Continued From page 26 Resident #4 was unsteady on his feet (shuffling to the side), the CNA held onto his hand and/or elbow while assisting him to the bathroom. The CNA failed to apply a gait belt prior to providing transfer/ambulation assistance. * On 02/01/15 at 3:45 p.m. a CNA (#15) cued Resident #4 to "stand and walk towards the bathroom." Because Resident #4 was unsteady on his feet, the CNA held onto his hand and/or elbow while assisting him to the bathroom. The CNA failed to apply a gait belt prior to providing transfer/ambulation assistance. During an interview on 02/02/15 at 5:00 p.m., an administrative nurse (#5) confirmed staff should use a gait belt whenever Resident #4 is unsteady on his feet. - Review of Resident #11's medical record occurred on February 03-04, 2015. The quarterly MDS, dated 12/08/14, identified severely impaired cognitive skills and extensive assistance of one person for transfers. The Resident Care Information Sheet identified Resident #11 transfers with extensive assist of one and pivot transfers with a gait belt. Observation on 02/03/15 at 1:35 p.m., showed a CNA (#3) assisted Resident #11 to transfer from the recliner to the wheelchair. The CNA (#3) applied a gait belt and assisted Resident #11 to a standing position by holding onto the back of the gait belt and lifting under the resident's arm. The CNA (#3) then held onto the back waistband of Resident #11's pants (instead of the gait belt) to pivot into the chair. The CNA (#3) wheeled the resident into the bathroom and used the gait belt to transfer from the wheelchair to the toilet. After	F 323	3. A. Residents with decline in mobility/transfer status will be evaluated by nursing management staff, charge nurse or PT/OT for need/use of w/c peddles, gait belts or appropriate mechanical lift. At CNA meeting on 3-10-15 CNA staff were educated on use of w/c break use on all transfers of residents in w/c's, proper use of gait belts, appropriate use of stand lift, not lifting under residents arms, use/need for w/c peddles and reporting to CN or nursing management immediately when a resident has a change in ability to transfer per care plan. Cares Management committee will continue to meet regularly to evaluate residents needs re gait belts, w/c peddles and mechanical lifts. B. All staff were educated at all staff meeting on 2-26-15 that all chemicals at HTH are to be locked at all times unless in possession of a staff member	

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F 323	Continued From page 27 completing personal cares, the CNA (#3) held onto the back waistband of Resident #11's pants to assist her to stand and pivot transfer to the wheelchair. After wheeling the resident to her recliner, the CNA (#3) held onto the gait belt and lifted under Resident #11's arm to stand and pivot transfer to the recliner. Observation on 02/03/15 at 4:00 p.m. showed a CNA (#24) applied a gait belt on Resident #11's waist and assisted the resident on the toilet by using the gait belt. The CNA (#24) assisted Resident #11 off the toilet by lifting under the resident's left arm. - Review of Resident #10's medical record occurred on February 03-04, 2015. Medical diagnoses included lumbago [low back pain]. Resident #10's quarterly MDS, dated 01/15/15, identified extensive of one person for transfers. Resident #10's current care plan identified : "Problem : Falls. . . . is at risk for falling due to unsteady at times. Goal: to minimize risk of injury related to falls through next review. Approach: All departments to observe for decrease or loss of functional status on a daily basis and report changes to charge nurse. . . . Provide resident with safety device/appliance as indicated appropriate. . . . Problem: ADL [activities of daily living] Function/Rehabilitation Potential. [Resident #10] is independent with a majority of her ADL's, some limited and extensive assist. . . . will call for assist when needed. . . . " The CNA "Resident Care Information" sheet, dated 02/01/15, identified "TRANSFERS: 1 - IND [independent] - Ext [extensive] PRN [as needed] Observation on 02/04/15 at 6:45 a.m. showed a	F 323	and tools will not be kept in utility rooms. Locked storage areas are to be locked with key kept in closed area or away from the lock. All utility rooms will have doors closed at all times. 4. A. 30% of residents requiring assist with transfers, use of gait belts, stand lifts or w/c peddles will be audited bi-weekly x 2; then after one month and at 3 months. Findings will be reported to the QA Nurse, Committee and the QA Quarterly Meeting. Continuing assessments/supervision will be ongoing by supervisory staff to ensure ongoing compliance at all times. B .Chemical storage, utility room doors and any tools present in utility rooms will be audited by management staff 3x week x 2 weeks; then 3x a week at 1 month and 3x a week at 3 months.	

