STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 01/30/17 and completed on 02/02/17, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, and staff interview, the facility failed to provide care in a manner that promoted dignity for 1 of 2 sampled residents (Resident #6) with an indwelling catheter. Failure to cover the catheter drainage bag when Resident #6 was in the chair and in public areas did not enhance the resident's dignity and self-esteem. Findings include: The facility procedure titled "Catheter" occurred on 02/02/17. The procedure, revised July 2016, stated, ". . . 18. Catheter bags should be covered when up in chair and out in public. These bag covers should be changed when visibly soiled.. . . " Observations during the survey identified the following: * 01/31/17 at 12:30 p.m.: Two Certified Nursing	F 241	1) Immediately following when surveyors pointed to this issue on January 31, 2017, facility staff covered up Resident #6's catheter bag. This resident continues to have her catheter bag covered to protect her dignity. 2) All residents with a catheter have the potential to be affected by this deficient practice. The facility staff will continue to advocate for and protect resident dignity by covering catheter bags immediately, if applicable. 3) As stated previously, Resident #6's catheter bag was covered and continues to be covered. In addition, staff education will be provided on resident dignity/respect of individuality, specifically speaking to the importance of covering catheter bags. This staff education will be provided on March 9, 2017 to all staff. 4) The deficiency will be corrected by	3/9/17

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

Electronically Signed | 02/22/2017

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F 241	Continued From page 1 Assistants (CNAs) (#9 and #10) assisted Resident #6 to sit in her recliner and elevated the leg rest. The CNA (#10) attached the uncovered catheter drainage bag (with urine visible) to the leg rest, in view of any staff/visitors who might enter the resident's room. * 01/31/17 at 2:42 p.m.: Resident #6 sat in her wheel chair at a table near the nurses' station with the uncovered drainage bag attached under the wheel chair seat. * 02/01/17 at 9:15 a.m.: A CNA (#10) transported Resident #6 down the hall with the uncovered drainage bag attached under the wheel chair seat. * 02/01/17 at 12:10 p.m.: Resident #6 sat at the dining table with the uncovered drainage bag attached under her wheel chair seat. When asked, during an interview on 02/01/17 at 12:30 p.m., an administrative nurse (#4) stated the facility had covers available for the drainage bags. Failure to cover the catheter drainage bag may result in Resident #6 experiencing a loss of dignity when seated in areas where staff and/or visitors could view the uncovered bag.	F 241	thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform a dignity audit on two residents with catheter bags weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 274		3/9/17

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F 274	Continued From page 2 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 10 sampled residents (Resident #3) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015, page 2-20 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, ". . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . . A SCSA is appropriate if there are either two or more areas of decline or	F 274	1) On February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or complete a significant change in status assessment for this resident. 2) All residents have the potential to be affected by this deficient practice. At care plans, the interdisciplinary teams will discuss any changes for upcoming residents. 3) As stated previously, on February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to complete a significant change in status assessment on Resident #3. However, staff education will be provided to all staff whom complete MDS's on the rules surrounding when to complete a significant change in status assessment for a resident. This education will be held on March 8, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform a	

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F 274	Continued From page 3 two or more areas of improvement. . . . [such as] Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance . . ." Review of Resident #3's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 06/03/16, identified limited assistance with bed mobility and supervision required for transfers and locomotion on and off the unit. The quarterly MDS, dated 08/27/16, identified extensive assistance with bed mobility, transfers, and locomotion on and off the unit (a decline in four activities of daily living). During an interview on 02/01/17 at 9:30 a.m., an administrative nurse (#5) stated the facility should have considered completing a significant change MDS for Resident #3's decline.	F 274	significant change audit on two random residents weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the medical provider's orders regarding the collection of a laboratory sample for 1 of 2 sampled residents (Resident #3) on Coumadin (anticoagulant medication) therapy. Failure to implement and monitor for completion of all provider orders, including	F 281	1) On February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or more closely follow physician orders on Resident #3. 2) All residents have the potential to be affected by this deficient practice.	3/9/17

