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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	600 S MAIN ST MINOT, ND 58701

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on April 7, 2014 and completed on April 9, 2014, the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included five (5) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	**F – 156 Notice of Rights, Rules, Services and Changes.** The facility strives to ensure that the resident and or his or her legal representative is provided with a liability notice and Medicare non- coverage notice informing them why specific coverage may not be covered by Medicare, the residents potential liability for payment of non-covered services and the right to have a claim (demand bill) submitted to Medicare. Resident #19 no longer resides in the facility. Residents that reside in the facility under Medicare benefits have the potential to be affected. The business office staff and or social service will issue the non-coverage notices and scan the notices into the computer system.	5/11/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 5-13-14

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

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	Staff was educated the weeks of 4-23-14 and 4-30-14 on the procedure for non-coverage letters. The Administrator and or designee will conduct weekly audits times 4, then monthly times 3 then quarterly thereafter to validate notices are being issued and scanned into the computer. Trends will be forwarded to QA&A committee for further review if needed.	

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records and staff interview, the facility failed to issue a liability notice and a Medicare provider non-coverage notice to 1 of 3 residents (Resident #19) reviewed for termination of Medicare coverage. A liability notice informs a resident why specific services may not be covered by Medicare, the resident's potential liability for payment of noncovered services, and the resident's right to have a claim (demand bill) submitted to Medicare. A Medicare provider non-coverage notice informs a resident of the right to an immediate, independent medical review from a Quality Improvement Organization of the decision to end Medicare coverage. Failure to issue a liability notice and a Medicare provider non-coverage notice limits the ability of residents or their responsible party to exercise these rights. Findings include: Review of the facility's Medicare billing records occurred on 04/09/14. The records identified Resident #19's Medicare coverage ended on	F 156		

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F 156	Continued From page 3 01/02/2014. During an interview on 04/09/14 at 11:30 a.m., a business office staff member (#8) stated the facility admitted Resident #19 on 12/31/13 following a qualified hospital stay and the resident received three days of Medicare benefits. The staff member (#8) reported the facility had no documentation they provided the resident a liability notice and a Medicare provider non-coverage notice at the time of termination of Medicare benefits.	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, resident interview, and staff interview, the facility failed to ensure 3 of 3 supplemental residents (Resident #20, #21, and #22) observed with positioning concerns in 1 of 3 dining rooms (Second Floor) received reasonable accommodation of individual needs regarding wheelchair and dining room table positioning. Failure to offer and provide appropriate dining room table height and wheelchair positioning resulted in discomfort (Resident #21), may limit the dining experience, and may result in weight	F 246	**F246 Reasonable Accommodation of Needs/Preferences** The facility strives to provide residents with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be in danger. Residents #20, #21 and #22 have been re-assessed for proper wheelchair positioning and table heights in the dining room. Residents sitting in wheelchairs in the dining room have the potential to be affected. Therapy will assess all existing residents and all new residents as to proper wheelchairs are provided and observe dining room positioning for correct placement at appropriate height tables.	5/11/14

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F 246	Continued From page 4 loss. Findings include: Review of the internet site, SouthwestMedical.com, occurred on 04/09/14. The reference, "Wheelchair Measuring Guide," stated ". . . Elbow to Seat Reference Point . . . Measure this width with arm in a 90 degree angle at the elbow and the shoulder in a neutral position. . . ." The Guide includes a diagram showing the wheelchair arm rest height should equal this measurement. Observation on all days of survey identified the following: *Resident #20 - seated in a wheelchair with her elbows at her sides. Occasionally, the resident alternated placing one arm at a time on the wheelchair arm rest, with the arm out from her side. The resident could not maintain her shoulders at her sides, keep her elbows at 90 degree angles, and keep her forearms on the arm rests because the arm rests were to be too high. Observation in the second floor dining room for the evening meal on 04/07/14, the breakfast and noon meals on 04/08/14, and the breakfast meal on 04/09/14 showed the dining room table height at approximately the resident's mid-chest level. This height required Resident #20 to lift her arms up and forward to access all her meal items. *Resident #21 - seated in a wheelchair with her elbows at her sides. Occasionally, the resident alternated placing one arm at a time on the wheelchair arm rest, with the arm out from her side. The resident could not maintain her shoulders at her sides, keep her elbows at 90	F 246	Staff was educated the weeks of 4-23-14 and 4-30-14 on proper wheelchair positioning and table heights for residents. DON and or Designee will conduct weekly dining room audits times 4, monthly audits times 3 and quarterly thereafter, with trends forwarded to QA&A committee for follow up if needed.	