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F 323	Continued From page 28 CNA (#8) assisted Resident #10 out of bed for the day. Resident #10 stated she was in a lot of pain and the CNA (#6) notified the charge nurse over the radio system. Resident #10 sat on the edge of her bed and told the CNA that because of the pain, "I don't know if I can get up this morning." The CNA stated it was very unusual for the resident to express concern about getting up. The CNA (#6) stated "I will help you" and then lifted under the resident's arm. Observation showed the resident had a difficult time attempting to stand, and was unsteady on her feet. The resident stood by the bed holding onto the FWW to gain her balance. Resident #10 then walked to the bathroom with the FWW and assist of the CNA (#6). The CNA failed to apply a gait belt to Resident #10 after the resident verbalized pain and a hesitancy to get up. During an interview the morning of 02/04/15, an administrative nurse (#20) confirmed CNAs should use a gait belt if the resident is unsteady. During an interview on 02/04/15 at 08:25 a.m. with administrative nurses (#5, #21 and #26) they confirmed staff should not lift under resident's arms. STAND LIFTS Review of the "EZ Stand" lift manual occurred on 02/04/15. The manual, dated 06/17/14, stated, ". . . The EZ . . . Stand was designed to transfer weight bearing patients to and from a chair, wheelchair, or bed . . ." - Review of Resident #9's medical record occurred on February 3-4, 2015. Medical diagnoses included included unsteady gait, fall	F 323	5. 3-16-15	

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risk, and anxiety. The quarterly MDS, dated 11/30/14, identified intact cognitive skills and extensive assistance of one person for transfers.

An occupational therapy (OT) note, dated 11/10/14, identified, "OT eval [evaluation] completed to assess stand aid transfers. . . . Patient able to grasp handles on stand aid and bear weight through her LE's [lower extremities]. Hips don't come to full extension [secondary to] muscle tightness or contracture. . . ."

Resident #9's current care plan identified, ". . . Approach: . . . [Resident #9] requires a stand up lift for all transfers. . . ."

Observations showed the following:
* On 02/03/15 at 3:20 p.m., a CNA (#13) transferred Resident #9 from the toilet to her bed using a sit-to-stand lift. The resident was not able to bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #9's axillae (armpits), her shoulders raised to ear level, elbows extended horizontally, and her midriff was exposed when her shirt was pulled upward. The resident told the CNA to "Hurry!" Staff failed to ensure Resident #9 was able to bear weight throughout the stand lift transfer and report her inability to bear weight to the nurse.
* On 02/03/15 at 4:03 p.m., a CNA (#3) transferred Resident #9 from the toilet to her wheelchair using a sit-to-stand lift. The resident was not able to bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #9's axillae, her shoulders raised to ear level and elbows extended horizontally. As the resident was being lowered into her wheelchair, she said "Oh!"

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and sighed deeply. Staff failed to ensure Resident #9 was able to bear weight throughout the stand lift transfer and report her inability to bear weight to the nurse.

During an interview on the morning of 02/04/15, an administrative nurse (#5) confirmed Resident #9 may be more fatigued/unable to bear her own weight in the stand lift following toileting/pericares.

WHEELCHAIR BREAKS

- Review of Resident #13's medical record occurred on February 3-4, 2015. Medical diagnoses included osteoarthrosis and history of femur fracture. The annual MDS, dated 11/17/14, identified severely impaired cognitive skills and extensive assistance of two or more persons for transfers.