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F 281	Continued From page 4 laboratory tests, may affect the care and services provided for Resident #3 and other residents who are on anticoagulant medication. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included atrial fibrillation, heart failure, and hypertension. The current physician's orders, dated 08/23/16, identified Coumadin 3 milligrams (mg) daily. The current care plan stated, "Focus: The resident has altered cardiovascular status R/T [related to] arrhythmia E/B [evidenced by] need for Coumadin and INR [International Normalized Ratio] [used to monitor individuals treated with a blood-thinning medication like Coumadin] status. Interventions . . . Monitor/document/report INR as ordered by MD [medical doctor]. . . ." On 08/30/16 facility staff checked Resident #3's INR and faxed the result to the physician. The "IMPORTANT-RESIDENT ON ANTICOAGULANT-TIMELY RESPONSE NEEDED" fax sheet, dated 08/30/16, identified ". . . INR: 2.0 Current Coumadin Dose: 3 mg PO [by mouth] daily . . . Response by Physician: New order: Same dose Next PT [Prothrombin time]/INR: next week . . ." The medical record lacked evidence the facility staff performed the PT/INR due on 09/06/16. During an interview on 02/01/17 at 3:00 p.m., an administrative nurse (#4) confirmed the facility failed to ensure the completion of the PT/INR ordered on 08/30/16. The nurse (#4) stated Resident #3 had not had a PT/INR drawn since	F 281	Moreover, there will be a designated folder/file in the charting room for all daily orders. This folder/file must be checked by the charge nurse after each shift in order to ensure all orders were observed and following through. The charge nurse will initial each order after reviewing. 3) Staff education will be provided to licensed nursing staff on following physician orders. This staff education will be provided on March 9, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform a physician order audit on two random residents weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	

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F 281	Continued From page 5 08/30/16 (five months ago).	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: DIABETES MANAGEMENT 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #3) receiving insulin. Failure to notify the physician of the	F 309	1) On February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or re-define blood sugar reporting parameters/more accurately administer insulin for this resident. On February 6, 2017, Resident #2	3/9/17

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F 309	Continued From page 6 resident's high blood glucose levels and staff holding ordered doses of insulin; failure to assess/reassess low blood glucose levels; failure to provide interventions for low blood glucose levels; and failure to administer insulin per physician orders may result in poorly controlled diabetes and does not allow the resident to maintain the highest practicable level of physical well-being. Findings include: Review of the facility policy titled "HYPOGLYCEMIC INCIDENTS" occurred on 02/02/17. This policy, revised December 2015, stated, "PROCEDURE . . . 2. For residents with diabetes, the practitioner should be called immediately when the blood glucose value is less than 70 mg/dL and is unresponsive or has consecutive blood glucose readings less than 70 mg/dL [milligrams per deciliter]. . . . 4. Repeat blood glucose test after 15 minutes. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The care plan stated, "Focus: The resident has Diabetes Mellitus. Interventions: Monitor and document blood sugars as ordered by physician. Follow sliding scale. Notify physician as needed. . . ." The care plan failed to identify individualized parameters for physician notification. The physician's orders included the following: * 12/29/16: Novolog (a short-acting insulin) "1 unit for every 10 points of blood sugar over 150" (Order discontinued on 01/31/17). * 01/17/17: Levemir (a long-acting insulin) 30	F 309	discharged from the facility. Therefore, we are unable to correct this deficiency and/or provide more timely wound assessments for this resident. 1) All residents with diabetic care management and/or non-pressure ulcer wounds have the potential to be affected by this deficient practice. Moreover, the facility will continue to follow its current hypoglycemic procedure for all residents. For incidents involving hyperglycemia, each resident with an ordered AccuCheck will also have parameters in their medical record which indicate when to notify the physician, interventions, and insulin administration instructions. In regards to foot ulcer management/non-pressure related wounds, each RN is assigned to specific residents and are responsible to complete their weekly wound assessments. This process will ensure that wound assessments are completed in a timely manner and a designated RN is responsible for each one. 2) Staff education will be provided to licensed nursing staff on proper diabetic care management, including blood sugar parameters and wound assessment timeliness. This staff education will be provided on March 9, 2017. 3) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 4) Beginning the week of March 6, 2017, the DNS or designee will perform a blood sugar parameter as well as a wound assessment audit on two random	