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F 246	Continued From page 5 degree angles, and keep her forearms on the arm rests because the arm rests were to be too high. Observation in the second floor dining room for the evening meal on 04/07/14, the breakfast and noon meals on 04/08/14, and the breakfast meal on 04/09/14 showed the dining room table height at approximately the resident's mid-chest level. This height required Resident #20 to lift her arms up and forward to access all her meal items. Observation also showed the resident placed bowls and plates of food on her lap for ease of access to meal items. During interview, on 04/09/14 at 7:45 a.m., Resident #21 reported she could not place her arms on the wheelchair arm rests due to the arm rests felt too high and her shoulders felt "sore" at times due to reaching up to the table and unsupported at her sides. Resident #21 also stated the facility had not offered her alternative table heights or wheelchair positioning. The facility identified Resident #21 was interviewable. *Resident #22 - Observation in the second floor dining room for the breakfast meal on 04/09/14 showed the resident seated in a wheelchair with the dining room table at her shoulder level. The table height required the resident to reach up and forward to access her meal items. During interview, on 04/09/14 at 8:00 a.m., Resident #22 stated the facility had not offered her alternative table heights. The facility identified Resident #22 was interviewable. On 04/09/14 at 8:15 a.m. rehabilitation services staff members (#9), (#10), and (#11) observed Resident #20, #21, and #22 seated in their	F 246		

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F 246	Continued From page 6 wheelchairs at the dining room tables as previously identified. These staff members agreed the wheelchair positioning for Resident #20 and #21 was not appropriate and the table heights were not appropriate for all three residents. Information regarding alternative wheelchair and table height positioning was requested. The facility provided no additional information.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to follow professional standards of care for 1 of 1 supplemental resident (Resident #23) with changes in blood sugar parameter orders. Failure to properly transcribe physician orders places all residents at risk for adverse health effects and has the potential to increase the risk of medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 850, stated, ". . . Medication Orders . . . for all verbal or telephone orders the nurse must first write down the order and then read it back, verbatim, to the prescribing care	F 281	**F281 Professional Standards** The facility strives to provide or arrange services that meet professional standards of quality. Resident #23 has had a clarification telephone order written for blood sugar parameters. Resident #10 Incident report and investigation have been completed which identified transfers to be re-assessed for proper transfers in the shower room and staff re-educated on showering transfer protocols. Residents with written telephone orders have the potential to be affected. Residents that use the mechanical lift have the potential to be affected. Staff was educated the week of 4-23-14 and 4-30-14 on professional standards of writing telephone orders and also to assess implement interventions and monitor effectiveness of interventions for	5/11/14

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F 281	Continued From page 7 provider. . . ." Page 852, stated, "The name of the drug to be administered must be clearly written. . . . Communicating a Medication Order A drug order is written on the client's chart by a primary care provider or by a nurse receiving a telephone or verbal order from a primary care provider. . . . The medication order is then copied by a nurse or clerk to a Kardex or medication administration record . . ." Review of the facility policy titled "MINIMUM RECORD CONTENT" occurred on 04/09/14. This policy, dated August 2009, stated, ". . . TRANSCRIBING OR NOTING ORDERS, Physician orders that are written, telephone or faxed are noted by a licensed nurse. The nurse is responsible for the accuracy of transcription and signs and dates the orders as noted. The licensed nurse, noting the order, transcribes the new medication or treatment onto the patient's Medication Administration Record (MAR) or Treatment Administration Record (TAR). If a medication or treatment is discontinued by the physician, the licensed nurse discontinues the item from the MAR or TAR per center practice. . . ." Review of Resident #23's medical record occurred on April 07-09, 2014. Current diagnoses included diabetes mellitus. Review of the physician orders identified a carbon copy physician telephone order, dated 03/31/14 at 4:00 p.m. The order stated, "Parameters of BS [blood sugar] < [less than] 60 or > [greater than] 200 call MD [medical provider]." An original copy physician telephone order (the order that is mailed to the physician to sign) dated 03/31/14 at 4:00 p.m. stated, "Parameters of BS < 60 or >	F 281	residents with injury during transfer with lifts. DON and or designee will audit written telephone orders ~~weekly times 8~~ with trends forwarded to QA&A for follow up if needed. DON and or designee will audit weekly times 4. Monthly times 3 and quarterly thereafter for occurrences with incident reports and investigations for interventions with trends forwarded to QA&A for follow up as needed. audit: weekly times 4, monthly x 3 and quarterly thereafter. T.C. per administrator 5/15/14 dl	