An event report, dated 03/05/14, identified, ". . . CNA was assisting resident from her wheelchair with the stand up lift. The wheelchair started to roll backwards so she grabbed the wheelchair. It continued to roll . . . Wheelchair fell backwards . . . so resident was assisted to floor . . . no bruising evident or injury post fall . . ."

During an interview on the morning of 02/04/15, an administrative nurse (#5) confirmed staff should apply the breaks prior to transferring a resident to/from a wheelchair.

WHEELCHAIR FOOT PEDALS

- Review of Resident #9's medical record occurred on February 3-4, 2015. Medical diagnoses included unsteady gait, fall risk, and

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anxiety. The quarterly MDS, dated 11/30/14, identified intact cognitive skills and extensive assistance of one person for transfers.

Observation on 02/01/15 at 9:15 a.m. showed an unidentified staff member transported Resident #9 down the hallway to her room in her wheelchair. Resident #9's feet/shoes caught and bounced on the floor as staff transported her in the chair. The staff member failed to cue Resident #9 to lift her feet and/or apply foot pedals during transport.

Observation on 02/04/15 at 8:30 a.m. showed a restorative therapy staff member (#24) transported Resident #9 down the hallway to the therapy room in her wheelchair. Resident #9's feet/shoes made an audible noise as the shoes slid along the surface of the floor. The staff member (#24) failed to cue Resident #9 to lift her feet and/or apply foot pedals during transport.

-Review of Resident #2's medical record occurred on February 3-4, 2015. Medical diagnoses included dementia without behaviors, osteoarthritis, and lower leg degenerative joint disease. The quarterly Medical Data Set (MDS), dated 11/30/2014, showed moderately impaired cognitive skills and extensive assistance of one person for transfers.

Observation on 02/02/15 at 12:15 p.m. showed a CNA (#17) transported Resident #2 in his wheelchair from the bathroom to the recliner in resident's room. Resident #2's feet/shoes made an audible noise as they caught on the surface of the floor while the CNA (#17) was pushing the wheelchair. The CNA (#17) was jolted to a stop and said "oops, lift your feet" to the resident. The

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staff member failed to cue Resident #2 to lift his feet and/or apply foot pedals during transport before the resident's feet caught on the floor.

Observation on 02/03/2015 at 7:41 a.m. showed a CNA (#9) transported Resident #2 down the hallway in a wheelchair with no foot peddles. The resident's feet got caught on the rug which jolted the wheelchair backward, the CNA (#9) stopped the wheelchair and the resident picked up his feet. The CNA (#9) stated to the resident "that's it" and proceeded to push the resident in the wheelchair to his room. The staff member failed to cue Resident #2 to lift his feet and/or apply foot peddles during transport.

- Review of Resident #14's medical record occurred on February 3-4, 2015. Medical diagnoses included weakness and fall risk. The quarterly MDS, dated 12/14/14, identified intact cognitive skills and extensive assistance of one person for transfers.

Observation on 02/03/15 at 3:50 p.m. showed a CNA (#3) transported Resident #14 down the hallway to the activity room in her wheelchair. Resident #14's feet/shoes made an audible noise as they slid along the surface of the floor. The staff member failed to cue Resident #9 to lift her feet and/or apply foot pedals during transport.

- A random observation on 02/04/15 at 9:40 a.m., showed a CNA (#8) attempted to transport Resident #15 in his wheelchair from the television/lounge area. Resident #15's feet/shoes caught and bounced on the floor as the CNA pushed the wheelchair. When Resident #15's feet caught on the floor, the CNA (#8) then attempted to pull the wheelchair backwards, however

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Resident #15's feet/shoes continued to bounce and catch on the floor. The CNA (#8) left the resident sitting in the television/lounge area and did not transport him.

During an interview on the morning of 02/04/15, an administrative nurse (#5) confirmed staff should cue residents to lift their feet and/or apply foot pedals prior to transport.

- Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included non weightbearing status due to fractured right hip. The significant change MDS, dated 12/31/14, identified severely impaired cognitive skills and extensive assistance of two persons for transfers.