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F 309	Continued From page 7 units at bedtime * 01/23/17: Novolog 60 units twice a day * 01/23/17: Novolog 70 units once a day * 01/23/17: Fax blood sugars to the physician. "May fax sooner if blood sugars are lower than 70." * Accucheck (bedside glucose monitoring) four times a day, prior to meals and at bedtime. Resident #3's prior physician orders stated, "Call MD [medical doctor] if over 400." The current physician's orders lacked individualized parameters for physician notification of high blood glucose levels. The progress notes identified the following: * 06/23/16 at 3:50 a.m.: "orange juice and slice of bread with peanut butter given for BS [blood sugar] of 42." The next blood glucose level was 81 and documented at 6:05 a.m. (2 hours later). * 09/20/16 at 8:13 p.m.: Resident #3's blood sugar was 469 at 8:13 p.m. and 486 at 9:34 p.m. "Operator at hospital states 'I do not know if [name of doctor] will talk to you or not, I can give you his number, he is not here' generally the MD is paged." The medical record lacked evidence the facility contacted the physician on Resident #3's elevated blood sugar. * 10/22/16 at 9:30 p.m.: "Novolog 20 Units per top end of sliding scale given for BS of 581 and MD on call . . . does not respond to phone call. Hospital operator unable/unwilling to page MD and something has to be done for this BS." Resident #3's blood sugar was 473 at 9:56 p.m. The medical record lacked evidence the facility contacted the physician on Resident #3's elevated blood sugar. * 10/26/16 at 2:07 p.m.: "Blood sugar 65 at this	F 309	residents weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	

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time." The medical record lacked evidence the facility provided interventions for Resident #3's low blood sugar. The next blood glucose level was 200 and documented at 4:55 p.m. (3 hours later).
* 11/14/16 at 8:40 a.m.: "Gluc [glucose] now 60. Resident's insulin given and she was eating her breakfast within 2 minutes. . . . 0930 [9:30 a.m.] gluc not done as resident had just completed breakfast at 0850 [8:50 a.m.]." The medical record lacked evidence the facility reassessed Resident #3's blood glucose level.
* 11/15/16 at 1:45 p.m.: "Resident's gluc check now only 72, even after resident ate 100% of dinner (serving of cauliflower, serving of potatoes, chicken, custard and glass of milk). Insulin held at this time." The facility staff failed to notify the physician prior to holding Resident #3's insulin.
* 11/16/16 at 2:11 p.m.: "Blood sugar is 67. Snack provided." The next blood glucose level was 190 and documented at 5:02 p.m. (3 hours later).
* 11/17/16 at 4:40 a.m.: "BS 43. Res. [resident] diaphoretic but alert. Non diabetic supplement given and will recheck." The next blood glucose level was 90 and documented at 7:56 a.m. (3 hours later).
* 11/17/16 at 3:16 p.m.: "Blood sugar only 121, insulin held." The facility staff failed to notify the physician prior to holding Resident #3's insulin.
* 11/19/16 at 5:00 a.m.: "BS this am was 64. Res. took 4 ounces of ensure clear." The next blood glucose level was 122 and documented at 7:40 a.m. (2 hours later).
* 11/26/16 at 5:53 p.m.: "Blood sugar 54." The medical record lacked evidence the facility provided interventions for Resident #3's low blood sugar. The next blood glucose level was

