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	355031	A. BUILDING _____ B. WING _____	05/04/2016

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 05/01/16 and completed on 05/05/16, the sample included four (4) residents for complete review, 12 residents for focused review, and three (3) closed records for review. The sample included 20 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		6/7/16

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

Electronically Signed | 05/19/2016

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician for 1 of 1 closed record review (Resident #19) who experienced a change in condition. Failure to notify the physician of the resident's fainting episode and low blood pressure does not allow the physician to be fully informed of the residents' status. Findings include: Review of Resident #19's medical record occurred on 05/03/16. Diagnoses included hypertension (high blood pressure), dementia, and fall history with fracture of right femur (thigh bone). Medications included Metoprolol (hypertensive medication). Review of the progress note, dated 12/01/15, stated, ". . . resident had a fainting spell while the CNAs [certified nurse assistants] were transferring to toileting from WC [wheelchair]. When this author got to patient she was responding et [and] following simple demands. VS [vital signs] as Following [sic]: . . . B/P [blood pressure] 84/55. will continue to monitor for acute changes. . . ." During an interview on the morning of 05/04/16, an administrative nurse (#1) confirmed staff failed	F 157	Resident #19 no longer resides at the facility. Residents who experience significant changes of condition have the potential to experience negative outcomes if the medical provider is not notified of these changes. A review of change of condition was completed and MD notifications were made if indicated. A 24 Hour Report has been initiated in the facility to record changes in condition and validate that notification was made when the change was noted. Notifications are reviewed and validated by nurse managers or designee. Education was provided by the DON or designee on May 11th, 12th,, and 18th to licensed nurses using the INTERACT tools that indicate when to notify the medical provider of changes in vital signs or changes in condition. The INTERACT Quality Improvement Program is designed to improve the early identification, evaluation, management, documentation, and communication about acute changes in conditions of residents. Education included the need to document these changes and document the notifications that are completed.	

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F 157	Continued From page 2 to notify the physician of Resident #19's change in status. The facility failed to notify the physician of Resident #19's low blood pressure following a fainting episode.	F 157	Audits of documentation and vital sign entries will be completed by the DON or designee five times weekly for four weeks, then twice weekly for four weeks, then once weekly for three months. Results of audits will be submitted to the QAPI committee for review and recommendation.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/25/15 Based on observation, review of the facility's Resident's Rights booklet, confidential resident interview, and staff interview, the facility failed to provide care for 6 of 16 sampled residents (Resident #2, #3, #7, #8, #16, and Residnet L) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors or wait for a reply before entering a resident's room (Resident #2, #3, #7, #8, and Resident L), failure to provide privacy during toilet use (Resident #2), and failure to feed a resident in a dignified manner (Resident #16) does not promote residents' dignity or enhance their quality of life.	F 241	Residents # 2,3,7,8,and 16 did not indicate that they were adversely affected by the observed practices. Staff were addressed regarding appropriate feeding techniques and speaking to residents in an adult like manner, shaving residents and honoring privacy. Facility did not receive identifying information for Resident L. Residents who reside in the facility and require assistance with personal care, shaving, oral intake, and assistance with privacy for personal cares were identified through care plan review and have the potential to be affected by this practice. The DON or designee provided education	6/7/16

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F 241	Continued From page 3 Findings include: Review of the "RESIDENT'S RIGHTS - a Guide to your RIGHTS as a Resident of a Nursing Facility in North Dakota" occurred on 05/05/16. This guide, revised April 2008, pages 18-19, stated, "PERSONAL AND PRIVACY RIGHTS: . . . You have the right . . . *To privacy in medical treatment and personal care . . . DIGNITY AND RESPECT: YOUR RIGHT to be treated with dignity and respect. You have the right: *To be treated courteously, fairly, and with dignity. . . ." - During the initial tour on 05/01/16 at 9:36 a.m., an unidentified housekeeping staff member knocked on Resident #2 and #3's door and entered their room without announcing herself and/or waiting for a response from either resident. - During an interview on 05/01/16 at 3:15 p.m., Resident L indicated staff knock and walk into his room without waiting for a response. In the middle of the interview, an unidentified CNA knocked on Resident L's door and entered his room without announcing himself and/or waiting for a response. - Observation on 05/01/16 at 4:40 p.m. showed a certified nursing assistant (CNA) (#25) provided personal cares for Resident #8. During the cares, another CNA (#26) knocked on the resident's door and, without waiting for permission, entered the room. - Observation on 05/02/16 at 2:30 p.m. showed two CNAs (#23 and #24) provided personal cares for Resident #7. During the cares, a nurse (#17)	F 241	to nursing staff on May 11, 12, and 18 regarding the need to protect privacy and to honor dignity in the care of each resident. The need for assistance with shaving,using appropriate feeding techniques, using appropriate tone and content when speaking with residents, and stopping, knocking, waiting, and announcing prior to entering the residents room were reviewed. The need for privacy with toileting or personal care was also reviewed with nursing staff. Audits of direct care will be completed by the DON or designee five times weekly for four week, two times weekly for four weeks then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 241	Continued From page 4 knocked on the resident's door and, without waiting for permission, entered the room. - Observation on 05/02/16 at 4:30 p.m. showed Resident #2 stood in front of the toilet adjusting his clothing. The door to the bathroom and the door to his room were both open. Three unidentified CNAs and a nurse stood directly outside his room discussing their schedule. When asked about Resident #2's whereabouts, one of the CNAs stated, "He's finishing up in the bathroom." - Observation on 05/02/16 at 8:40 a.m. showed a staff member (#22) assisted Resident #16 with his meal. Throughout the meal, the staff member used a spoon and scrapped excess food from the resident's face and re-fed the food or placed it back on his plate. During an interview on the afternoon of 05/05/16, an administrative nurse (#1) stated she expected facility staff to knock and wait for permission before entering a resident's room.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE	F 244	Residents who attended resident council	6/7/16

