| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355101 | A. BUILDING _____ B. WING _____ | 04/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| DAKOTA ALPHA | 1303 27TH STREET NW MANDAN, ND 58554 |

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on April 14, 2014 and completed on April 16, 2014, the sample included 2 residents for complete review, 5 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey. | F 000 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to assess and implement effective approaches to manage the aggressive, inappropriate and wandering behavior of 1 of 1 sampled resident (Resident #5) identified with ineffective behavior management. Failure to adequately manage the behaviors placed staff and the residents at risk for physical and psychological injury/harm, and failed to allow the attainment of the highest level of overall well-being and preserve/promote Resident #5's dignity.<br><br>Findings include:<br><br>Review of Resident #5's medical record occurred on all days of survey. Diagnoses included | F 250 | #F250<br>For a 14-day period, one staff will be assigned per shift to observe Resident #5 every one (1) hour while Resident #5 is awake. The staff will document: any behaviors observed, the emotional state the resident is in, and describe the environment; who else is in the area, and what area of the facility the resident is in. After a week, the data collected will be evaluated, and modifications to the data collection process will be made if needed.<br><br>The data collected will be evaluated. If applicable, patterns of behavior, as well as reinforcing or aversive influences will be identified. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5-20-2014

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 250 | Continued From page 1<br>traumatic brain injury, organic personality disorder, cognitive disorder, impulse control disorder, and history of strokes.<br><br>An annual Minimum Data Set, dated 02/19/14, identified the resident usually makes self understood, usually understands others, minimal depression symptoms, no behavioral symptoms, wandering behavior with no impact on self or others, independent in ambulation and toilet use, supervision of one person for personal hygiene, occasional urinary incontinence, no bowel incontinence and no urinary or bowel training program.<br><br>The Care Area Assessment, dated 02/19/14, triggered:<br>* Mood and Behavior problems of impaired decision making, severely impaired, and "difficulty attending longer than one to two minutes on structured therapy tasks. . . . requires consistent cues to initiate and complete tasks successfully."<br>* Urinary Incontinence: ". . . occasional episodes of urinary incontinence. . . . The psychologists and psychiatrists that have worked with him in the past have attributed some of it to him getting a sexual thrill out of urinary and bowel movements. At times, he has urinated or defecated [expelled bowel movement - BM] in the sink, in the shower, in plants, outside, etc. . . . In regard to what to do when he is incontinent and in regard to checking his room to be sure he does not slip and injure himself, it will be covered. In regard to changing it, nothing can be done as [resident] has had urological work ups many times. The amount of times it occurs also varies and does not seem to increase too much over his baseline."<br>* Behavior Symptoms: ". . . is on a behavioral agreement. Staff needs to redirect him if he is in | F 250 | The information; the data collected along with past nursing, social service, and activity notes will be used to develop an appropriate Behavior Plan.<br><br>The interdisciplinary team reviews all residents nursing, therapy, social services, and dietary information on a monthly basis. Residents with a need for a formal behavior plan will be discussed, a plan formulated and the team will make recommendations for changes to the plan at intervals individually needed.<br><br>The 14-day behavior monitoring procedure will be presented to all staff at the all staff meeting on May 15, 2014. The staff will also be educated on the importance of consistency in following through with behavior plans on all shifts, as well as tracking behaviors as they arise. | |

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| F 250 | Continued From page 2<br>an area that he's not supposed to be in and/or if he takes something that doesn't belong to him. . . . continues to be monitored by . . . consulting psychiatrist . . . consulting psychologist . . . LSW [licensed social worker]."<br><br>Resident #5's current care plan identified problems and interventions, effective date of 11/23/13, regarding behaviors:<br>* "I have incontinence that is more related to masturbation and self stimulation than urinary problems. I also sometimes choose to have a BM in my room on the floor instead of using the toilet" with interventions of "I have signs posted in my room as a reminder to go into the bathroom to use the bathroom. I have had my flooring replaced due to urinating in my room and the odor that it has caused. The housekeeper scrubs my room and the bathroom daily but cannot keep up with my behaviors. It is the recommendation of my psychologist that I help with cleaning if I urinate in my room. The staff needs to assist as I am not thorough enough on my own and my attention span does not allow me to carry through on tasks."<br>* "I have downloaded 'kiddie porn' on the computer and have also tried to buy things with a made up credit card number (fraud) so I am not allowed to be on the internet unsupervised." with an intervention of "I have my own computer which does not have internet access that I can play computer games on. I haven't been very interested in playing games on it for the past few months." Revised on 03/06/2014<br>* " I have 'sweaty' feet and I frequently urinate in my shoes which causes my feet to be wet frequently. . . My shoes also need to be washed frequently/replaced frequently and sprayed with a deodorizing/drying agent nightly." with an | F 250 | A 7 day tracking period will be done 1 month following the implementation of a new behavior plan and the interdisciplinary team will evaluate the effectiveness.<br><br>If the plan is successful in addressing the objective, it will continue as written until it's re-evaluated. If not, the plan will be modified.<br><br>The process will be implemented and staff meeting will be completed by 5/21/2014.<br><br>Residents with a Behavior Plan will be reviewed by the interdisciplinary team on a weekly basis for 4 weeks, and then monthly for the remainder of a 6 month period. The social worker will report the review and revision results at the Q.A. meeting on a quarterly basis. | 5/21/14 |

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| F 250 | Continued From page 3<br>intervention of "My shoes should be inspected daily to see if they need to be washed. . . . I should have my shoes replaced at least every 6 months. . . ."<br>* "I need leisure interest to occupy my time. . . ." with an intervention of "Staff will continue to offer suggestions/ideas of things to do in my free time. I am easily distracted so I may need help with staying on task. I continue to enjoy music, TV/movies, Wii, crafts, bingo, cards, shopping, and other supervised community outings." Revised on 03/04/2014<br>* "I sometimes go into others' rooms or areas that are not my own and steal other's belongings (movies, CD's, gum, keys, money). Other residents are angry at me when I take things that are not mine. Sometimes these items are dangerous such as scissors and razors. I sometimes hide them in my closet or the drop ceiling." Revised on 03/06/2014<br>* "I masturbate frequently in inappropriate/public places" with an intervention of "I will be redirected by staff to a private area (my room) if they notice me masturbating in public areas or inappropriate places."<br><br>Resident #5's "Room Care Plan," dated 03/05/2014, stated: "Toileting & PeriCare, Check room frequently for incontinence of bowel. He is usually continent of urine during the day hours. He is occasionally incontinent of urine during the night. When [resident] is incontinent of urine he is encouraged to do as much of the clean up per self as he is able. Constant staff supervision and step by step direction is required to keep [resident] on task as he is easily distracted." The plan stated to "Monitor [resident] for antagonizing male peers. Redirect as needed and encourage to go to a 'cool down' areas if engaged in conflict | F 250 | | |

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| F 250 | Continued From page 4<br>with peers. Encourage him to masturbate in his room, instead of public areas."<br><br>A "Behavior Agreement," dated 07/12/13, signed by Resident #5 and the LSW, stated "I, [resident name], agree to the following for my safety and the safety of other residents . . . This will also help me improve the quality of my life." The agreement included talking to staff when upset with another resident; not entering other resident rooms or staff areas unless invited; not taking things that do not belong to him; sexual behavior only in privacy of his room; urinating and having BMS only in a toilet; not possessing sexual or violent items; and cooperating with other residents while watching TV and not changing the channel without permission. The agreement included incentives of money, and rewards.<br><br>A revised Behavior agreement, unsigned and undated, included some of the same as above, but also listed consequences including cleaning up urine and BM "with staff supervision/assistance" and the loss of privileges of watching TV for a half hour if changing TV channels in the lounge without permission. Incentives for the agreement included "At least once per shift, staff will 'catch me doing something good,' and give me verbal praise for this" and "As staff is available, I will choose a simple one-on-one outing . . ."<br><br>Review of Resident #5's daily activities roster for January and February 2014 showed the resident's primary activities included, almost daily, television, socializing, music, exercise/walking, and video games/computer. The calendar identified other less than weekly activities. | F 250 | | |