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271 and documented at 7:45 p.m. (1.5 hours later).
* 11/28/16 at 5:00 a.m.: "BS 64. Res. is asymptomatic. Did drink 120cc [cubic centimeters] of ensure." The next blood glucose level was 99 and documented at 7:50 a.m. (2.5 hours later).
* 12/06/16 at 10:00 p.m.: "BS 62 Snack of meat and cheese along with ensure clear." The medical record lacked evidence the facility reassessed Resident #3's blood glucose level.
* 12/10/16 at 4:23 p.m.: ". . . Resident's blood sugar only 59. Scheduled insulin and sliding scale held. Given carton of Ensure Clear and she took 100%." The facility staff failed to notify the physician prior to holding Resident #3's insulin.
* 12/10/16 at 5:45 p.m.: "Resident's gluc check only 69. Resident refused supper tray, taking only 200cc of milk. Scheduled insulin held at this time due to low blood sugar. . . ." The facility staff failed to notify the physician prior to holding Resident #3's insulin. The next blood glucose level was 78 and documented at 9:39 p.m. (3 hours later).
* 12/13/16 at 5:15 a.m.: "BS 52. Asymptomatic. Mighty shake given." The next blood glucose level was 104 and documented at 8:03 a.m. (3 hours later).
* 12/15/16 at 6:39 p.m.: "Scheduled dose of Novolog 8 units held as resident's blood sugars have been running low for her today." The facility staff failed to notify the physician prior to holding Resident #3's insulin.
* 12/20/16 at 5:20 a.m.: "BS 68 Supplement taken." The next blood glucose level was 165 and documented at 7:22 a.m. (2 hours later).
* 01/02/17 at 5:07 p.m.: Blood sugar 421 at 5:07 p.m. and 503 at 8:39 p.m. The medical record

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lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.
* 01/05/17 at 8:27 p.m.: Blood sugar 450. The medical record lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.
* 01/13/17 at 9:30 p.m.: Blood sugar 494. The medical record lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.
* 01/14/17 at 5:15 p.m.: Blood sugar 492. The medical record lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.
* 01/26/17 at 7:15 p.m.: Blood sugar 456. The medical record lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.
* 01/30/17 at 8:00 p.m.: Blood sugar 441. The medical record lacked evidence the facility updated the physician at the time of Resident #3's elevated blood sugar.

The January 2017 MAR showed Resident #3 had blood sugars of 160 and greater on 71 occasions. On 13 of the 71 occasions staff failed to administer Resident #3's sliding scale Novolog per the physician's orders, "1 unit for every 10 points of blood sugar over 150".

During an interview on 02/01/17 at 3:00 p.m., an administrative nurse (#4) stated she expected facility staff to notify physician's with Resident #3's low and high blood glucose levels and obtain a physician order prior to holding Resident #3's insulin. The nurse (#4) confirmed Resident #3's physician's orders lacked blood sugar parameters and stated the facility does not have

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F 309	Continued From page 11 a hyperglycemia (high blood glucose) policy. Facility staff failed to provide interventions for Resident #3's low blood glucose levels on two occasions; failed to reassess Resident #3's low blood glucose levels on two occasions; failed to reassess Resident #3's low blood glucose levels within 15 minutes per the facility policy on 10 occasions; failed to notify the physician prior to holding Resident #3's insulin on five occasions; failed to notify the physician of Resident #3's elevated blood sugars on eight occasions; and failed to administer Resident #3's sliding scale Novolog as ordered on thirteen occasions. These failures may result in Resident #3 experiencing complications related to her diabetes mellitus. FOOT ULCERS 2. Based on observation, record review, review of a facility document, and staff interview, the facility failed to monitor wounds in accordance with facility protocol for 1 of 1 sampled resident (Resident #2) identified with foot ulcers related to circulatory issues. Findings include: Review of an untitled document provided by the facility occurred on 02/02/17. The undated document listed types of wound assessments and stated, "Wound Data Collection . . . required at least weekly when skin integrity is impaired or open area is present . . . Wound RN [Registered Nurse] Assessment . . . Required at least every 7 days and PRN [as needed] when skin integrity is impaired or open area is present. Completed in conjunction with the Wound Data Collection. . . ."	F 309		