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F 244	Continued From page 5 SURVEY COMPLETED ON 03/25/15 Based on observation, review of Resident Council Meeting minutes, resident group interview, and staff interview, the facility failed to act on a grievance of the resident group (12 of 13 residents) regarding call light response times. Failure of staff to answer call lights in a timely manner may affect the quality of life and quality of care provided to all residents. Findings include: Review of the Resident Council Meeting minutes occurred on the morning of 05/02/16. The minutes identified the following regarding call lights: * 02/15/16 - The group voiced concerns. An administrative staff member (#18) stated, "Managers will be doing call light audits. Those audits will be carefully looked over and reviewed . . ." * 03/21/16 - "One resident commented that they asked a question to a CNA [certified nursing assistant] and the CNA left to find an answer but never returned. One resident said they had their call light on for 45 min. [minutes]. * 04/18/16 - [Administrative staff member (#18)] addressed if call lights have improved. Nine residents, out of eleven, have agreed that they have experienced improvement. . . ." Although nine of the 11 residents expressed improvement, the residents (12 of 13) continued to voice concerns during the resident group interview. During the group interview on 05/02/16 at 10:00 a.m., 12 of the 13 residents in attendance stated they have waited 30 minutes or more for facility	F 244	were not identified in the 2567. Resident council was held on May 16, 2016 and the Administrator attended the meeting and addressed the concern and reviewed the plan for continued follow up on call light concerns. Residents who reside in the facility have the potential to be negatively impacted by a delay in call light response. Resident council concerns as well as any other daily concerns are communicated in daily stand-up meetings conducted weekdays. At that time the concern is discussed and assigned for investigation and resolution. Resident council meets every third Monday and QA meets every third Tuesday of the month, so any emergent concerns can be communicated in morning meetings and discussed at QA. Group grievance resolution communication would be presented at the next scheduled meeting. Any immediate response would be communicated to the individual or responsible party upon resolution. The DON or designee provided education to facility staff including the interdisciplinary team, licensed nurses, CNAs, housekeeping, dietary and management staff regarding call light response on May 11 th ,12 th , 18 th and 19 th . Education included review of the guideline that all staff answer call lights and that call lights take priority over	

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F 244	Continued From page 6 staff to answer their call light. Seven of the 12 residents admitted they have had an incontinence "accident" waiting staff to answer their call light. Resident R stated she has waited 45-60 minutes, and "they turn off the light" and never come back. Resident L stated "It's a constant thing, short help." Resident Q stated she had her light on and four staff members were outside her door talking. Resident Q also stated too many CNAs have cell phones and talk on them while they are in resident rooms. During an interview on the afternoon of 05/02/16, two administrative staff members (#1 and #18) stated they were aware of the residents' concerns regarding call lights and are in the process of addressing the concerns.	F 244	routine tasks being completed on the unit. The facility will also implement team lead CNAs to assist with improving customer service and compliance with call light response. Team lead selection will be completed on or before June 1 st and implemented on day and evening shifts on or before June 6 th . The Administrator or designee will complete call light response audits five times weekly for four weeks, three times weekly for three weeks and then weekly for three months. Follow up with resident council meeting will be completed during each monthly QA meeting. Audits and meeting minutes will be submitted to QA committee for review and recommendations.	
F 246 SS=E	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, record review, review of facility policy, resident and family interview, and staff interview, the facility failed to provide reasonable accommodation regarding call lights	F 246	Residents were not identified in the 2567. Residents who reside in the facility have the potential to be negatively impacted by	6/7/16

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F 246	Continued From page 7 for 14 of 14 supplemental residents (Resident A, B, C, D, E, F, G, H, I, J, K, L, M, and N) on 1 of 2 units. Failure to answer call lights in a timely manner may result in avoidable incontinence and falls, and a decreased quality of life. Findings include: Review of the facility policy titled "CALL LIGHT RESPONSE POLICY" occurred on 05/04/16. This undated policy, stated, "2. Ensure residents have access to their call light when in their rooms 3. All staff members are responsible for answering call lights, even if resident is not a part of their assignment. . . . 5. The staff member finds out what the resident needs and if able to meet the resident need the call light is turned off and staff provide the care or service requested. 6. If the staff member responding to the call light cannot meet the need the call light is left on and the staff member exits the room to find additional assistance for the resident. 7. All staff members are responsible to monitor the call lights and answer them promptly." During the initial tour on 05/01/16, between 9:36 a.m. and 11:00 a.m., the residents and/or their family members stated the following regarding the length of time they have waited for staff to respond to their call lights: * Resident A: "he/she once waited three hours for staff to respond to his/her call light." * Resident E: "he/she waited over two hours for staff to respond to his/her call light in the morning." * Resident B: "he/she waits forty-five minutes for staff to respond to his/her call light."	F 246	a delay in call light response. The DON or designee provided education to facility staff including the interdisciplinary team, licensed nurses, CNAs, housekeeping, dietary and management staff regarding call light response on May 11th ,12th , 18th and 19th . Education included review of the guideline that all staff answer call lights and that call lights take priority over routine tasks being completed on the unit. The facility will also implement team lead CNAs to assist with improving customer service and compliance with call light response. Team lead selection will be completed on or before June 1st and implemented on day and evening shifts on or before June 6th . The Administrator or designee will complete call light response audits five times weekly for four weeks,three times weekly for three weeks and then weekly for three months. Follow up with resident council meeting will be completed during the meetings in June, July, and August and then as requested by resident council members. Audits and meeting minutes will be submitted to QA committee for review and recommendations.	