An event report, dated 08/30/14, identified, ". . . res. [resident] was being pushed into the activity room by [the CNA] and he went to bend over as if to pick something up off floor and . . . fell forward and landed on his left side. . . . was assisted up off floor without any problems and no injuries noted. . . ."

During an interview on 02/04/15 at 10:17 a.m., a managerial nurse (#1) reported at the time of the fall, Resident #5 was "[self]-propelling his wheelchair all over the place." When asked if foot pedals had been applied to his wheelchair prior to him being transported to the activity room, she stated, "My guess is no."

CHEMICAL AND TOOL STORAGE

2. Based on observation, review of facility policies and procedures, review of material safety data sheets, and staff interview, the facility failed to

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	355092	A. BUILDING _____ B. WING _____	02/04/2015

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HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 323	Continued From page 34 maintain an environment free of hazardous chemicals and tools on 1 of 4 units (Spring Creek Road). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury. Findings include: Review of the facility's policy and procedure titled "Hazard Communication Program" occurred on 02/04/15. This policy, dated 2001, stated, " . . . Access to the storage area is limited to authorized personnel only . . . Chemicals must be secured from resident handling. Cabinets containing chemicals in resident areas must remain locked. Areas where chemicals are stored will be inaccessible to residents . . ." Review of the material safety data sheets identified the following: * Febreze- " . . . inhalation of high concentrations of ethanol vapor may cause irritation of the eyes and respiratory tract, drowsiness, and fatigue . . ." * Mikro Quat- ". . . Acute Toxicity: . . Harmful if swallowed. Causes severe skin burns and eye damage. . ." * Steriphine II Brand Disinfectant Deodorant- " . . . causes substantial but temporary eye injury. Harmful if absorbed through the skin. Inhalation of product mist may cause respiratory irritation. . ." * Consume- ". . . causes eye and skin irritation. . . May be harmful if swallowed. . . inhalation of product mist may cause respiratory irritation. Contains living bacterial spores. The bacteria in this product may cause infection if introduced into an open would, broken skin or mucous membrane in sufficient quantity. . . "	F 323		

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F 323	Continued From page 35 - Observation on 02/03/15 at 9:35 a.m. showed the door of the soiled utility room of the Spring Creek Road unit unlocked. Observation showed no staff members present in the area. The unlocked room contained the following chemicals in an unlocked cabinet with a key to the cabinet in the keyhole: two cans of Febreze, two plastic containers of Mikro Quat, two spray bottles of Mikro Quat, three Steriphine II Brand Disinfectant Deodorant cans, one bottle of Consume. Observation on 02/03/15 at 1:00 p.m., while on environmental inspection with environmental staff (#15 and #16), showed the door to the soiled utility room in the Spring Creek Road unit unlocked. Upon inspection of the cabinet, a sign posted on it stated "this cabinet must remain locked at all times." The cabinet had a key in the keyhole and was unlocked. The unlocked cabinet contained the following chemicals: two cans of Febreze, two plastic containers of Mikro Quat, two spray bottles of Mikro Quat, three Steriphine II Brand Disinfectant Deodorant cans, one bottle of Consume. During the interview on 02/03/15 at 1:00 p.m. an environment staff member (#16) stated "This is supposed to be locked" and took the key out and placed it in the drawer of the sink cabinet. After opening the drawer, observation of contents in the drawer showed two hammers and a paint scraper in this unlocked drawer. Environment staff member (#16) stated, "these should not be in here." Environment staff member (#15) removed the two hammers and the paint scraper.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	F 364 3-16-15 1. All residents will receive foods that are palatable, attractive and proper temperatures.	