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F 281	Continued From page 8 300 call MD." Review of Resident #23's April 2014 MAR showed the entry for blood sugar parameters crossed out and handwritten above it, staff wrote the less than "60" and the greater than was indecipherable. During an interview on 04/09/14 at 3:00 p.m., an administrative nurse (#13) stated a staff member received an order to call the physician for blood sugars greater than 200. The staff member then received a new order to call the physician for blood sugars greater than 300 and wrote the new order over the old order. Administrative nurse (#13) confirmed the nurse should have written a new physician order and a new entry in the MAR. 2. Based on record review, review of facility policies and procedures and staff interview, the facility failed to ensure services provided met professional standards of practice for 1 of 2 sampled residents (Resident #10) transferred with a sit to stand lift. Failure to thoroughly assess an injury for causative factors, identify, evaluate and analyze hazards and risks, implement interventions and monitor effectiveness placed Resident #10, and other facility residents transferred with a mechanical lift, at risk of injury. Findings include: Review of the facility's policy "Prevent Practice Guide" occurred on 04/09/14. The policy, dated April 2011, stated ". . . Trigger events with actual or potential harm . . . Determining who, what, where, why and how is essential in deciding the appropriate course of action to reduce or eliminate the risk of recurrence for both the	F 281		

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F 281	Continued From page 9 affected patient as well as others . . ." and " . . . correct the identified concern . . . tasks and action steps to be implemented . . . evaluate effectiveness of actions taken . . ." Review of Resident #10's medical record occurred on April 7-8, 2014. A Nursing Progress Note, dated 02/08/14 at 9:39 p.m., stated, "While transferring resident from wheelchair to shower chair in the shower room, the edge of resident's right hand was caught between the lift and the sharps container on the wall . . . resident's hand was noted to have developed a small bruise measuring 6 cm by 3 cm (centimeter) on right side of pinky finger and hand . . ." During an interview on 04/09/14 at 8:30 a.m., an administrative nurse (#13) stated the facility did complete an incident report; but failed to conduct a follow up to the incident. A copy of the complete incident report was requested by the surveyor, but none provided. Failure to ensure the facility thoroughly investigated and analyzed the incident involving Resident #10 and, if indicated, implemented systemic corrective action to ensure the safety of all residents transferred in the shower room placed residents at risk of injury.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F309 Provide Care/Services For Highest Well Being** The facility strives to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	5/11/14

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/07/13. Based on record review, the facility failed to provide the necessary care and services for 1 of 1 supplemental resident (Resident #23) regarding blood sugar parameters. Failure to notify the physician of blood sugars outside of the parameters has the potential to result in poorly controlled diabetes and does not allow the resident to attain or maintain the highest practicable level of physical well-being. Findings include: Review of Resident #23's medical record occurred on April 07-09, 2014. Current diagnoses included diabetes mellitus. Physician orders included blood sugar checks three times a day, with parameters to call the physician if blood sugar is less than 60 or greater than 300, and scheduled insulin injections twice a day. The following blood sugars documented in the medication administration record were outside of the parameters: *03/31/14 - 352 mg/dL (milligrams per deciliter) *04/02/14 - 44 mg/dL *04/04/14 - 327 mg/dL *04/06/14 - 360 mg/dL *04/07/14 - 414 mg/dL *04/08/14 - 44 mg/dL Resident #23's medical record lacked evidence	F 309	Resident #23's physician has been notified of the blood sugars that were out of the parameters. Residents receiving blood sugar checks have the potential to be affected. Staff was educated on notification to physician of blood sugars out of range week of 4-23-14 and 4-30-14 DON and or designee will audit residents receiving blood sugars weekly times 4, monthly times 3 and then quarterly thereafter for notification trends forwarded to QA&A for follow up if needed.	

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F 309	Continued From page 11 the facility staff contacted the resident's physician on four of the six incidents when the blood sugars fell outside the parameters. Failure to notify the physician of blood sugar readings outside the parameters limited the facility's ability to accurately control Resident #23's blood glucose level, placed all diabetic residents at risk, and limited the physicians' ability to ensure the quality of the resident's care.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329 Drug Regimen Is Free From Unnecessary Drugs.** The facility strives to have the residents' drug regimen free from unnecessary drugs. Resident #5's care plan has been reviewed and revised to include non-pharmacological interventions and to document interventions attempted prior to giving the prn anti-anxiety medication. Residents receiving prn anti-anxiety medication have the potential to be affected. Residents with prn anti-anxiety medication care plans reviewed and revised to include non-pharmacological interventions to be attempted prior to administration of prn. Staff was educated the week of 4-23-14 and 4-30-14 on attempting and documenting non-pharmacological interventions prior to giving an anti-	5/11/14