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F 246	Continued From page 8 * Resident C: "he/she waits thirty minutes for staff to respond to his/her call light." * Resident F: "I've been left in the bathroom [up to] 30 minutes." * Resident G's family member: "Sometimes [they are] short staffed. He's sat in the bathroom 20 minutes or more." * Resident H's family member: "[They are] short staffed. I've had to stand in the hallway to wave someone down." * Resident I: "I've waited 30 minutes. My roommate waited an hour and a half. My wife timed it." * Resident J: "One night I waited 35 minutes." * Resident L: "My roommate waits 25 minutes or more. I wheel out [into the hallway] to get help" * Resident N: "The other night I waited over 45 minutes. The longest I've waited was an hour and a half. Not to be mean, they are short staffed." Observation showed the following: * During the initial tour on 05/01/16 at 9:36 a.m., Resident F was unable to locate her call light and wheeled herself into the hallway looking for staff to assist her. * On 05/01/16 at 10:04 a.m., Resident E turned on his/her call light. At 10:11 a.m., an unidentified certified nurse assistant (CNA) entered the resident's room, shut off the call light, and exited the room. At 10:23 a.m. Resident E was observed self propelling in his/her wheelchair through the door to the hallway. Resident E stated, "They always say they will be right back, I need to use the toilet." Observation at 10:33 a.m. showed Resident E still at the doorway waiting to be assisted to the bathroom. After informing another unidentified CNA that Resident E needed assistance to the bathroom, the resident was	F 246		

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F 246	Continued From page 9	F 246		

toileted at 10:35 a.m.
* On 05/03/16 at 8:30 a.m., Resident M waited 29 minutes for staff assistance.
* On 05/03/16 at 8:50 a.m., Resident O waited 33 minutes for staff assistance.
* On 05/03/16 at 9:00 a.m., Resident K's family member stood in the doorway of her room and addressed this surveyor. He reported they had been left waiting and asked this surveyor to assist his family member into bed. An unidentified nurse stood in the hallway and overheard the discussion. She stated she was aware Resident K wanted to be transferred into bed, and was looking for someone to assist her.

During an interview on 05/01/16 at 3:15 p.m., Resident L again reported he has searched for staff in the hallway after his roommate was left waiting for assistance. He stated his roommate has waited between 45 minutes and an hour and a half for assistance.

During an interview on 05/02/16 at 9:35 a.m., Resident E stated he/she waited a long time for someone to assist with urine soaked clothes on the evening of 05/01/16. The resident stated, "About 9:30 p.m. my foley bag was leaking and my pants were all wet. I put the call light on. An hour later a CNA answered the light and I told her I need to be changed. I laid there cause she said I will be back. My light stayed on the whole time. I dozed off waiting and woke back up at 1:00 a.m. and was hollering out the hallway for someone to assist me. No one came to my room, but a resident across the hallway came out of his room in his wheelchair and went to get me help. A CNA came into the room and said they do not know how to change a foley catheter and placed a pad

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F 246	Continued From page 10 under me. About 1:30 a.m. a nurse came into my room and changed my catheter and my clothing." Review of medical records occurred on all days of survey. The records identified the following: * Resident D: ". . . has negative comments about CNAs not answering his light in a timely fashion. . . ." * Resident M: ". . . Has been doing some yelling out if light not answered promptly. . . ." During an interview on 05/02/16 at 10:20 a.m., a staff member (#9) confirmed Resident E's foley catheter leaked during the night and staff changed it at 1:30 a.m.	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide housekeeping services to maintain a clean/sanitary, comfortable, and odor free environment during 3 of 4 days of survey (May 01, 03, and 04, 2016). Failure to prevent odors and maintain a clean/sanitary environment placed residents and staff in an uncomfortable and unpleasant environment. Findings include: - During the initial tour on 05/01/16 at 9:36 a.m., observation showed the following:	F 253	Residents #28,29,and 30 have had garbage cans inspected and cleaned to remove any odor. All residents have the potential to be negatively impacted if a homelike environment is not maintained. All staff have been educated to report and respond to interventions to abate and prevent practices that cause odors. Personal care staff will round at beginning and end of shift to assure rooms are clear	6/7/16

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F 253	Continued From page 11 * Resident #28's room: A soiled brief in the garbage can in the bathroom. * Resident #29 and #30's room: A soiled brief in the garbage can in the bathroom and a commode containing urine sitting near the foot of a bed. - Observation throughout the day on 05/03/16 revealed an unpleasant odor on the north resident hallway on the first floor. - The environment tour of the facility occurred on 05/04/16 at 8:30 a.m. with three administrative staff members (#18, #19, and #20). Observation showed a soiled brief in the garbage can in the bath/shower room on the first floor. During an interview on 05/04/16 at 9:30 a.m., an administrative staff member (#20) stated he/she expected facility staff to remove soiled briefs from residents' rooms after cares and when exiting the room.	F 253	of products used in cares. Random audits will be conducted to ensure designated audits (below) meet standards. The DON or designee provided education on May 11th, 12th, 18th, and 19th to the interdisciplinary team including managers, licensed nurses, CNAs, housekeeping, dietary and activities staff regarding the need to maintain a homelike environment. Education included the need to remove soiled incontinence products from garbage when cares are provided to reduce the potential for unpleasant odors. The Administrator or designee will complete audits five times weekly for four weeks, three times weekly for four weeks, then weekly for three months to determine compliance with removal of incontinence products from trash cans in resident care areas. Results of audits will be forwarded to the QAPI committee for review and recommendations.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		6/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 12 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the RAI (Resident Assessment Instrument) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 3 of 5 sampled residents (Resident #9, #10 and #15) identified as experiencing behaviors. Failure to accurately code behaviors does not allow the residents' assessments to reflect their current status/needs, and may affect the development of a comprehensive care plan, and affect the care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 1 page 1-8, stated, ". . . While CMS [Centers for Medicare	F 278	Resident #15 had MDS correction completed to reflect accuracy. Residents #9 and 10 were discharged from the facility and corrections were not made. Validation that the coding did not affect the rate was completed by the MDS coordinator on May 19, 2016. Residents with behaviors have the potential to be impacted by this practice. MDS entries for current residents who have had behaviors recorded in the most recent MDS were reviewed and corrected if indicated. The MDS coordinator is responsible to audit the coding and overall completeness of the MDS prior to signing	