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F 364	Continued From page 36 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 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, surveyor sampling of meal trays, and staff interview, the facility failed to prepare palatable food for 3 of 3 sampled residents (Resident #4, #5, and #6) on the Special Care Unit. Failure to monitor food temperatures limited the facility's ability to ensure the residents receive an enhanced dining experience and may have placed the residents at risk of unintended weight loss. Findings include: On the morning of 02/02/15, observations on the Special Care Unit showed the following: * At 7:30 a.m., Dietary delivered the food cart to the Special Care Unit. * At 8:23 a.m. (53 minutes), staff provided Resident #6 his breakfast tray. * At 8:37 a.m. (1 hour 7 minutes), staff provided Resident #5 his breakfast tray. * At 8:50 a.m. (1 hour 20 minutes), staff provided Resident #4 his breakfast tray. Staff failed to reheat the residents' food prior to passing their trays. On 02/02/15, observations on the Special Care Unit showed the following: * At 11:39 a.m., Dietary delivered the food cart to the Special Care Unit.	F 364	2. All residents in Carus Court have potential to be affected 3. Provide education to all dietary staff at our meeting on 3/3/15. Carus Court trays will be prepared and immediately be taken to Carus Court to be served. Any food not immediately served temperatures will be checked, and microwave to appropriate temperatures. CNA's will also be educated on the appropriate temperatures of resident's foods at their CNA meeting 3/10/15. 4. We will audit temperatures when they go to Carus Court by temping first tray that goes into the warmer, and the last tray that is served. We will temp 4 meals a week for two weeks and 2 meals a week for 3 months. A heated holding cart will be ordered by 3/16/15.	

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F 364	Continued From page 37 * At 11:50 a.m. (11 minutes), staff provided Resident #5 his dinner tray. * At 11:54 a.m. (15 minutes), staff provided Resident #6 his dinner tray. * At 12:00 p.m. (21 minutes), staff provided Resident #4 his dinner tray. Staff failed to reheat the residents' food prior to passing their trays. * At 12:01 p.m. (22 minutes after the food cart was delivered to the unit), the surveyor obtained food temperatures. The meat registered 115 degrees Fahrenheit (F) and the asparagus registered 114 degrees F. Both of these foods were luke-warm when tasted. On the morning of 02/03/15, observations on the Special Care Unit showed the following: * At 7:30 a.m., Dietary delivered the food cart to the Special Care Unit. * At 8:06 a.m. (after the last tray had been passed and 36 minutes after the food cart was delivered to the unit), the surveyor obtained food temperatures. The biscuits with gravy registered 99 degrees F and were cold and unpalatable when tasted. During an interview on the morning of 02/04/15, an administrative nurse (#5) confirmed staff should reheat the food prior to serving residents who have arrived late to the dining room.	F 364	5. 3/16/15	
F 371 SS=D	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	F 371		

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F 371	Continued From page 38 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 kitchen and 1 of 2 refrigerators on the nursing units (Special Care Unit). These practices can increase the risk of cross-contamination and/or foodborne illness and can affect all resident who eat food prepared or served from these areas. Findings include: Review of the policy titled "Storage areas and procedures" occurred on 02/04/15. This policy, dated 01/14/04, stated, ". . . Storage of Perishable Food Items: . . . 4. . . . prepared or cooked food is stored above the raw food. . . ." Review of the policy titled "General Sanitation" occurred on 02/04/15. This policy, dated 01/14/04, stated, ". . . d. Monthly, depending on the need. . . . Refrigerator and freezer motors are vacuumed . . . Vents . . . are cleaned. . . ." An initial tour of the kitchen occurred on 02/01/15 at 9:20 a.m. Observation showed the following in the walk-in cooler: * A container of raw beef steaks stored on a shelf above an open box of apples, uncovered tomatoes, and a covered container of banana cream pie stored on the lowest shelf of the shelving unit.	F 371	F371 3-16-15 1. All prepared or cooked foods are to be stored above raw foods. Refrigerator and freezer motors are to be vacuumed monthly to keep them clean and running well. 2. Anyone consuming foods from this facility could be affected. 3. Education will be given to all staff at the dietary meeting on 3/3/15 on how foods should be stored. A PM card will be started for maintenance to check and clean the fans monthly. 4. The morning and evening cooks will monitor foods that are stored in the walk in coolers. Maintenance will check fans monthly. 5. 3/16/15	