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F 309	Continued From page 12 On the afternoon of 01/30/17 the facility provided a list of residents with current pressure ulcers. The list included Resident #2 and identified the resident had unstageable ulcers on the left ankle and left first toe. Review of Resident #2's medical record occurred on all days of survey and identified diagnoses included diabetes mellitus. Review of Wound Data Collection Tools showed the most recent measurements as follows: * 01/14/17: left heel intact and pink (not identified on facility list) - measured 1.5 centimeters (cm.) by 3.5 cm. * 01/16/17: left second toe (identified on facility list as left first toe) 100% eschar (thick leathery dead tissue) - measured 1.6 cm. by 1.8 cm. * 01/16/17: left ankle 100% slough (moist/stringy dead tissue) - measured 3.8 cm by 3 cm. On 01/31/17 at 8:23 a.m. a registered nurse (#6) changed the dressings and measured Resident #2's wounds. Observation showed the following: * Left heel: dark purple with reddened edges - measured 4 cm. by 5 cm. * Left second toe: covered with black eschar - measured 2 centimeters (cm) * Left outer ankle: partially covered with yellow/brown slough - measured 4 cm. by 2 cm. The record indicated staff failed to measure Resident #2's ulcers for a period greater than two weeks (from 01/14/17 and 01/16/17 until 01/31/17). During that period of time, all three ulcers increased in size. During an interview on 02/01/17 at 4:21 p.m., an	F 309		

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F 309	Continued From page 13 administrative nurse (#6) confirmed staff should complete the Wound Data Collection Tool weekly, including measuring the ulcers. On the afternoon of 02/02/17, the facility provided documentation from the physician, dated 02/02/17, which stated, ". . .The open area on her (L) [left] foot (Ankle, Heel, toe) is most likely related to circulatory issues. . . ." Failure to monitor the resident's skin breakdown weekly did not allow staff to quickly identify deterioration of the ulcers. This failure may result in staff and the physician not being aware of the current condition of the ulcers and may delay treatment for deteriorating ulcers.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to provide activities of daily living (ADL) assistance to 1 of 10 sampled residents (Resident #9) who required staff assistance with bathing. Failure to provide assistance to residents who cannot perform ADLs independently may result in poor hygiene and a loss of dignity and comfort. Findings include: During an interview on the morning of 01/31/17, a family member (#1) identified concerns that staff	F 312	1) On February 7, 2017, Resident #9 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or provide activities of daily living assistance to this resident. However, the facility did provide this resident with the proper bathing assistance, both independently and with staff members. The facility failed to properly document this practice. 2) All residents have the potential to be affected by this deficient practice. Moreover, the facility will implement a	3/9/17

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F 312	Continued From page 14 has not provided Resident #9 with a shower since his admission on 01/19/17. Review of Resident #9's medical record occurred on all days of survey. Bathing records failed to show Resident #9 received a bath/shower since his admission. During an interview on 01/31/17 at 11:09 a.m., a supervisory nurse (#6) identified Resident #9's bath day was Wednesday, but he missed it due to therapy. During an interview on the morning of 02/02/17, a supervisory nurse (#4) identified residents receive a weekly bath/shower at a minimum, and staff should have reapproached Resident #9 at a later time to ensure he received his bath.	F 312	procedure in which newly admitted residents are placed on a bathing schedule immediately. A checklist for this process will be implemented in which the bath aides complete a daily listing of all baths given, refused/refused reason, complete with prior weight and current weight. This process will ensure that every resident gets on the bathing schedule and receives regular baths. 3) Staff education will be provided all nursing staff on bathing scheduling and general expectations/regulations/documentation surrounding bathing of residents. This staff education will be provided on March 9, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform a bathing audit on two random, recently-admitted residents weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		3/9/17