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F 278	Continued From page 13 and Medicaid Services] does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. . . ." The Long-Term Care Facility RAI Manual, revised October 2015, Chapter 3 pages E-4 stated, ". . . E0200: Behavioral Symptom - Presence and Frequency . . . A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . ." - Review of Resident #9's medical record occurred on May 01-04, 2016. A significant change MDS, dated 03/07/16, identified the resident with severe cognitive impairment,	F 278	and submission. A behavior monitoring form will be implemented by June 1st for identified and like residents to ensure documentation of behavior is completed. Education was provided by the DON or designee on May 11th and 12th to the MDS Coordinator and the social services director regarding accuracy of MDS entries and need for supporting documentation. Education was provided by the DON or designee to licensed nurses and nursing assistants on recording behaviors on the behavior tracking sheet. Audits of the behavioral monitoring form will be completed by the DON or designee five times weekly for four weeks then twice weekly for four weeks then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and follow up.	

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F 278	Continued From page 14 displayed both physical and verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others with behaviors occurring daily during the 7-day assessment period. The medical record lacked evidence of daily physical, verbal, and other behaviors demonstrated by Resident #9 during the assessment period. - Review of Resident #10's medical record occurred on May 01-04, 2016. A quarterly MDS, dated 04/12/16, identified the resident with long and short term memory impairment, displayed physical behavioral symptoms 1 to 3 days, verbal behavioral symptoms 4 to 6 days, and other behavioral symptoms not directed toward others 1 to 3 days, all during the 7-day assessment period. The medical record lacked evidence of physical, verbal, or other behaviors demonstrated by Resident #10 during the assessment period. - Review of Resident #15's medical record occurred on May 03-04, 2016. A quarterly MDS, dated 01/22/16, identified the resident with severe cognitive impairment, and displayed physical and verbal behavioral symptoms directed toward others 1 to 3 days during the 7-day assessment period. The medical record lacked evidence of physical or verbal behaviors demonstrated by Resident #15 during the assessment period. During an interview on the morning of 05/04/16, two administrative staff members (#1 and #2) confirmed the medical records for Resident #9, #10, and #15 failed to identify the behaviors as coded by each MDS.	F 278		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		6/7/16

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F 281 SS=D	Continued From page 15 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the nursing staff failed to administered medications in a safe manner (Resident #22 and 1 unidentified resident) on 1 of 4 days of survey (05/04/16). Failure to ensure proper identification prior to the administration of medications and administer medications in a timely manner as ordered may result in a negative outcome. Findings include: Review of the facility policy/procedure titled "Medication Administration-General Guidelines" occurred on 05/04/16. This policy/procedure dated, April 2014, stated, ". . . B. Administration . . . 2) Medications are administered in accordance with written orders of the attending physician. . . . 9) Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered, based on meal times. . . . C. Documentation. 1) The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual	F 281	Resident #22 has been discharged from the facility. Residents who receive medication have the potential to be impacted by this practice. A review of MARs was completed to validate photos were present. Photos were added to MARs when needed. Licensed staff were informed of the nature of the error and a medication error report was created. Formal education was not provided prior to May 11th. Licensed nurses were educated on by the DON or designee on May 11th, 12th, the six rights of medication pass and this included correct time, correct intervals, steps for identification of the resident, and documentation of medication given. This information was added to the orientation packet for agency nurses as well. Audits will assure that the MAR includes resident picture. The facility random audits will provide regular QAPI data to protect residents in similar situations. Observations of medication passes will be	

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F 281	Continued From page 16 who administered the medications report off-duty without first recording the administration of any medications. . . . 6) Residents are identified before medication is administered. Methods of identification include: a) Checking identification band. b) Checking a photograph attached to the medical record. c) Asking the resident to state their name. d) If necessary, verifying resident identification with other facility personnel. . . . 3. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter does of antibiotic is needed), it is noted on the MAR and an explanatory note is entered in the area of the record provided for this documentation. If vital medications are withheld or refused, the physician is notified. . . ." - During a random observation of medication pass on 05/04/16 at 9:30 a.m., observation showed an unidentified resident approached a contract nurse (#10) at the medication cart and requested medication. The contract nurse asked the resident her name. The unidentified resident replied with a first name only. The nurse looked through the MARs, stated the MAR lacked a picture of the resident, prepared medication for a resident with that first name, signed off the medication, and administered the medication to the resident. The contract nurse (#10) failed to ensure proper identification of the resident and document the administration of the medication after the medication was administered, not before, as observed. - Review of Resident #22's medical record occurred on 05/04/16. Medications included	F 281	completed by the DON or designee five times weekly for four weeks, then three times weekly for four weeks, then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 281	Continued From page 17 Sinemet (anti-Parkinson's) scheduled for 7:00 a.m., 11:00 a.m., 3:00 p.m., and 7:00 p.m.; Midodrine (hypotension) scheduled for 8:00 a.m. and 2:00 p.m.; Pramipexole (anti-Parkinson's) scheduled for 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.; and Furosemide (diuretic), multivitamin with minerals, Ocuvite (supplement), fish oil, aspirin, calcium citrate, vitamin D3, cranberry tablet, miralax (laxative), symbicort inhaler, digoxin (cardiac) scheduled for 8:00 a.m. During observation of a medication pass on 05/04/16 at 9:57 a.m., observation showed a contract nurse (#10) approached by Resident #22 and the family member (#1) at the medication cart. The family member (#1) stated, "my husband never got his seven o'clock medication." The nurse asked the resident for his name and the resident replied with his first name. The nurse looked through the MAR, found the resident's name, pointed to a blank folder divider and stated "look there are no pictures here." The nurse then stated the resident did not receive his eight o'clock medications also. The family member (#1) stated, "yes we had a doctors appointment today and left at eight this morning." At 10:18 a.m. the nurse (#10) administered the 7:00 a.m. Sinemet and all of the scheduled 8:00 a.m. medications. The contract nurse (#10) failed to ensure proper identification and administer medications within the 60 minute time frame as per facility policy. During the afternoon of 05/04/16, review of Resident #22's MAR identified the nurse administered the Sinemet again at 11:00 a.m. and the Pramipexole again at 12:00 p.m. The nurse failed to adjust the time for the next	F 281		