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| F 250 | Continued From page 5<br>Progress notes identified the following behaviors:<br>* 09/23/13, untimed, had a brief altercation with another resident (unidentified) and no injury occurred. When the surveyor requested the incident report, no additional information was provided<br>* 11/24/13: argued with another peer (unidentified) before supper regarding the television<br>* 12/01/13 at 5:30 p.m.: tried to hit one of the staff and was asked to stay in his room until calmed down. A December monthly summary included additional information of turning the TV on and off when other residents were watching it<br>* A December 2013 and January 2014 monthly summary stated masturbates frequently and comes out of the room or stands in public places with exposure; is incontinent while in bed and onto clothes, will not get up and go to the bathroom, and stands by the side of bed and urinates<br>* A February 2014 monthly summary identified incontinence of BM and the BM throughout his room<br>* 02/24/14: a facility wide room search for missing items and found multiple DVDs, a CD, books, a box cutter, and medical scissors in Resident #5's room<br>* 02/28/14 and 03/05/14: went to another resident's room without permission and was told not to do that again<br>* 03/05/14: identified the resident still doing some "stealing" of other residents stuff and facility items<br>* 03/21/14: Sexually inappropriate to staff in dining room; exposed his private parts and staff redirected<br>* 04/01/14: Sitting in living room masturbating - redirected to room | F 250 | | |

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| F 250 | Continued From page 6<br>Review of "Social Service Notes" dated 03/13/14 through 04/15/14 lacked documentation of the approaches/interventions for identified behaviors and an evaluation of their effectiveness.<br><br>On the morning of 04/16/14, a supervisory social services staff member (#7) stated the facility has no behavior monitoring or management policy, protocol or procedure. The staff member provided the following information:<br>* Resident #5 has a short attention span; urinates and has BMs on the floor between the bed and the wall, and this worsens when the resident is unable to go outdoors<br>* the facility had not conducted a formal evaluation of Resident #5's behavior patterns including analyzing the behavior including the precipitating factor to each behavior, and develop interventions and evaluate the interventions for success; the psychologist indicated the picking up other resident's belongings from rooms will remain a struggle for the resident for the rest of his life; stressed the psychiatrist performs the assessments of the resident's behavior; at weekly team meetings, the behaviors are discussed, but could not provide documentation from the meetings; nothing can be done except change the behavior agreement, although agreed the behavior agreement has not been effective<br><br>Failure to assess causative factors for behaviors, track, and trend behaviors, establish an individualized behavior management program, monitor behaviors, communicate interventions, and evaluate for effectiveness placed Resident #5 and other residents at risk of physical harm. This failure contributed to Resident #5 not receiving the highest level of physical, mental and psychosocial well-being. | F 250 | | |

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| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/08/13.<br><br>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), review of | F 278 | F-278<br>For the Resident's #4, #6, and #7, a modification was sent of H0500 on their last MDS to CMS and the state to indicate they are not on a bowel program. We will no longer code a bowel program on further residents with a neurogenic bowel diagnosis. For other residents who have bowel program reported on their MDS, a modification to CMS and the state was sent for section H0500.<br><br>The Social Worker will double check Section H for accuracy on all MDS's for the next 6 months and report the results to the Q.A. committee to assure that a bowel program is not coded in any subsequent MDS. | |

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| F 278 | Continued From page 8<br>facility policy, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the residents' status for 3 of 3 sampled residents (Resident #4, #6, and #7) identified on a bowel training program, and 1 of 1 sampled resident (Resident #2) identified with delusions. Failure to accurately assess and code the MDS may affect the level of care provided to residents.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, version 3.0, October 2013, pages E-1 and E-2, stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . ."<br><br>The Long-Term Care Facility RAI User's Manual, page H-11 and H-12, stated, ". . . Bowel Toileting Program . . . A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences of incontinence . . . scheduled times to attempt bowel movement . . . Steps for Assessment . . . Look for documentation . . . showing that the following three requirements have been met: implementation of an individualized, resident specific bowel training program based on an assessment of the resident's unique bowel pattern; evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and | F 278 | Resident #2's 3/14/14 MDS was corrected and resubmitted removing the delusion from it. All other residents' charts were reviewed and no other residents had delusions charted on their MDS.<br><br>As a result we have had a nurse's meeting to instruct the CNA's and nurses that CNA's who observe hallucinatory and delusionary behaviors of the need to alert the nurses to the behavior and nurses need to observe and chart it so there is charting by those who are trained observers. Social worker documentation is also allowed and we have instructed the social worker to be on the alert to follow up on notations by the CNA's and nurses when delusions and hallucinations occur. A reminder note has also been placed on the computer where the CNA's do their POC charting for them to notify the nurse and social worker for follow up. | |

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| F 278 | Continued From page 9<br>written report; and notations of the resident's response to the toileting program and subsequent evaluations, as needed. . . ."<br><br>Review of the facility policy "BOWEL TRAINING PROGRAM" occurred on 04/16/14. The policy, undated, stated, "Upon admission, each resident is assessed by nursing staff to see if they are having regular bowel movements. . . . Our medical director writes orders for a bowel program for residents who have neurogenic bowel conditions due to medical concerns; those residents are likely not to have improvement in the need for a bowel program. . . . After each program is established, re-evaluation of the program is necessary at individualized times."<br><br>- Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses included traumatic brain injury (TBI), neurogenic bowel and bladder, expressive aphasia (disturbance in comprehending and formulating language) and cognitive deficits related to the TBI.<br><br>Resident #4's most recent MDS, dated 03/07/14, and admission MDS, dated 12/30/13, identified Resident #4 on a bowel toileting program.<br><br>Resident #4's current care plan identified the problem (focus) of "I have bowel incontinence r/t [related to] neurogenic bowel . . ." and interventions included "I will be on a bowel program three days a week with a suppository to avoid constant stooling which was a problem at my previous nursing home. I can indicate that I need to use the bathroom sometimes by putting my right hand under my thigh. This sign also can indicate that I have muscle spasms so you need | F 278 | The social worker will check for the necessary charting on E0100A on the MDS before coding it and the MDS coordinator will report on the accuracy of this section to the Q.A. committee for the next 6 months of all residents who have MDS's done. | 5/21/14 |

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| F 278 | Continued From page 10<br>to ask me which need I am trying to indicate."<br><br>Resident #4's "Room Care Plan" stated, "Toileting & [and] PeriCare: . . . Toileting: Is incontinent of urine and BM [bowel movement]. Can sit on the toilet with use of PAL [stand lift], and may go sometimes. Wears med [medium] attends. Has Bowel program 3x [three times] a week."<br><br>Resident #4's "March Monthly Summary" dated April 2014, stated, ". . . is incontinent of both bowel and bladder. [Resident] does receive a dulcolax supp [suppository] 3x/week, and when he is placed on the toilet after suppository, he will have a BM on the toilet . . ."<br><br>- Review of Resident #7's medical record occurred on 04/16/14. Medical diagnoses included TBI and neurogenic bowel.<br><br>Resident #7's most recent annual MDS, dated 02/06/14, and quarterly MDSs, dated 11/06/13, 08/07/13, and 05/08/13, identified Resident #7 on a bowel training program.<br><br>Resident #7's current care plan identified the problem of "I have bowel incontinence r/t neurogenic bowel . . ." and interventions included "Staff will give me a glycerine suppository three times weekly and chart the results. This will keep me regular and avoid frequent stooling without emptying my bowel. I have hemorrhoids and glycerine suppositories are easier on my hemorrhoids than other types. . . ."<br><br>During interview on the morning of 04/16/14, an administrative staff (#2) stated bowel assessments are not completed on residents with neurogenic bowel. The staff stated Resident #4 is | F 278 | | |

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| F 278 | Continued From page 11 | F 278 | | |

not appropriate for a bowel program. The staff stated resident BM records are reviewed for evidence of the resident's response to the toileting program.