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F 314	Continued From page 15 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development and/or deterioration of pressure ulcers for 2 of 3 sampled residents (Resident #3 and #4) identified with a pressure ulcer. Failure to routinely assess/monitor pressure ulcers and ensure consistent implementation of interventions and treatment may result in the deterioration of existing pressure ulcers. Findings include: Review of the facility policy titled "PRESSURE ULCERS" occurred on 02/02/17. This policy, revised January 2017, stated, ". . . A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Residents will receive appropriate assessments and services to promote and maintain skin integrity. . . ."	F 314	1) On February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or provide more timely wound assessments for this resident. In regards to Resident #4, his wound has since healed and therefore no wound assessment will need to be completed. 2) All residents with pressure sores have the potential to be affected by this deficient practice. Moreover, all licensed nursing staff will know and understand how to initiate a wound data collection followed by a RN Wound Assessment. In addition, each RN is assigned to specific residents and are responsible to complete their weekly wound assessments. This will ensure wound assessments are completed and completed in a timely manner. 3) Staff education will be provided all licensed nursing staff non-pressure ulcer wound assessment timeliness. This staff education will be provided on March 9,	

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F 314	Continued From page 16 - Review of Resident #3's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/26/16, identified a Stage 4 pressure ulcer present on admission. The current care plan stated, "Focus: The resident has actual impairment to skin integrity R/T [related to] Impaired circulation, Diabetes and tendency to lay on her left side E/B [evidenced by] Stage 4 decubitus left trochanteric [hip] area. Interventions: Monitor location, size and treatment of skin injury. . . ." Review of the facility's "Wound Data Collection" forms identified the following: * 08/01/16: Left trochanter pressure ulcer measured 4.4 centimeters (cm) by 3.8 cm and 0.7 cm depth. 100% granulation and no tunneling. * 09/10/16: Left trochanter pressure ulcer measured 5 cm by 4 cm and 1.0 cm depth. 95% granulation and 5% slough with 1.3 cm tunneling at 11 to 2 o'clock. During an interview on 02/01/17 at 3:00 p.m., an administrative nurse (#4) confirmed staff failed to complete weekly pressure ulcer measurements four weeks in a row. Facility staff failed to monitor the pressure ulcer measurement for four weeks. This may have contributed to the deterioration of Resident #3's pressure ulcer. During an interview on 02/01/17 at 4:21 p.m., an administrative nurse (#6) confirmed staff should complete the Wound Data Collection Tool weekly, including measuring the ulcer.	F 314	2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform a wound assessment audit on two random residents weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	

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F 314	Continued From page 17 - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included a right femur fracture and Parkinson's disease. An admission nursing assessment, dated 01/24/17, identified a 1.5 centimeter (cm), Stage II open area to the resident's left buttock. The medical record lacked further assessments/treatments/monitoring of the pressure ulcer. On 01/31/17 at 8:20 a.m., a supervisory nurse (#6) stated Resident #4 had a Mepilex (a type of dressing) in place to his left buttock due to shearing which was present on admission. Observation of Resident #4's personal cares occurred on 01/31/17 at 12:26 p.m. The certified nursing assistants (CNAs) (#9 and #10) verified there was no Mepilex to the resident's buttocks and stated they were unaware of a pressure ulcer. During an interview on 02/02/17 at 8:16 a.m., a supervisory nurse (#6) stated staff should have gotten an order for Mepilex and added it to the treatment administration record so they could monitor the area.	F 314		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 328		3/9/17

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F 328	Continued From page 18 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 328		

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F 328	Continued From page 19 (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and review of facility policy, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #3) with physician's orders for oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and/or hospitalization related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 1259 states, ". . . Like any medication, oxygen is not completely harmless to the client. Clients can receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. . . . Excessive amounts of oxygen can lead to pulmonary tissue damage, increased duration of mechanical ventilation, and longer ICU [intensive care unit] and hospital stays. . . . The lowest concentration needed to achieve the desired blood oxygen saturation (e.g. [example given], greater than 90% or a level prescribed by the primary care provider) should be used. . . ."	F 328	1) On February 10, 2017, Resident #3 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or ensure this resident's oxygen order is upheld at all times. 2) All residents utilizing oxygen supplementation have the potential to be affected by this deficient practice. Moreover, there will be a designated folder/file in the charting room for all daily orders, including oxygen orders. This folder/file must be checked by the charge nurse after each shift in order to ensure all oxygen orders were observed and following through. The charge nurse will initial each order after reviewing. 3) Staff education will be provided all licensed nursing on the importance of providing the necessary care and services for residents with physician's orders for oxygen. This staff education will be provided on March 9, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform an oxygen order audit on two random residents weekly for one month. After that	