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F 281	Continued From page 18 medication dose to ensure the four hour intervals between each dose. During an interview on the afternoon of 05/04/16, a contract nurse (#10) could not identify how to indicate on the MAR medication holds or a change in administration of scheduled medications. During an interview on 05/04/16 at 1:27 p.m., an administrative nurse (#1) verified nurses should be identifying residents by their full name, their identification bracelet, their picture, or ask other staff members.	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. This REQUIREMENT is not met as evidenced by: CONSTIPATION 1. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 3 sampled residents (Resident #4 and #5) who did not have a bowel movement (BM) for four or more days. Failure to monitor the resident's bowel status and provide as needed (PRN) laxatives to relieve constipation has the potential	F 309	Residents #4 and #5 were assessed for current constipation and interventions implemented if indicated. Resident #7 was assessed for any untoward effect related to receiving thin liquids with medication pass and did not develop any signs or symptoms of respiratory issues. Resident #22 has discharged and did not have any signs or symptoms of respiratory issues prior to discharge.	6/7/16

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F 309	Continued From page 19 to cause discomfort due to the lack of a bowel movement. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Resident #4's diagnoses included quadriplegia (paralysis of lower body). Medications included Senna Plus twice a day for constipation, Milk of Magnesia 10 [milliliter] daily as needed for constipation, Bisac-Evac 10 [milligram] suppository daily as needed for constipation, and Senna plus twice daily as needed for constipation. Review of Resident #4's current care plan stated, ". . . Focus . . . The resident has bowel incontinence [related to] immobility secondary to ischemic encephalopathy with quadraplegia. Potential for constipation. . . ." The care plan failed to include interventions related to constipation. Review of Resident #4's bowel movement record showed the following: * 12/16/15 - 12/19/15: no bowel movement for four days * 12/21/15 - 12/25/15: no bowel movement for five days * 12/30/15 - 01/02/16: no bowel movement for four days * 01/05/16 - 01/10/16: no bowel movement for six days * 01/14/16 - 01/21/16: no bowel movement for eight days * 02/03/16 - 02/06/16: no bowel movement for four days * 03/15/16 - 03/17/16: no bowel movement for	F 309	Resident records were reviewed to identify those that have episodes of constipation and interventions were reviewed for these residents. Residents who require thickened liquids were identified and MAR checked to ensure this was on the MAR. A bowel management protocol was developed and implemented detailing actions to be taken for residents who have not had a bowel movement documented in three days. The DON or designee provided education on May 11th, 12th, and 18th to licensed nurses on the bowel protocol and on thickened liquids with medication pass. CNAs were educated on the same dates regarding the need to record bowel movements in the electronic chart. Audits of recorded bowel movements will be completed by the DON or designee five times weekly for four weeks, twice weekly for four weeks, then weekly for three months. Direct observation of residents who receive medications and thickened liquids will be completed five times weekly for four weeks, then twice weekly for four weeks, then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 309	Continued From page 20 three days * 03/19/16 - 03/21/16: no bowel movement for three days * 04/05/16 - 04/08/16: no bowel movement for four days * 04/17/16 - 04/19/16: no bowel movement for three days * 04/23/16 - 04/25/16: no bowel movement for three days Review of Resident #4's Medication Administration Record (MAR) showed no PRN medications administered for constipation during the months of December through April of 2016. During an interview on 05/02/16 at 4:55 p.m., an administrative nurse (#1) confirmed no PRN medicationsto treat constipation were administered January through Apirl 2016. - Review of Resident #5's medical record occurred on all days of survey. Resident #5's diagnoses included constipation. Medications included Senna Plus twice a day for constipation, Milk of Magnesia 30 [milliliter] daily as needed for constipation, Miralax 17 GM [gram] with prune juice mix and drink daily as needed for constipation. Review of Resident #5's current care plan stated, ". . . Focus . . . Bowel Elimination Alteration; Risk Constipation related to: Lack of Exercise . . . Goal . . . Will have bowel movement at least [every] three days . . . Interventions . . . Report [sign and symptoms] constipation such as abdominal cramping, diarrhea, . . . no BM for 3 days . . ."	F 309		

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F 309	Continued From page 21	F 309		

Review of Resident #5's bowel movement record showed the following:
* 11/13/15 - 11/17/15: no bowel movement for five days
* 12/04/15 - 12/08/15: no bowel movement for five days
* 12/19/15 - 01/03/16: no bowel movement for sixteen days
* 01/18/16 - 01/20/16: no bowel movement for three days
* 01/23/16 - 01/25/16: no bowel movement for three days
* 02/08/16 - 02/11/16: no bowel movement for four days
* 02/22/16 - 02/26/16: no bowel movement for five days
* 03/08/16 - 03/12/16: no bowel movement for five days
* 03/15/16 - 03/17/16: no bowel movement for three days
* 03/19/16 - 03/23/16: no bowel movement for five days
* 03/25/16 - 03/27/16: no bowel movement for three days
* 04/16/16 - 04/20/16: no bowel movement for five days
* 04/27/16 - 04/29/16: no bowel movement for three days

Review of Resident #5's Medication Administration Record (MAR) showed no PRN medications administered for constipation during the months of November through April 2016.