- Review of Resident #6's medical record occurred on 04/16/14 and diagnoses included quadriplegia and neurogenic bowel and bladder. The resident's quarterly MDS, dated 04/04/14, and admission MDSs, dated 01/16/14 and 12/26/13, identified Resident #6 on a bowel toileting program.

Resident #6's current care plan stated, "Focus: I have a neurogenic bowel due to my . . . spinal cord injury . . . Goals: I will have regular bowel movements with no accidents by review date . . . Interventions: My bowel program is done by nursing staff every Monday, Wednesday, and Friday. . . ."

Resident #6's "February Nursing Summary," dated 02/28/14, stated, ". . . Bowel and Bladder Issues . . . Due to neurogenic bowel, [Resident #6] is on 1/2 Fleets enema rectally, Monday, Wednesdays, and Fridays for bowel program. [Resident #6] refused fleets enema once this month. [Resident #6] is also on Miralax powder 17 gm [grams] PO [by mouth] M-W-F [Monday, Wednesday, Friday]. [Resident #6] wears a brief due to bowel incontinence. Staff takes him to sit in the toilet right after he gets fleets enema and [he] does not make to the toilet at times. . . ."

During an interview on the morning of 04/16/14, an administrative nurse (#2) stated she did not assess Resident #6's bowel pattern due to his diagnosis of neurogenic bowel and identified the resident chose when staff administered the

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| F 278 | Continued From page 12<br>medications used for his bowel program and when staff toileted him.<br><br>The facility failed to implement individualized, resident-specific toileting programs, periodically evaluate the effectiveness of these specific toileting times, and make revisions to the program, if needed, based on an assessment of Resident #4, #6, and #7's unique bowel pattern.<br><br>- Review of Resident #2's medical record occurred on April 14-15, 2014 and diagnoses included a mood disorder, personality disorder, depression, anxiety, hydrocephalus, and a traumatic brain injury. The quarterly MDS, dated 03/04/14, and the readmission MDS, dated 12/13/13, identified the resident had delusions during the look back periods. The resident's medical record lacked evidence to support the coding of the delusions on both MDSs.<br><br>During an interview on 04/15/14 at 2:45 p.m., a social services staff member (#7) confirmed Resident #2's record lacked evidence to support the coding of the delusions on the quarterly MDS, dated 03/04/14, and the readmission MDS, dated 12/13/13. | F 278 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, review of professional reference, and staff | F 281 | | |

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| F 281 | Continued From page 13<br>interview, the facility failed to ensure competency of 1 of 1 staff nurse (A) observed setting up the suction machine. Staff's lack of knowledge on setting up the suction machine in case of an emergency situation placed residents at risk for choking and aspiration.<br><br>Findings include:<br><br>Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 1406-1407, states, ". . . Suctioning . . . When clients have difficulty handling their secretions or an artificial airway is in place, suctioning may be necessary to clear air passages . . . The nurse decides when suctioning is needed by assessing the client for signs of respiratory distress or evidence that the client is unable to cough up and expectorate secretions. Dyspnea, bubbling or rattling breath sounds, poor skin color . . . or decreased oxygen saturation . . . levels . . . may indicate the need for suctioning. . . ."<br><br>Review of the facility policy titled "Portable Suction" occurred on 04/16/14. This policy, dated July 2013, stated, "Suction education is done once a year and the following steps must be completed to pass education requirement.<br>1. Connect either end of the tubing to the tubing connector then connect the other end to the filter. Ensure that the clear side of the filter is toward elbow and bottle when installing/re-installing. Do not reverse direction of filter.<br>2. The filter should then be connected to the 90 [degree] elbow connection, and the 90 [degree] connection should be connected to the top of the canister lid where it says 'Vacuum.' | F 281 | F-281<br>Education on proper use of the suction machine is provided on a yearly basis. The next scheduled in-service is due in July of 2014, however it has been rescheduled for May 15, 2014. All nurses and CNA's are required to attend this in-service and if they are not able to attend, they will have a 1:1 in-service with the DON within the next week that they work. A memo to travel nurses to review the suction machine protocol was attached to the front of the nurse report book so travel nurses who do not attend our in-services are reminded to check the protocol.<br><br>The suction machine will be kept set up within a plastic bag that is secured and dated so it will be ready at all times. A laminated instruction card will also be placed with the suction machine that addresses the step-by-step set up process. If the machine is used, it will be taken apart for cleaning and re-assembled using the instructions and tested to be sure it is assembled correctly. | |

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| F 281 | Continued From page 14<br>3. The patient tubing should be connected to the canister lid at the outlet labeled 'Patient.'<br>4. Please assure that all connections are secure and without leaks before using.<br>5. Verify that unit is at desired suction level before beginning patient suction. . . ."<br><br>Observations and record review during the week of survey identified residents at risk for choking and aspiration, including those with traumatic brain injuries, excessive drooling, dysphagia, and enteral nutrition via gastrostomy tubes.<br><br>Observation on the morning of 04/16/14 identified a nurse (A) attempted to set up the emergency suction machine. The nurse incorrectly hooked one end of the suction tubing to the filter attached directly to the machine and the other end to the canister lid. After seeing the connection was incorrect, the nurse (A) unhooked the tubing and then attached it only to the filter directly on the machine. The nurse (A) then attached a suction catheter to the other end of the tubing and began to suction water into the machine. Since the tubing was not connected to the actual suction canister itself, water was being suctioned directly into the internal components of the machine. After the third attempt, the nurse (A) correctly set up the suction machine.<br><br>During an interview on the morning of 04/16/14, the nurse (A) stated she received annual training on emergency procedures, including the suction machine, but stated it had been "years" since she actually had to use it. | F 281 | The nurse who did not accurately assemble the suction machine when asked will be tested on ability of setting up the suction machine after in-service is given to ensure accurate assembly.<br><br>The DON will do weekly checks to make sure the suction machine is assembled and operable weekly for 4 weeks and monthly for 6 months reporting results to the Q.A. committee. | 5/21/14 |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS | F 322 | | |

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| F 322 | Continued From page 15<br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and<br><br>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and professional reference review, the facility failed to provide the appropriate treatment and services necessary for 1 of 1 sampled resident (Resident #1) observed receiving medications and a bolus feeding via gastrostomy tube. Failure to limit the amount of air in the stomach during feedings and medication administration may result in avoidable discomfort and stomach distention.<br><br>Findings include:<br><br>Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., | F 322 | F-322<br>A review of the protocol for tube feedings including clamping/kinking the tubing between medications/feedings to decrease the amount of free air was discussed. Nurses were educated on the need to follow the protocol when feeding Resident #1 as well as other residents having nasogastric treatments. All nurses including those who were unable to attend signed off on the in-service minutes. A memo to travel nurses to review the tube feeding protocol was attached to the front of the nurse report book so travel nurses who do not attend our in-services are reminded to check the protocol.<br><br>The DON will "spot check" nurse's performing tube feedings on random resident's who receive nasogastric treatments two times per week each full week of May, 2014. Making sure to address all residents with nasogastric treatments. By May 31, 2014 8 checks will be done. | |