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F 371	Continued From page 39 * A build-up of black debris on two fans in the cooler. A tour of the kitchen occurred on 02/03/15 at 1:00 p.m. with an administrative dietary staff member (#27). Observation showed the black debris on the two fans in the walk-in cooler remained. The staff member (#27) stated she was unsure when facility staff last cleaned the fans. The staff member (#27) confirmed the raw beef steaks should not be stored above ready-to-eat food.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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	F 441	F 441 3-16-15 1. Residents # 4, # 9, and # 12 2. Residents requiring assistance with all care have the potential to be affected. 3. The CNA's have reviewed the revised ADL policy and procedure for pericare at the 3/10/15 CNA meeting. A copy was provided for each CNA and additional instruction was provided. Reminders have been placed in the CNA log books. Management will monitor for compliance (see below).	

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F 441	Continued From page 40 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 11 sampled residents (Resident #4, #9, and #12) observed during toileting cares. Failure to follow infection control practices related to glove usage and hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy titled " Hand Hygiene" occurred on 02/05/15. This policy, dated 11/13/2010, stated, ". . . When to perform hand hygiene . . . Before and after each resident contact or assisting a resident with personal care. After touching a resident or handling his or her belongings. Before and after nursing procedures. After invasive procedures or contact with any body fluids . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included colon cancer with colostomy. The	F 441	4. The QA Coordinator and/or nursing management will audit 25% of CNA's who are providing pericares for appropriate technique bi-weekly x2 and at 2 and 3 months. Findings will be reported to the QA Committee. 5. 3-16-15	

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F 441	Continued From page 41 quarterly Minimum Data Set (MDS), dated 11/06/14, identified severely impaired cognitive skills and extensive assistance of one person for toileting. Observation on 02/01/15 at 1:50 p.m., showed a certified nursing assistant (CNA) (#14) assisting Resident #4 with cares. The CNA (#14) gloved, removed Resident #4's colostomy bag, cleansed feces from the colostomy site, and removed his gloves. The CNA (#14) regloved, prepped the new colostomy bag, noticed additional feces draining from the colostomy site, cleansed the area again, and removed his gloves. The CNA (#14) regloved and applied the new colostomy bag. The CNA (#14) cleansed Resident #4's frontal area twice and removed gloves. The CNA failed to perform hand hygiene after providing colostomy cares prior to cleansing the frontal area. - Review of Resident #9's medical record occurred on February 03-04, 2015. Medical diagnoses included catheter placement and history of urinary tract infections (UTIs). The quarterly MDS, dated 11/30/14, identified intact cognitive skills and extensive assistance of one person for toileting. Observation on 02/03/15 at 3:25 p.m., showed a CNA (#13) assisting Resident #9 with toileting cares. The CNA (#13) gloved, cleansed feces from Resident #9's rectum/buttocks, and removed his gloves. The CNA failed to use a different part of the wipe each time he cleansed the area. The CNA (#13) regloved, cleansed the resident's buttocks with a wet cloth, patted them dry with a towel, and removed his gloves. The CNA (#13) regloved, placed a new brief, adjusted	F 441		

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F 441	Continued From page 42 her clothing, and removed his gloves. The CNA failed to perform hand hygiene after providing toileting cares/prior to regloving. During an interview on the morning of 02/04/15, an administrative nurse (#5) confirmed staff should wash their hands after removing soiled gloves. - Observation on 02/03/15 at 4:32 p.m. showed two CNA's (#3 and #19) providing perineal cares to Resident #12 in bed. When finished with the perineal cares, the CNA (#3) removed his gloves, put on new gloves, applied a clean brief, then washed and sanitize his hands before leaving Resident #12's room. The CNA (#19) collected soiled items, placed them in a plastic bag, removed his gloves, then left Resident #12's room without washing or sanitizing his hands.	F 441		