During an interview on 05/02/16 at 4:55 p.m., an administrative nurse (#1) confirmed no PRN medications to treat constipation were administered January through April 2016.

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F 309	Continued From page 22 THICKENED LIQUIDS 2. Based on observation, record review, and staff interview, the facility failed to ensure staff provided the care and services necessary for 2 of 2 residents (Resident #7 and #22) observed receiving thinned liquids during medication pass. Failure to ensure the residents received liquids in the consistency ordered by the physician may result in aspiration. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included oropharyngeal dysphagia (difficulty swallowing). The current care plan stated, "Focus: Nutritional status as evidenced by . . . swallowing difficulty r/t [related to] Parkinsons. Need for altered texture food and fluids. . . . Interventions: . . . Thickened liquids as ordered Honey [honey thickened] . . ." Observation on 05/01/16 at 4:25 p.m. showed a contract nurse (#17) administered Resident #7's medications with a glass of un-thickened water. Review of the MAR showed a thickened liquids precaution sign in the patient's record. - Observation on 05/04/16 at 10:18 a.m. showed a contract nurse (#10) administer medications to Resident #22 with a glass of un-thickened water. The contract nurse (#10) placed the glass in the resident's hand. The family member (#1) stated, "[Resident #22] is not allowed to have the water he must have thickened liquids." The nurse then removed the glass from the resident's hand. A	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 23 thickened liquids precaution sign was noted in the resident's medication administration record (MAR).	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/25/15 AND ON 05/13/15 TRANSFERS 1. Based on observation, record review and the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 sampled resident (Resident #7) who required a sit to stand mechanical lift for transfers and 5 supplemental residents (Resident #23, #24, #25, #26, and #27) observed during wheelchair transfers. Failure to use the proper assistive device and foot pedals on wheelchairs placed these residents at risk for sustaining a fall or injury. Findings include: - Review of Resident #7's medical record	F 323	All staff were instructed to utilize foot pedals. Resident # 7 was assessed for injury related to the transfer and no evidence of injury was found. Residents # 24, 25, 26 and 27 did not have any injury noted from wheelchair being propelled without foot pedals in place. Resident #23 has been discharged from the facility. Each of the residents identified have been assessed for WC foot pedals and implemented. Other residents who require foot pedals for safe transport are being assessed for need and equipment secured for safety and availability. Care plans will be updated as identified needs change. No residents were identified that were directly impacted by unsecured chemicals. Concerns found on tour were corrected and post exit a safe chemical	6/7/16

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	355031	A. BUILDING _____ B. WING _____	05/04/2016

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MINOT HEALTH AND REHAB, LLC	600 S MAIN ST MINOT, ND 58701

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F 323	Continued From page 24 occurred on all days of survey. Diagnoses included Parkinson's disease, muscle weakness, and a history of falls including a femur fracture. Patient #7's quarterly Minimum Data Set (MDS), dated 01/28/16, identified extensive assistance of two or more staff members for transfers and one fall with injury during the assessment period. The current care plan stated, "Transfers with 2 Person assist and sit-stand lift . . ." Observation on 05/02/16 at 2:30 p.m. showed two certified nurse assistants (CNAs) (#7 and #16) transferred Resident #7 from the bed to her wheelchair with a gait belt. The CNAs failed to follow the resident's care plan and utilize the sit-stand lift for the transfer. - An observation of Resident #27 on the afternoon of 05/03/16 showed the resident sitting in his wheelchair with one foot tucked back under the wheelchair and without foot pedals in place. An unidentified CNA approached the resident and told him it was time for dinner. The CNA attempted to pull Resident #27's wheelchair backwards into his room and stated she did not understand why his wheelchair would not move. Observation showed the front wheel of the wheelchair had caught on Resident #27's foot tucked under the wheelchair. The CNA applied foot pedals to the wheelchair and transported Resident #27 to the dining room. - Review of Resident #26's medical record occurred on 05/04/16. Medical diagnoses included spinal stenosis, osteoarthritis, dizziness, and repeated falls. The admission MDS, dated 04/25/16, identified intact cognition and	F 323	storage tour was conducted. Staff were educated on the safe storage of chemicals and locking devises have been replaced on mobile carts. Safety committee will check safe storage of chemicals on the monthly tours and auditing as scheduled below will monitor compliance. Residents who transfer with lifts and those who require assistance with propelling wheelchairs have the potential to be negatively impacted by this practice. Residents who could access unsecured chemicals have the potential to be negatively impacted by this practice. Education was provided by the Administrator and DON to the interdisciplinary team including nurses,nursing assistants, management staff, housekeeping and dietary staff on May 11th , 12th , and 18th regarding following the care plan for transfers, using wheelchair pedals when assisting to propel patient wheelchairs, and securing all chemicals in the housekeeping carts or locked storage room. The Administrator or designee will complete audits of housekeeping carts and chemical storage five times weekly for four weeks, twice weekly for four weeks, and then weekly for three months. The DON or designee will complete direct observation of transfers with lifts five times weekly for four weeks then twice weekly for four weeks then weekly for	