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| F 322 | Continued From page 16<br>New Jersey, page 871, states, ". . . Administering Medications by . . . Gastrostomy Tube . . . When administering the medication(s):<br>Remove the plunger from the syringe and connect the syringe to a pinched or kinked tube. Rationale: Pinching or kinking the tube prevents excess air from entering the stomach and causing distention.<br>Put 15 to 30 mL [milliliter] . . . of water into the syringe barrel to flush the tube before administering the first medication. Raise or lower the barrel of the syringe to adjust the flow as needed. Pinch or clamp the tubing before all the water is instilled to avoid excess air entering the stomach. . . ." Page 1292 states, ". . .<br>Administering a Tube Feeding . . . Syringe (Open System) . . .<br>Remove the plunger from the syringe and connect the syringe to a pinched or clamped . . . tube. Rationale: Pinching or clamping the tube prevents excess air from entering the stomach and causing distention.<br>Add the feeding to the syringe barrel.<br>Permit the feeding to flow in slowly at the prescribed rate. Raise or lower the syringe to adjust the flow as needed. Pinch or clamp the tubing to stop the flow for a minute if the client experiences discomfort.<br>Rationale: Quickly administered feedings can cause flatus, cramps, and/or vomiting. . . ."<br><br>Review of Resident #1's medical record occurred on April 14-15, 2014 and diagnoses included traumatic brain injury, dysphagia, and chronic diarrhea. The current "Room Care Plan" stated, ". . . Meals: as of now he has a G [gastrostomy] tube and gets feedings throughout the day. . . ."<br><br>Observation on 04/15/14 at 12:30 p.m. identified | F 322 | If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2014). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. The DON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached. | 05/21/14 |

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| F 322 | Continued From page 17<br>a nurse (#9) administered Resident #1's medications and a bolus feeding via his gastrostomy tube. During the observation, the nurse (#9) failed to clamp the tube in between each administration of medication, water flush, and feeding, allowing excess air to freely enter the gastrostomy tube and stomach. The nurse (#9) clamped the gastrostomy tube and capped the opening once she completed administration. | F 322 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide adequate supervision and assistance devices necessary to prevent accidents for 4 of 5 sampled residents (Resident #2, #3, #4 and #5) who experienced injuries with falls. Failure to develop goals and a plan of care in order to reduce the risk of accidents, implement measures consistent with each resident's needs, and evaluate those measures, resulted in injuries to each resident.<br><br>Findings include:<br><br>- Review of Resident #4's medical record occurred on all days of survey. Resident #4's | F 323 | **F323:**<br>Resident #4: We have tracked falls and have re-assessed his fall risk status. His alertness has changed since admission and he is seeking to get out of bed/his chair more than he had before. Resident #4 is using the side rail as an assistive device when the staff asks him to use it; he is able to move away from it and is not at risk of entrapment.<br><br>His bed is to be in lowest position when he is in bed and the fall mat is to be beside the bed whenever he is in it so if he does manage to get out of bed, it | |

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| F 323 | Continued From page 18<br>admission occurred in December 2013. Medical diagnoses included traumatic brain injury (TBI) and spastic hemiplegia (paralysis) of the left side.<br><br>Resident #4's admission Minimum Data Set (MDS), dated 12/30/13, identified the facility was unable to determine if falls occurred prior to admission (Resident #4 transferred from another long-term care facility). A quarterly MDS, dated 03/07/14, identified Resident #4 experienced falls since admission, one with no injury and one with minor injury. A fall risk assessment, dated 12/20/13, identified Resident #4 at low risk for falls.<br><br>Review of the Care Area Assessment (CAA), dated 12/30/13, identified the following regarding Resident #4's fall risks:<br>* Difficulty maintaining sitting balance<br>* Gait problem, such as unsteady gait<br>* Impaired balance during transitions<br>* Cognitive, visual and hearing impairment<br>* Neuromuscular/functional impairment including Hemiplegia/Hemiparesis, TBI, and muscle weakness<br>The CAA stated the resident's "Falls - Functional Status" ". . . will be addressed to avoid any future falls and to continuously keep the risk of falls as low as possible."<br><br>Resident #4's current care plan identified the following:<br>* requirements for staff assistance for performing Activities of Daily Living (ADL's) which included "I require maximal assistance of 2 staff or use of Hoyer lift [full body lift] for transfers. . . . I require maximal assistance of 1-2 staff to reposition in bed and turn in bed. . . . I am dependent on staff to provide a bath/shower three times a week, and | F 323 | will decrease the chances of him getting injured.<br><br>These measures have been put into his care plan, discussed with the CNA's and nurses via the nurse's and CNA report book and put on the room care plan.<br><br>We will track further falls to see if the measures have been effective. Resident #4 uses varied methods of transfer depending on his level of alertness at that particular time. His level of alertness varies hour by hour depending on any number of factors. The licensed nursing staff will assess resident prior to transfer to determine correct transferring method. This will also be put on the care plan. His safety will be the primary determining factor in what type of assistance to transfer will be used.<br><br>His level of assistance with his ADL's also varies with his level of alertness and cooperation | |

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| F 323 | Continued From page 19<br>as necessary."<br>* "I have Hemiplegia [total paralysis of one arm, leg and trunk on one side of the body] /Hemiparesis [weakness of one side of the body]" with no interventions identified<br>* "I have limited physical mobility . . ." with interventions of "At the present time, I am not able to use my wheelchair very effectively for long distances so the staff needs to push me. I can use one side of my body for very short distances with cuing and assistance. I need to have a head rest as I am not able to hold my head up at all times. I am working on increased independence in therapies."<br>The care plan failed to address the resident's potential for falls and approaches or interventions for keeping the risk of falls as low as possible.<br><br>Review of the "Room Care Plan" provided to direct care staff included ADL assistance of showers for bathing on Mondays, Wednesday, and Fridays; mobility and transfer assistance of "PAL [stand lift] staff assistance" and "While in bed [residents's] bed should be in the low position."<br><br>Resident #4's progress notes identified two falls which occurred in March 2014. "Reportable Event" reports identified the following:<br>* 03/05/14: A fall which occurred while "OT (occupational therapy) assisting resident at completing a shower. Resident was sitting in shower chair & began to lean forward in a flexed posture. Resident continues to lean forward as OT attempted to bring resident back to a seated position at neutral. However, secondary to momentum of leaning forward, OT unable to prevent fall. Resident fell forward off of shower chair, hitting [left] knee & middle of forehead on | F 323 | with the staff; this will all need to be assessed on a task by task basis with licensed nursing staff.<br><br>The lack of seat belt mentioned on the deficiency statement had been remedied before the end of survey. Seatbelt assessment was completed. The use of seatbelt is on the care plan. Resident #4 can open the seatbelt himself.<br><br>Resident #3: Resident #3 had been re-evaluated by PT for a fall risk assessment using the Berg balance test on 2/3/14, on 3/7/14 and 3/14/14. It was repeated again today (5/5) and he scored 53/56. | |

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| F 323 | Continued From page 20<br>shower wall/floor. OT assessed pt. [patient] for alertness, assisted resident to seated position on shower room floor and notified staff via call light regarding fall & assistance needed from thereafter." A reportable event form identified injury as a red area to the forehead, and an abrasion to the left knee and asked "What could you have done to prevent incident from occurring? Continued to verbally encourage resident to sit upright, lean back, etc. In the future, could benefit from appropriate fitted shower chair." An administrative review stated, "Educated staff to call for help when needed prior to fall occurring" and "Minor abrasions - ? [questionably] need to have a belt for back-up when resident less responsive."<br>* 03/14/14: "Around 1600 [4:00 p.m.], nurse found [resident] lying down on floor [with] his back down and his head under the bed. Bed was raised up at that time. . . . No physical injuries noted . . . CNA's [certified nursing assistants] stated they had toileted [resident] around [2:30 p.m.] and had the bed in it's lowest position." An administrative review stated, "Remind all staff that bed needs to be in lowest position. No injuries noted. . . . should have seatbelt on when in chair and bed in low position so if rolls out, has short distance to roll."<br><br>During interview on the afternoon of 04/15/14, an administrative staff (#3) stated, regarding Resident #4's fall from the bed, another resident (Resident #5) may have raised the bed to the up position as Resident #5 was seen in the hallway about that time (Resident #5's room is located in the same unit). When asked how to prevent this from re-occurring, the staff stated they would "re-direct him out." The administrative review of this fall failed to identify Resident #5's | F 323 | On 3/7, when the Berg balance test was 39, assistance with walking was suggested and transfers to bed and toileting were reviewed. The resident refused the use of a walker or wheelchair. We have consistently offered suggestions to Resident #3 for interventions after evaluating him when he falls, but they are not always followed by him. His family has attempted to get him to follow the suggestions also, with limited success. We have also had him evaluated by medical professionals but they have not found a cause for the falls. We have tested his blood sugars which usually are not low at the time of the falls. We insist he uses the wheelchair to go out to smoke when the weather is inclement or he does not get his cigarettes which are dispensed from the nurse's station (this was with his guardian's permission). We check his blood pressure daily to see that he has normotensive blood pressures and check after each | |