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F 328	Continued From page 20 Review of the facility policy titled "OXYGEN ADMINISTRATION" occurred on 02/02/17. This policy, revised July 2016, stated, ". . . Oxygen administration will be carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and be responsible for the correct administration of oxygen to the resident. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included shortness of breath. The physician orders, dated 05/27/16, stated, "Oxygen @ 2L/nc [two liters per nasal cannula] one time a day for Congestion; Cough at HS [hour of sleep] and as needed during the day." The current care plan stated, "Focus: The resident has shortness of breath R/T [related to] Hypoxia Interventions . . . Oxygen therapy 2 liters per nasal cannula. . . ." Observations showed the following: * 01/30/17 at 5:03 p.m.: Resident #3 sitting in her wheelchair wearing a nasal cannula connected to an oxygen tank set at 2 liters per minute (LPM). * 01/31/17 at 8:05 a.m.: Resident #3 sitting in her wheelchair wearing a nasal cannula connected to an oxygen tank set at 2 LPM. * 01/31/17 at 8:15 a.m.: A certified nursing assistant (CNA) (#1) transferred Resident #3 to her bed and applied a nasal cannula connected to an oxygen concentrator set at 4 LPM. * 01/31/17 at 9:05 a.m.: Resident #3 lying in bed wearing a nasal cannula connected to an oxygen concentrator set at 4 LPM. * 01/31/17 at 12:30 p.m.: A CNA (#2) and a Certified Medication Assistant (CMA) (#3) transferred Resident #3 to her recliner and	F 328	point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	

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F 328	Continued From page 21 applied a nasal cannula connected to an oxygen concentrator set at 4 LPM. * 01/31/17 at 2:31 p.m. and at 4:57 p.m.: Resident #3 sitting in her wheelchair wearing a nasal cannula connected to an oxygen tank set at 2 LPM. * 02/01/17 at 10:10 a.m.: Resident #3 sitting on her bed wearing a nasal cannula connected to an oxygen concentrator set at 4LPM. * 02/01/17 at 1:40 p.m.: Resident #3 lying in bed wearing a nasal cannula connected to an oxygen concentrator set at 4 LPM. The facility failed to consistently provide Resident #3's oxygen at the ordered flow rate.	F 328		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		3/16/17

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F 371	Continued From page 22 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's instructions, record review, and staff interview, the facility failed to ensure appropriate sanitization in food preparation/service areas in 1 of 1 facility kitchen. Failure to monitor quaternary (quat) sanitizer concentrations on a routine basis may result in improper sanitization and places residents at risk for food-borne illness. Findings include: Review of the facility policy titled "Sanitation Pots and Pans" occurred on 02/02/17. This policy, revised February 2016, stated, ". . . Sanitize . . . b. Chemical . . . The third compartment of the three compartment sink will be filled with hot water (75 degrees of per manufacturer's instructions). Sanitizing solution will be measured/dispensed according to manufacturer's instructions. . . ." The manufacturer's instructions for Ecolab Oasis 146 Multi-Quat Sanitizer identified an acceptable concentration range of 150-400 parts per million (ppm). Observation during the initial kitchen tour on 01/30/17 at 12:30 p.m. showed a three compartment sink with quat mixed in the third compartment. When asked to test the quat, a	F 371	1) The facility dietary staff procured testing strips and began performing testing every two hours, and/or every time the sink water is changed, of the third compartment of the three compartment sink on February 1, 2017. 2) All residents have the potential to be affected by this deficient practice. Facility staff will continue to monitor the sanitization of the third compartment of the three compartment sink. 3) Staff education will be provided on the three compartment sink sanitizing testing process to all dietary staff at the next dietary in-service. This staff education will be provided on March 16, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the Director of Food and Nutrition Services or designee will perform a sanitizer concentration audit weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the Director of Food and Nutrition Services or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING _____ B. WING _____	02/02/2017