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F 323	Continued From page 25 limited-to-extensive assistance of one person for transfers and locomotion on the unit. Observation on 05/01/16 at 3:10 p.m. showed an unidentified staff member transported Resident #26 down the hallway in her wheelchair. Resident #26's feet/shoes were audible on the carpet, caught and bounced on the linoleum as the staff member transported her. The staff member failed to cue Resident #26 to lift her feet and/or apply foot pedals during transport. - Review of Resident #23's medical record occurred on 05/04/16. Medical diagnoses included altered mental status, arthritis, muscle weakness, difficulty walking, and history of falls. The significant change MDS, dated 02/11/16, identified moderately impaired cognition and extensive assistance of two or more people for transfers. Observation on 05/01/16 at 4:22 p.m. showed an unidentified staff member transported Resident #23 down the hallway in his wheelchair. Resident #23's feet/shoes caught and bounced on the linoleum as the staff member transported him. The staff member failed to cue Resident #23 to lift his feet and/or apply foot pedals during transport. - Review of Resident #25's medical record occurred on 05/04/16. Medical diagnoses included dementia, aphasia following cerebral infarction, muscle weakness, and abnormalities of gait and mobility. The admission MDS, dated 03/31/16, identified severely impaired cognition and extensive assistance of one person for transfers and locomotion on the unit.	F 323	three months. The DON or designee will complete direct observation and audit of staff propelling wheelchairs five times weekly for four weeks, twice weekly for four weeks, then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 323	Continued From page 26 Observation on 05/01/16 at 5:20 p.m. showed a CNA (#7) transported Resident #25 down the hallway in her wheelchair. Resident #25's left foot/shoe had slipped off the footrest and caught and bounced on the linoleum as the staff member transported her. The staff member failed to cue Resident #25 to lift her left foot. - Review of Resident #24's medical record occurred on 05/04/16. Medical diagnoses included dementia, osteoporosis, weakness, and history of falling. The admission MDS, dated 04/04/16, identified moderately impaired cognition and extensive assistance of one or more people for transfers and locomotion on the unit. Observation on 05/02/16 at 11:53 a.m. showed an unidentified staff member transported Resident #24 down the hallway in his wheelchair. Resident #24's left foot/shoe and right heel/shoe were audible on the carpet. The staff member failed to cue Resident #24 to lift his left foot and/or apply foot pedals during transport. HAZARDOUS CHEMICALS 2. Based on observation, review of facility policy, and staff interview, the facility failed to maintain an environment free of hazardous chemicals for 3 of 4 days of survey (May 01, 02, 04, 2016). This practice placed residents with memory loss and/or wandering behaviors at risk of exposure to hazardous chemicals. Findings include:	F 323		

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	355031	A. BUILDING _____ B. WING _____	05/04/2016

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F 323	Continued From page 27	F 323		

Review of the facility policy titled "HOUSEKEEPING IN-SERVICE" occurred on 05/04/16. This policy, dated January 2000, stated, ". . . A locking box is required if chemicals are stored on the cart. This is especially important in patient areas. In addition, a cart should never be left unattended in any work area."

- The initial tour of the facility occurred on 05/01/16 from approximately 9:30 to 11:00 a.m. Observation showed two unlocked housekeeping carts on the second floor, one in the hall outside the dining room door and the other in the hallway between residents rooms 258 and 260. These carts contained cleaning items harmful or fatal if swallowed or inhaled. Items included Crew toilet bowl cleaner, Virex chemical cleaner, and a blue liquid with a toilet brush in it. Observation showed residents self-propelling in wheelchairs by the carts.

- Observation on 05/03/16 at 10:24 a.m. showed an unlocked housekeeping cart outside the dining room. This cart contained the same items listed above.

- The enviornmental tour of the facility occurred on 05/04/16 at 8:30 a.m. with three administrative staff members (#18, #19, and 20#). Observation showed the following:
* An unlocked and unattended housekeeping cart on the first floor in a resident hallway. This cart contained Crew, Virex, and an bucket of an unidentified blue liquid.
* A bottle of Oasis Quat Sanitizer located in an unlocked cupboard in the second floor activity/dining room. The bottle stated "harmful if

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F 323	Continued From page 28 swallowed." During an interview on 05/04/16 at 9:30 a.m., an administrative staff member (#19) stated he/she expected unattended housekeeping carts and all cupboards containing chemicals to be locked.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure adequate interventions to prevent weight loss and maintain an acceptable nutritional status for 2 of 5 residents (Resident #5 and #7) identified with weight loss. Failure to initiate timely and effective interventions, re-evaluate and modify the interventions as needed, and consistently implement existing interventions resulted in significant weight loss for Resident #5. Findings include: - Review of Resident #5's medical record	F 325	Resident #5 continues to receive the interventions. Resident #7 has maintained her weight and is being offered fortified foods as ordered. All Care Staff were educated that " fortified" is delineated on the tray card with an option existing at each meal to offer an alternative as an intervention for resident #5 and all other residents identified as needing nutritional monitoring. Tray card identification and recorded consumption with regular weight monitoring will ensure the problem does	6/7/16