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| F 323 | Continued From page 21<br>involvement. When asked who performed Resident #4's bathing, the staff (#3) stated OT performs the bathing, unless they are off-duty, and then the CNAs are expected to complete the bathing in the shower.<br><br>A physical therapy progress note, dated 03/31/14, stated, ". . . seating posture looked good with the exception of his head falling forward; because of his inability to hold his head up he was put back in the reclining wheelchair. . . ." During observation of a stand lift transfer at 1:00 p.m. and 4:00 p.m. on the afternoon of 04/14/14, Resident #4's head fell forward with movement to the standing position. During the observation at 4:00 p.m., observation showed right leg spasticy once staff positioned the resident in bed.<br><br>Observation on all days of survey identified a half rail on the exit side (right) on Resident #4's bed. Observation on 04/14/14 did not show Resident #4 access the rail for repositioning. A "Review for Use of Side Rails," dated 12/20/13 and 03/07/14, identified the following regarding Resident #4's side rails:<br>* Unable to transfer independently in/out of bed safely<br>* Reason for side rail use as "Assistance in bed mobility/Turning"<br>* Unable to cognitively move the side rail up/down independently<br>* Not requested by the resident (or family)<br>* Side rail use effective<br>* Recommended continued use of the side rails<br>* The team decision is care planned<br>The team failed to address the risk of the side rail use for Resident #4 in consideration of the resident's need for extensive assistance with all ADL's, limited physical mobility related to his | F 323 | fall to see if it is a hypotensive incident (if he allows it to be taken), we continue to investigate each fall for the cause and attempt to eliminate the cause and track and trend the falls. The above measures have been put on the care plan and his room care plan.<br><br>Resident # 5: The room care plan has been amended to include reminding or assisting the resident to put his brace and shoes on before going to breakfast each morning to decrease the possibility of him falling due to his shoes slipping.<br><br>It also has been added to remind Resident #5 to slow his pace when he is seen walking faster than he is capable of doing so safely.<br><br>Resident #2: The care plan for Resident #2 was amended to state that she needs to be toileted every four hours after she is put to bed for the night at a minimum and that she should be checked on every two hours to | |

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| F 323 | Continued From page 22<br>physical condition including hemiplegia, and spasticy. The team failed to re-address the side rail use following Resident #4's fall from the bed as a potential entrapment hazard on 03/14/14.<br><br>Observation on the morning of 04/15/14 showed Resident #4 sat in a high backed wheelchair slightly tilted back while receiving speech therapy. The speech therapist (#11) indicated the wheelchair should have a seat belt and called upon a physical therapist (#12) who confirmed this and said the wheelchair had been put in place a week ago. The therapist lacked knowledge of how to attach a seat belt on the wheelchair.<br><br>The facility failed to re-assess Resident #4's risk for falls and injury following two falls, including re-assessing the use of the side rails after the fall from the bed, develop preventative measures to prevent additional falls, and implement and communicate measures considered after each fall. This limits the facility's ability to re-evaluate measures for effectiveness. Inconsistencies in the plan of care (Hoyer lift verses PAL lift for transfers) or lack of measures to address each risk factor placed Resident #4 at risk for additional falls and injury.<br><br>- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, impulse control disorder, and legal blindness.<br><br>Review of Resident #3's annual MDS, dated 11/02/13, and current quarterly MDS, dated 02/02/14, identified symptoms of inattention and disorganized thinking as a fluctuating behavior. The CAA, written for the annual MDS, stated, ". . . | F 323 | assure that she does not try to get out of bed. If she does not want to get up to toilet, staff should check to see if her incontinence product is wet and change it so she does not have a reason to attempt to get out of bed. Staff will have a nighttime toileting schedule to complete to track when this is done to see if there is a pattern of her getting up. Her room care plan was also changed to reflect the above.<br><br>We will be able to track and trend from this if falls are decreasing from this toileting schedule. Her bed continues to be in the lowest position when she is in bed and her bed alarm is connected into the call light system. Her bedroom is the closest to the health station so she can easily be heard if she calls out as she usually does instead of using her call light.<br><br>A formal fall prevention policy and procedure will be developed to ensure all residents have a consistent procedure to be followed to assess, evaluate and track fall risks, develop | |

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| F 323 | Continued From page 23<br>He has falls on occasion and he had one fall in this quarter when he tripped over his feet while following staff after coming back from the bathroom while he was in a hurry to rejoin his fellow residents . . . This could also be in part due to his legal blindness. . . . is unsteady; . . ."<br><br>A fall risk assessment completed on 11/07/13, and completed on 02/07/14 indicated Resident #3 as a low risk for falls. The record lacked a re-evaluation of the resident's fall risk following five falls between 02/14/14 and 03/26/14.<br><br>Resident #3's current care plan addressed the problem of "one fall with no injury within the past quarter" with interventions of working with PT on balance and strengthening." The "Room Care Plan" identified the resident walks per self without assistance devices; and "Due to visual deficits avoid changes to [resident's] physical environment." The care plan lacked interventions regarding the resident's vision in relation to falls, and interventions for ensuring staff and family were aware of the hazard risk of his ambulating on uneven surfaces.<br><br>Nursing progress notes identified the following:<br>* 09/26/13: "Walking in living room D [with] a staff member laughing and joking around he lost his balance and tripped over his own feet, landed on buttocks. Assessed for injury and none noted. . . . Make sure he is concentrating on walking"<br>* 11/01/13: "I am legally blind. . . . I can see a little more than shadows but I recognize people more by their voices. This is a problem when I walk over uneven terrain when I am out on pass so whoever is with me should alert me to changes in where I am walking."<br>* 02/14/14: A fall on the ice which resulted in two | F 323 | interventions to prevent them, monitor for effectiveness of interventions and follow up to evaluate and update plans. (See Appendix "C") Fall Risk Assessment.<br><br>The fall committee will meet on a monthly basis to discuss the falls for that month and the causes to see if care plans were followed, if additions, changes need to be made and what evaluations, etc. need to be redone. Committee actions will be reported to the Q.A. committee quarterly by the O.T., and we will continue this for a year with re-evaluation after 6 months.<br><br>During the quarterly Q.A. meetings, falls are always enumerated according to number but the committee will determine what information will be needed to be reported from then on to decrease the falls by 50% by the end of the year. | |

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| F 323 | Continued From page 24<br>rib fractures. The facility attributed the fall to decreased attention and debility.<br>* 03/02/14: ". . . return to facility accompanied by his mom at 7 p.m. Mom stated [resident] has fallen [at] 3 times [at] home when his [left] knee gives out. Mom stated [resident] caught himself and did not hit his head during the falls. [Resident] stated 'His left knee hurts and is giving him some problems. . . . No injury or swelling noted. . . ."<br>* 03/24/14: "Resident walking out of health station. Stated that he tripped over his own feet, landing on buttocks, did not hit head, no bumps or bruises . . . Ambulates [without] problems . . ."<br><br>An administrative staff member (#2) provided the investigation of the 09/26/13 fall on the morning of 04/16/14. The staff member stated no investigation would be completed by the facility for falls occurring outside of the facility. Failure to assist Resident #3's family with interventions to reduce the resident's fall risk when out on pass placed the resident at risk of falls and may have resulted in falls with harm on 03/02/14. The staff member (#2) provided no additional information regarding the fall on 03/24/14 including preventative measures/interventions developed regarding the fall.<br><br>- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included TBI, organic brain damage, gait abnormality, flat feet, cognitive disorder, impulse control disorder, and history of three cerebrovascular accidents (CVA) (strokes) and late effects of left hemiparesis.<br><br>The record identified the following falls:<br>* 08/27/13: A fall in the dining room with injury to | F 323 | | |