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F 371	Continued From page 23 kitchen staff member (#12) identified the facility did not have testing strips and no longer tested the quat concentration. Review of the facility's logs identified staff last tested the quat on 11/02/16. During an interview on 02/02/17 at 10:23 a.m., a service provider representative (#13) identified the appropriate quat concentration should be 150-400 ppm, and staff should check the concentration at least daily to ensure adequate sanitization.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		3/9/17

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F 441	Continued From page 24 facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an	F 441		

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F 441	Continued From page 25 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, and staff interview, the facility failed to ensure staff followed appropriate infection control practices during urostomy (a surgical procedure that creates a channel for urine to drain outside the body) cares for 1 of 1 sampled resident (Resident #9) with a urostomy. Failure to follow appropriate infection control practices may result in the resident experiencing an infection of the urostomy site. Findings include: Review of the facility procedure "Catheter Drainage Bag Emptying" occurred on 02/02/17. The procedure, revised in May 2016, stated, ". . . 3. Open drainage port and allow urine to drain into measuring container placed underneath. Do not allow tip of tubing to touch side of graduate or any surface. . . . 7. Discard urine in toilet. 8. Wash and dry measuring container according to location procedure. . . ." On 02/01/17 at 8:15 a.m., observation of urostomy cares for Resident #9 showed two Certified Nursing Assistants (CNAs) (#7 and #8) assisted the resident to the bathroom. Observation showed a bedside drainage bag attached to the resident's urostomy appliance. Without prompting Resident #9 to wash his hands, the CNAs assisted him to sit on the toilet, then asked him to disconnect the bedside drainage bag from the urostomy appliance. One CNA (#8) emptied the drainage bag into a	F 441	1) On February 7, 2017, Resident #9 discharged from the facility. Therefore, we are unable to correct the deficiency for this resident and/or provide better infection control practices during catheter cares for this resident. 2) This deficiency has the potential to affect all residents, especially those with catheters. Moreover, a sign with infection control guidelines for catheter cares will be placed within each resident bathroom that has a catheter. Staff will be oriented to proper catheter cares when a resident does not have a catheter with a closed drainage system. 3) Staff education will be provided all nursing staff on safe infection control practices and practices specific to catheter cares. This staff education will be provided on March 9, 2017. 4) The deficiency will be corrected by thirty-five (35) days from the date of survey, which is March 9, 2017. 5) Beginning the week of March 6, 2017, the DNS or designee will perform an infection control audit on two random residents with catheters weekly for one month. After that point, biweekly for one month, and then monthly for four months. Progress will be measured and tracked by the QA Committee. Corrective action of issues noted in the audits will be carried out by the DNS or designee.	

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F 441	Continued From page 26 graduate (measuring container), then asked Resident #9 to stand while she emptied the urine into the toilet. During this process, the tubing from the bedside drainage bag fell to the floor and the uncovered port that connected to the urostomy appliance made contact with the floor. One CNA (#7) took the graduate used to empty the urine into the toilet, filled it with water from the sink, picked up the drainage bag from the floor, and poured the water from the graduate into the drainage bag tubing. She then rinsed the bag and placed the bag and the graduate in a cabinet in the resident's bathroom. During an interview on 02/01/17 at 12:30 p.m., an administrative nurse (#4) stated the CNAs should have disposed of the bedside drainage bag which was on the floor, reminded Resident #9 to wash his hands prior to handling the urostomy appliance, and used a clean graduate to rinse the bedside drainage bag. The staff member (#4) accompanied the surveyor to Resident #9's bathroom and disposed of the bedside drainage bag and tubing (which fell to the floor during the above observation).	F 441		