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(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 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify and implement non-pharmacological interventions for 1 of 3 sampled residents (Residents #5) before administering as needed (PRN) antianxiety medications. Failure to implement non-pharmacological interventions before administering a PRN antianxiety medication may result in administering an unnecessary medication. Findings include: Review of the facility policy titled "Mood and Behavior Symptom Management" occurred on 04/08/14. This policy, dated 2012, stated, ". . . Interdisciplinary Care Planning: . . . The interdisciplinary team designs the patient's care plan to focus on all of the patient's issues including those associated with behavior and mood symptoms. . . . Range of Interventions: The range of possible interventions includes non-pharmacological as well as pharmacological options. Non-pharmacological approaches used as initial interventions can minimize the need for medications, permit use of the lowest dose, or result in the discontinuation of medication. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnosis included anxiety and chronic pain. Resident #5's care plan stated the following: ". . . Focus: At risk for changes in mood r/t [related to] dx [diagnosis] of anxiety, depression; anti-anxiety medication as ordered. . . . . Interventions: Administer medication per physician orders and monitor for/report any side effects. Assess for physical/environmental	F 329	anxiety medication. DON and or designee will audit weekly times 4, monthly times 3, then quarterly thereafter residents receiving prn anti-anxiety medication trends forwarded to QA&A for follow up if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING _____ B. WING _____	04/09/2014

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F 329	Continued From page 13 changes that may precipitate change in mood . . . Observe for and report any changes in mood. . . .Validate feelings of loss." Resident #5's medication administration record (MAR) identified Ativan (antianxiety medication) 0.5 mg (milligram) one tablet twice a day as needed for anxiety. Resident #5's MAR and progress notes identified the staff administered Ativan 0.5 mg prn for anxiety without identifying specific non-pharmacological interventions attempted prior to the administration of Ativan as follows: * February 2014 - 15 times * March 2014 - 21 times * April 1-7, 2014 - 4 times During an interview on 04/08/14 at 12:25 p.m., an administrative nurse (#5) stated non-pharmacological interventions are in the progress notes. During an interview on the afternoon of 04/09/14, this nurse (#5) confirmed the progress notes lacked documentation of any non-pharmacological interventions attempted before administering the prn antianxiety medication.	F 329		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371 Food Procure, Store/Prepare/Serve – Sanitary** The facility strives to ensure a sanitary environment in the kitchen. The rusty vents have been replaced and the peeling paint has been fixed. Residents residing in the facility have the potential to be affected.	5/11/14

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 1 kitchen. Failure to identify environmental hazards in the kitchen has the potential to result in biological and physical contamination of food and equipment/dishware/utensils. Findings include: Observation of the kitchen occurred on 04/09/14 at 10:00 a.m. with two administrative dietary staff members (#6 and #7). Observations revealed the following: *Peeling, chipped paint on the ceiling above the dishwashing machine *A rusty vent with dirt/debris above the clean dishes in dishwashing area *A rusty vent covered with black, mold-like debris above a food preparation counter in the kitchen During an interview on 04/09/14 at 10:15 a.m., two administrative dietary staff members (#6 and #7) confirmed staff should repair the ceiling and clean the vents in the kitchen.	F 371	Staff was educated the week of 4-23-14 and 4-30-14 on reporting and repairing of vents and peeling paint in the kitchen Administrator and or designee will audit the kitchen weekly times 4, monthly times 3, quarterly thereafter for environmental issues in the kitchen with trends forwarded to QA&A for follow up if needed.	
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**F514 Resident Records Complete/Accurate/Accessible.** The facility strives to maintain accurate records in accordance with accepted professional standards and practices. Resident #8's nutritional assessment has been corrected.	5/11/14

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F 514	Continued From page 15 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure accurate documentation in the clinical record for 1 of 15 sampled residents (Resident #8). Including a diagnosis of colostomy in the resident's medical record placed this resident at risk of incomplete care planning, limited continuity, and quality of care. Findings include: Review of Resident #8's medical record occurred on April 07-09, 2014. The facility admitted the resident in March 2014. The admission Minimum Data Set (MDS), dated 03/20/14, identified the resident occasionally incontinent of bowel and required extensive assistance of two or more persons for toileting. Resident #8's Nutrition Assessment, dated 03/17/14, and his Nutritional Care Area Assessment (CAA), dated 03/25/14, identified the resident requested "no gasey [sic] vegetables" due to his "colostomy." Resident #8's current care plan lacked any information regarding a "colostomy." Observation on 04/08/14 at 8:40 a.m. showed two	F 514	Residents with nutritional assessments have the potential to be affected. Staff was educated the week of 4-23-14 and 4-30-14 on ensuring assessments are accurate. DON and or Designee will audit nutritional assessments weekly times 4, monthly times 3 and quarterly thereafter trends will be forwarded to QA&A for follow up if needed.	

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F 514	Continued From page 16 rehabilitation services staff members (#9) and (#12) assisting Resident #8 in the bathroom. Staff member (#9) provided perineal care for the resident and confirmed the resident had a bowel movement. During interview, on 04/08/14 at 3:30 p.m., a nursing management staff member (#13) confirmed Resident #8 did not have a colostomy and the nutritional documentation was an error.	F 514		