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| F 323 | Continued From page 25<br>the left elbow and xrays not identifying a fracture. No additional information was provided.<br>* 01/18/14: fall on way to dining room, he tripped on his feet and fell to the floor face down hitting his nose. An event report indicated to "continue to encourage him to attend snack early and on time." Administrative review did not identify any additional interventions.<br>* 02/06/14: fall trying to get out of a recliner when he flipped around and ended up on his back, resulted in no injuries<br><br>A fall risk assessment completed on 02/18/14 indicated Resident #5 at low risk for falls. The record lacked a re-evaluation of the fall risk following the falls on 01/18/14 and 02/06/14.<br><br>An annual MDS, dated 02/19/14, identified Resident #5 with an inattention behavior that fluctuated and an impairment of the lower extremity affecting one side of his body. The CAA stated, "Has had two falls this quarter - one while walking in the dining room which was due to falling over his feet (shoes were not on properly) and one while getting out of the recliner in the entrance lounge (not having good balance before getting out of chair). There were no injuries in either fall. . . . At times is preoccupied with getting places fast and short attention span . . . All staff are alert [sic] to reminding [resident] to have shoes on properly and tied; remind to have brace on so shoe fits properly and ask him to slow down so he doesn't trip on feet due to abnormal gait."<br><br>A focus on Resident #5's care plan stated, "PHYSICAL THERAPY: My gait pattern is very spastic, and it is causing a lot of trauma to my body. My balance is also very poor, and I have had numerous falls as a result. I also have a very | F 323 | The care plans will be completed by 5/21/14; our next Q.A. meeting is scheduled for July 2014. The fall prevention policy and procedure will be completed by 5/21/14. | 5/21/14 |

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| F 323 | Continued From page 26 | F 323 | | |

hard time staying on task because of my brain injury. I sometimes complain of pain in my left posterior thigh." The intervention stated: "Because of the severity of my brain injury I am not able to carry through with PT's suggestions for my walking. PCT [Physical Conditioning Therapy] is working with me on stretching and strengthening my legs; PT is providing periodic assessments." The "Room Care Plan" identified Resident #5 walks "per self without assistive devices, has an unsteady gait, is easily distracted and tends to walk very fast. Encourage [resident] to slow down." The care plan failed to include interventions reminding or assisting the resident with shoes and use of the brace.

On all days of survey, observation showed Resident #5 with an unsteady, guarded gait pattern.

- Review of Resident #2's medical record occurred on April 14-15, 2014 and identified diagnoses of a TBI, CVA, and nerve palsy. The quarterly MDS, dated 03/04/14, identified severely impaired cognition, required extensive assistance of one staff member for transfers and toileting, frequently incontinent of urine, and two falls without injury.

The current care plan stated, ". . . Focus: I have mixed bladder incontinence r/t [related to] neurogenic bladder . . . Sometimes I can tell if I have to void and some days I cannot tell if I am wet so staff need to remind me to toilet every two hours or I become anxious or ask to use the toiletas [sic] I do not have a predictable bladder schedule . . . Interventions: . . . I use incontinence products which need to be checked and changed at least every two hours during the daytime and

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| F 323 | Continued From page 27<br>checked at least once during the night but everytime I am awake for sure. Sometimes I am able to let you know if I am wet or need to void or have a bowel movement at the time I need to go, but I would not know after a few minutes if I had gone. I sometimes would be able to find my bathroom or use the call light to let you know I had to 'go,' but usually staff need to stay outside the bathroom and ask me after a few minutes if I am finished. I continue not to be able to tell if I am wet or dry so staff take me to the bathroom at least every two hours to decrease wetness episodes . . . It is difficult to establish voiding patterns for me because when I am anxious, I don't have a pattern and I may refuse to urinate, then urinate as soon as I get out of the bathroom. When I am not feeling well, I also don't have a pattern . . . Focus - Falls: I have limited balance and sometimes forgot [sic] that I need help to walk . . . Interventions - My call light is hooked up to my bed alarm to let staff know when I get out of bed so they come right away. My bed is always in low position when I am in it. . . ."<br><br>Resident #2's current "Room Care Plan" stated, ". . . [Resident #2] should be taken to the bathroom upon rising, after meals, before bedtime & prn [as needed]. She usually knows if she needs to go, and if she is very anxious taking her helps. May need prompts on how to sit on the toilet . . . Is incontinent of B&B [bowel and bladder] occasionally . . . Bed alarm on when in bed and bed in low position. Fall Mat: DO NOT use as is more of a fall hazard due to [Resident #2's] impulsivity and cognitive deficits . . . Safety: Use a quick release seatbelt with an alarm at all times when in w/c [wheelchair] due to being impulsive and having impaired balance. . . ." | F 323 | | |

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| F 323 | Continued From page 28<br>Review of Resident #2's Nurse's Notes identified the following:<br>*12/01/13 - "Awake @ [at] 2:30 am, slid out of bed et [and] sat on floor. Cheerful. Voided, back to bed [with] assist of 1. . . ."<br>*12/09/13 at 2:40 a.m. - "[Resident #2] was found lying on floor next to her bed [with] face up. Staff was rounding up on residents @ this time . . . Staff had last checked on [Resident #2] about 0030 [12:30 a.m.], changed, turned, repositioned . . . When questioned, [Resident #2] said, 'I just wanted to get out of bed.' Bed alarm in place, turned on but didn't go off. . . ."<br>*12/14/13 at 3:30 a.m. - ". . . Found [Resident #2] sitting cross-legged on the floor of her room. Calm, smiling. Said needs to use the bathroom. Stood [with] assist [assistance] of [two]. Leaning to the left. Amb [ambulated] [with] assist. Voided on toilet, dried well . . . Put monitors in her room et Health Station so she can call us if she needs assist instead of sliding/crawling on the floor. [Resident #2] agrees to try this. Door open for freq [frequent] checks. No injury. . . ."<br>*02/04/14 2:45 a.m. - "[Resident #2] slid out of bed, landing on her bottom trying to get to bathroom. [Resident #2] did not use her call light and was reminded to. [Resident #2] denies pain or injury. Pt [patient] walked to bathroom with assist of one, still denying any pain. No obvious external injury. Placed [Resident #2] back in bed, call light in reach bed wheels locked, bed alarm on. Reminded [Resident #2] to use call light. Will continue to monitor. . . ."<br>*02/06/14 at 6:15 a.m. - "Resident sitting on floor mat in room next to her bed this am. No s/s [signs or symptoms] of injury. Resident denies c/o [complaints of] pain and discomfort. Also denies hitting head. . . ."<br>*02/14/14 at 4:30 a.m. - "[Resident #2] slid out of | F 323 | | |

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| F 323 | Continued From page 29<br>bed this morning, told staff she accidentally rolled out then told staff she was trying to go to the bathroom. [Resident #2] denies any pain. Assessment negative for any physical injury. Bed alarm was on. Took [Resident #2] to and from bathroom, reset alarm. . . ."<br>*04/13/14 at 2:00 a.m. - "Resident's chair/bed alarm began to alarm. Upon entering room resident was sitting on the floor. Blankets were wrapped around her legs. Did not hit her head. No injuries noted . . . Bed was in low position upon entering room. Bed alarm was active. Will continue to monitor resident closely. . . ."<br>*04/14/14 at 6:00 a.m. - "Resident found on floor by CNA. Nurse assessed for any bruises or injurys [sic] non [sic] noted. Resident assisted back into bed. . . ."<br><br>The facility failed to track and trend Resident #2's falls and review and revise her fall interventions in an attempt to decrease her number of falls which occurred between 2:00 a.m. and 6:15 a.m.<br><br>During interview on the morning of 04/16/14, an administrative staff (#2) stated the facility lacked a fall prevention policy or procedure. | F 323 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | |

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| F 371 | Continued From page 30<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to safely thaw meat and use the correct concentration of chlorine sanitizer to wipe kitchen counters on 1 of 1 day of survey (04/14/14). Failure to thaw meat in a safe manner placed all residents at risk of food-borne illness. Failure to follow manufacturer's guidelines for mixing sanitizing solution placed all residents at risk for adverse health affects related to high chemical concentrations.<br><br>Findings include:<br><br>- Review of the facility policy "Thawing of Food" occurred on 04/16/14. This policy, revised June 2010, stated, "All food will be thawed following proper sanitation standards.<br>PROCEDURE:<br>1. The most desirable method to thaw meat is in the refrigerator. Meat should be placed in bottom drawer in a pan with sides. The time needed to defrost meat will vary depending on the amount. No other food should be placed in the pan or on top of the thawing meat as this poses a risk for cross contamination. Thawed meat should be used within 24 hours.<br>2. Other thawing methods include the cold water method or the microwave oven.<br>Cold Water Method: Place frozen meat in a leak proof container and place in a sink of cold water. The water should be changed every 10 minutes and the meat should be in the sink no longer than 2 hours.<br>Microwave: Use defrost cycle in the microwave | F 371 | F-371<br>In a dietary staff meeting held on 4/23/2014 the dietary department was educated on the proper practice for thawing meats (see Appendix "A" for the staff meeting minutes). Staff was educated that meats need to be thawed in the fridge on the bottom shelf or in the bottom drawer.<br><br>Other options for staff to thaw the meat is in cold water in the sink changing the water every ten minutes, or in a microwave on the defrost setting. Staff was also informed that the meat needs to be cooked immediately after thawing.<br><br>The staff was also educated on the proper concentration of bleach in ppm to water. Two teaspoons of bleach are recommended to be diluted in 1 gallon of water and should measure between 50-100 ppm. | |

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| F 371 | Continued From page 31<br>and utilize manufacturer's directions. Cook meat immediately after thawing. . . ."<br><br>Initial observation of the kitchen occurred on 04/14/14 at 9:00 a.m. with a dietary staff member (#13) and showed four packages of steak and a roll of hamburger on the kitchen counter. A dietary staff member (#14) stated she obtained the meat from the freezer and placed it on the counter at approximately 8:30 a.m. At 10:00 a.m. observation showed the roll of hamburger on the bottom shelf of the refrigerator, but the four packages of steak remained on the kitchen counter. At 10:15 a.m. observation showed all four packages of steak on the bottom shelf in the refrigerator. The hamburger sat on the kitchen counter for at least one hour and 30 minutes and the steaks sat on the kitchen counter for at least one hour and 45 minutes. The dietary staff member (#13) stated the hamburger will be used for the supper meal and the steaks for lunch the following day.<br><br>During an interview on the morning of 04/16/14, a dietary staff member (#13) stated usually staff pull food from the freezer two days before it is needed for meals and place it in a pan on the bottom of the refrigerator to thaw. The staff member (#13) confirmed thawing meat on the kitchen counter is an unsafe and incorrect practice.<br><br>- Review of an internet reference titled "Cleaning, Sanitizing & Disinfecting" occurred on 04/16/14. This reference, found at www.clorox.com/products, states ". . . To Sanitize: Wash, rinse and wipe surface area with a solution of 2 teaspoons of bleach per 1 gallon of water for (at least) 2 minutes. Let air dry. *Safe for hard, | F 371 | The sanitizer solution (Quat by Diversey) for disinfecting the dining room tables should have a concentration of 200 ppm (see Appendix "A" for the staff meeting minutes).<br><br>The mixing station should be checked weekly and documented on the attached form (Appendix "B"). The dietary manager will review the form to make sure that the solution is mixed to the manufactures recommendation.<br><br>The bleach water should be checked every time it is made to make sure that it falls within manufacturers recommendations at 50-100 ppm. The dietary manager will do weekly spot checks to make sure the staff are mixing the bleach solution correctly and report it along with the results of the weekly checks of the mixing station to the Q.A. committee for 6 months. | 5/21/14 |

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| F 371 | Continued From page 32<br>nonporous surfaces only. . . ."<br><br>Initial tour of the kitchen occurred on 04/14/14 at 9:00 a.m. with a dietary staff member (#13) and identified a mixture of water and chlorine in a bucket in the kitchen sink. A dietary staff member (#13) tested the solution with a test strip which identified a concentration of greater than 225 ppm [parts per million]. Both dietary staff members (#13 and #14) present during the tour stated the chlorine sanitizing solution should be 175-200 ppm and disposed of the solution in the sink (correct concentration for chlorine bleach sanitizers is 50-100 ppm).<br><br>During an interview on 04/15/14 at 9:45 a.m., a dietary staff member (#14) stated she mixed 2 tablespoons of chlorine with 2 quarts to 1 gallon of water to make the solution used to sanitize the kitchen counters. The staff member (#14) stated she changed the sanitizing solution about twice per shift and more if needed.<br><br>On the morning of 04/16/14, a dietary staff member (#13) stated staff failed to follow manufacturer's recommendations when using the chlorine as a sanitizing solution for the kitchen counters. | F 371 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. | F 425 | **F425:**<br>No residents were affected by the practice as we are not sure when the medication was taken out of the expired box and no residents had injectable diphenhydramine ordered.<br><br>All residents who take OTC meds had the potential to be affected but since we have the night nurse checking all OTC meds on the 3rd Monday of the | |

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| F 425 | Continued From page 33<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility policy, the facility failed to ensure the removal of expired medications in 1 of 1 medication room and in 1 of 1 emergency medication kit. Failure of facility staff to ensure the removal of expired medications may result in residents receiving these expired medications and experiencing possible adverse affects.<br><br>Findings include:<br><br>Review of the facility policy titled "Emergency or Stock Drug Supply" occurred on 04/16/14. This policy, revised March 2014, stated, ". . . e. The consulting pharmacist checks the stock medication box for outdates during his monthly pharmacy visits and replaces outdated medications as needed. . . ."<br><br>Review of the facility policy titled "Medication Storage" occurred on 04/16/14. This policy, revised March 2014, stated, ". . . Outdated . . . | F 425 | month and are monitoring this the problem is resolved.<br><br>A procedure was set up that the night nurse will review all medications in the stock area on the third Monday of every month to check for outdated or soon to be outdated medications. Meds that will be outdated by the end of the month will be put in the destruction area for the pharmacist to destroy on his monthly visit. Meds will be reordered to replace them if they continue to be needed.<br><br>The consulting pharmacist was contacted about the outdated medications in the emergency kit. His response was: "A monthly review of the emergency kit will continued (sic) to be done by the consulting pharmacist.<br><br>Documentation of that review will be noted on the form inside the emergency kit. Quality Assurance will be done to assure the monthly check is being done." | |

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| F 425 | Continued From page 34<br>are immediately removed and disposed of according to procedures for medication disposal. . . ."<br><br>On the morning of 04/16/14, observation of the medication room with a staff nurse (#9) identified three boxes of expired over-the-counter (OTC) Imodium 2 mg (milligrams) in a medication cupboard. The expired Imodium included: one unopened box, dated December 2013; another unopened box, dated March 2014; and an opened box, dated March 2014.<br><br>Review of the emergency medication kit on the morning of 04/16/14 with a staff nurse (#9) identified four vials of diphenhydramine with an expiration date of November 2013. | F 425 | We will have the pharmacist open the emergency kit and sign the monthly check form and the DON will report to the Q.A. committee quarterly on the status of the monthly checks and the recheck of the nurse OTC checks. We will do this quarterly for a year to see if it has been effective and modify if it has not been.<br><br>The medication in the emergency box was not listed in the list of emergency drugs; it did not contain a prescription label. | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program | F 441 | On the monthly checks, the pharmacist will check to see that only the drugs listed are in the emergency box.<br><br>During our quarterly Q.A. meetings, the Assistant Administrator will obtain the check list from the emergency box to assure that the pharmacist has signed off on the emergency box checks monthly for the next 6 months and then spot check every other month for the next 6 months if compliance has been reached.<br><br>The corrective action was completed on May 6, 2014. | 5/06/14 |

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| F 441 | Continued From page 35<br>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility policy, the facility failed to follow standard infection control practices for 3 of 3 sampled residents (Resident #2, #4 and #7) observed during personal cares; 1 sampled resident (Resident #2) observed with a dressing change; 1 sampled resident (Resident #3) observed receiving insulin, and 1 sampled resident (Resident #1) observed with a feeding tube. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility.<br><br>Findings include:<br><br>Review of the facility policy "Handwashing/Hand Hygiene" occurred on 04/16/14. The policy, revised August 2009, stated, "Policy Statement: | F 441 | F-441<br>For residents 1, 2, 3, 4, and 7 and all other residents that may have the potential to be affected, on 4/24/14, the DON and Assistant Administrator during the Nurse/CNA in-service went over the list of deficiencies that were listed during the exit interview. A review of the hand washing protocol to prevent the development and transmission of disease and infection was discussed. All nurses including those who were unable to attend read and signed off on the hand wash protocol update after reading the minutes. An all staff meeting discussing proper hand wash protocol will be held 5/15/2014. All staff including those unable to attend will read and "sign off" on the all staff meeting minutes. A memo to | |

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| F 441 | Continued From page 36<br>This facility considers hand hygiene the primary means to prevent the spread of infections. . . . All personnel . . . must wash their hands . . . under the following conditions: a. Before and after direct contact with residents; b. When hands are visibly dirty . . . c. After contact with blood, body fluids, . . . d. After removing gloves; . . ." A second policy, also titled "Handwashing/Hand Hygiene", stated, ". . . use an alcohol-based hand rub for all the following situations: . . . c. Before preparing or handling medications; d. Before handling clean or soiled dressings, gauze pad, etc.; e. Before moving from a contaminated body site to a clean body site during resident care; f. After contact with resident's intact skin; g. After handling used dressings, contaminated equipment, etc.; h. After contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the resident . . . Hand hygiene is always the final step after removing and disposing of personal protective equipment. . . ."<br><br>Review of the facility policy titled "Dressing Changes" occurred on 04/16/14. This undated policy stated, "Non-sterile: . . .<br>4. Wash hands, apply gloves . . .<br>7. Remove soiled dressing, place it in trash bag.<br>8. Remove gloves, wash hands, apply new gloves . . .<br>10. Clean wound with normal saline or prescribed cleanser.<br>11. Pat the tissue surrounding the wound dry with a 4 X 4.<br>12. Remove gloves, wash hands, apply new gloves . . .<br>14. Apply prescribed topical agent to wound if ordered.<br>15. Apply wound dressing. Wound dressing should cover the entire wound. | F 441 | travel nurses to review the hand washing protocol was attached to the front of the nurse report book so travel nurses who do not attend our in-services are reminded to check the protocol. The DON will "spot check" nurse's performing hand washing during residents cares two times per week each full week of May, 2014.<br><br>By May 31, 2014, 8 checks will be done. If spot checks result in no errors, the DON will reduce the number of "spot checks" to one per month for the following six months (through October 2014). At the end of October, if no errors have been found, the checks will be discontinued. If errors are found, the number of checks will be increased and re-education will be done with the nurses repeating the errors. | |

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| F 441 | Continued From page 37<br>16. Tape the dressing in place as indicated . . .<br>17. Discard gloves and all used supplies . . .<br>18. Wash hands. . . ."<br><br>- Observation of personal cares provided by two certified nursing assistants (CNAs) (#4 and #5) for Resident #4 occurred on the afternoon of 04/14/14. The CNA (#5) performed incontinence pericares. Following other personal cares by both CNAs the CNAs removed their gloves and left the room without performing hand hygiene.<br><br>- Observation of personal cares provided by a CNA (#6) for Resident #7 occurred on the afternoon of 04/14/14. Observation showed a large amount of incontinent stool to the outside Resident #7's brief and on a cloth protector under of Resident #7. The CNA (#6) performed posterior and frontal pericares with gloved hands. Upon completion, the CNA (#6) removed the gloves and failed to perform hand hygiene. After removal of the soiled clothing, the CNA applied clean clothing to the resident while he laid in bed. Observation showed the soiled cloth protector remained under the resident. After transferring Resident #7 from the bed to wheelchair, the CNA (#6) placed Resident #7's glasses on his face and hat onto his head. The CNA donned new gloves, bagged the garbage and the cloth protector, replaced the garbage liner, and removed the remaining bedding. The CNA removed the gloves, failed to perform hand hygiene and opened the bathroom door looking for a clean linen bag.<br><br>- During an observation on 04/14/14 at 1:30 p.m., a CNA (#5) donned gloves, removed Resident #2's brief, wet with urine, performed perineal cares, and removed her gloves. The CNA (#5) | F 441 | The DON will report the error rate to the Q.A. committee on a quarterly basis for the remainder of the year or until compliance is reached. | 5/21/14 |

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| F 441 | Continued From page 38 | F 441 | | |

placed a new brief, bagged the garbage, assisted the resident to the lounge area, transferred her into a recliner, and turned on the television. The CNA (#5) failed to perform hand hygiene immediately after performing perineal cares.

- During an observation of medication administration on 04/15/14 at 8:40 a.m., a nurse (#9) donned gloves, administered insulin to Resident #3, removed her gloves, documented in the medication administration record, and continued to administer medications to other residents. The nurse (#9) failed to perform hand hygiene after administering insulin and prior to administering other residents' medications.

- Observation on 04/15/14 at 8:45 a.m. identified a CNA (#5) assisted Resident #2 with toileting. After the resident voided in the toilet, the CNA (#5) performed perineal cares, changed her gloves, transferred the resident to her wheelchair, and then assisted the resident to shower. The CNA (#5) failed to perform hand hygiene immediately after performing perineal cares.

- Observation on 04/15/14 at 9:35 a.m. showed a nurse (#9) entered Resident #2's room, donned gloves, removed the dressing covering Resident #2's abdominal wound (scant purulent drainage observed), disposed of the dressing, and changed her gloves. Without performing hand hygiene, the nurse (#9) sprayed the wound with "Wound Cleanser Spray" and dabbed the area with gauze. The nurse (#9) changed her gloves, applied a new piece of gauze over the wound, taped it in place, removed her gloves, and took the resident into the lounge area. The nurse (#9) returned to the resident's room, put away the dressing supplies, bagged the garbage, and then

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| F 441 | Continued From page 39<br>washed her hands. The nurse (#9) failed to perform hand hygiene prior to completing the dressing change, after removing her gloves, prior to placing the new dressing, and before exiting the resident's room.<br><br>- Observation on 04/15/14 at 12:30 p.m. showed a nurse (#9) administered medications and a bolus feeding to Resident #1. The nurse (#9) entered the resident's room, donned gloves, administered the medications and bolus feeding, removed her gloves, and exited the room. The nurse (#9) failed to perform hand hygiene prior to administering the resident's medications and feeding and prior to exiting the room. | F 441 | | |