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F 325	Continued From page 29 occurred on all days of survey. Diagnoses included diabetes, constipation, and depression. The significant change Minimum Data Set (MDS), dated 03/30/16, identified a weight loss. The current care plan stated, ". . . Focus . . . At risk for alteration in skin integrity . . . Interventions . . . Diet and supplements per physician order . . . Focus . . . ADL [activity of daily living] Self care deficit . . . Interventions . . . Assist with . . . eating as needed . . . Focus . . . Bowel Elimination Alteration; Risk Constipation . . . Interventions . . . Dietary to evaluate and modify meal and snack plan as needed to include high fiber foods, prune juice, etc . . . Nutritional Status as evidenced by weight loss related to varying intakes and recent illness limits self to diabetic items and limited snacks . . . Interventions . . . Regular diet . . . Snacks per patient preference . . . Supplement in the afternoon . . . Focus . . . Nutritional status as evidenced by actual weight loss/gain r/t [related to] involuntary weight loss related to skipping meals . . . Interventions . . . Encourage and assist as needed to consume foods and/or supplements and fluids offered Discourage from skipping meals or bring meal to room . . . Provide diet as ordered Regular diet . . . Snack per patient preference . . ." Resident #5's weights showed the following: * 04/11/16: 130 pounds (lbs) * 03/02/16: 125 lbs * 02/03/16: 131.8 lbs * 01/02/16: 133.4 lbs * 12/01/15: 135.8 lbs * 11/01/15: 136.6 lbs * 10/07/15: 140.2 lbs * 09/02/15: 145 lbs * 08/01/15: 146.2 lbs	F 325	not recur. Residents with weight loss have been identified and have the potential to be negatively impacted by this practice. It was validated that these residents have nutritional interventions in place. Education will be provided by the Food Service Manager to the dietary staff on May 23, 24, and 25th regarding the need to provide fortified foods as ordered. Education was/will be provided by the DON or designee to CNAs on May 18,19,25 and 26 regarding the need to validate fortified foods are present on meal trays when they are served. Fortified food items were reviewed with staff during education sessions as well to ensure they are aware of which items are considered fortified. The DON or designee will complete audits five times weekly for four weeks then twice weekly for four weeks then weekly for three months to validate fortified foods are received as ordered. The DON or designee will complete audits three times weekly for four weeks for acceptance of nutritional interventions then twice weekly for four weeks then weekly for three months.	

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F 325	Continued From page 30 * 07/01/15: 149.8 lbs * 06/03/15: 154.8 lbs * 05/01/15: 157 lbs May 2015 to October 2015 represents a 16.8 pound weight loss in 6 months (10.6 percent (%)), and October 2015 to March 2016 represents a 15.2 pound weight loss in 6 months (10.8 %), i.e. a severe weight loss. Nutrition notes stated the following: * 05/06/15 at 5:14 p.m.: ". . . [resident] is on a regular diet. . . . Potential for [weight] change with decrease in intakes. . . . Continue to monitor at this time." * 07/24/15 at 1:49 p.m.: ". . . Current [weight] 150 [pounds]. [Resident] has a variable intake averaging [approximately] 70% of her meals. She makes her preferences known. She self limits her snacks and foods she takes at meals. Her appetite in the past was consistently over 85%. In the past few months her intakes are more variable. . . . Continue to monitor. [Weight] loss is beneficial for her mobility." * 10/07/15 at 1:20 p.m.: ". . . Weight review [Resident] continues to have a gradual [weight] loss. She states she is not concerned with the loss. She self limits herself at meals. . . . Encourage to maintain her [weight]." * 10/23/15 at 1:39 p.m.: ". . . has had a significant [weight] change in the past 6 months. She feeds herself a regular diet. . . . Her [weight] is down to 140 [pounds]. This author visited with her and she has been skipping some evening meals. She will try not to miss meals. Encouraged her to maintain her [weight]. She said she will try to do that. Continue to monitor." * 01/27/16 at 4:11 p.m.: ". . . Continues to receive	F 325		

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F 325	Continued From page 31 a regular diet. . . . Current weight is 133, No significant change past [month]/3[month], this is a significant change in 6 months. . . . Will continue to monitor weights, intakes and encourage and assist as needed." 03/08/16 at 3:22 p.m.: ". . . continues to have [weight] loss related to her intakes. Eats poor to fair at supper refuses supper. . . . Continues on a regular diet with sugar free items. Current [weight] 125 [pounds]. Recommend offering supplement in afternoon. . . ." 03/25/16 at 11:13 a.m.: ". . . returned from hospital. Potential for [weight] change related to loss of hospital fluids. She has had a significant [weight] change in the past 6 months. . . . Has been encouraged in the past not skip meals due to her gradual [weight] loss. supplement being offered for added calories. She is is on regular diet. Offer fortified or high [calorie] items." The progress notes show no dietary interventions were implemented during the significant weight loss period until March of 2016, after a severe weight loss occurred. During an interview on the afternoon of 05/04/16, an administrative staff (#1) stated Resident #5's weight loss was due to the resident's self limit of intake. No explanation was provided for the lack of interventions implemented before March 2016. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease and dementia. Resident #7's quarterly MDS, dated 01/28/16, identified supervision required for meals and weight loss. The current care plan stated, "Focus: Nutritional status as evidenced by recent wt.	F 325		

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F 325	Continued From page 32 [weight] loss. Has swallowing difficulty r/t Parkinsons. Need for altered texture food and fluids. Needs assistance with meals. . . . Interventions: . . . Encourage and assist as needed to consume foods and/or supplements and fluids . . . Provide Pureed diet as ordered. Extra gravy with meals . . . Fortified cereal at Breakfast and fortified soup at supper . . ." A dietary note, dated 05/01/16, stated Resident #7 currently receives fortified cereal at breakfast, fortified soup at lunch and supper, yogurt at all three meals, and a nutritional supplement three times a day. Review of Resident #7's weights showed a weight of 146 lbs on 08/02/15, 124 lbs on 03/02/16 (a 22 lb weight loss in 6 months), and 131.4 lbs on 05/01/16 (a 7.4 lb weight gain). Observation on 05/03/16 at 8:35 a.m. showed dietary staff failed to serve Resident #7 yogurt at breakfast. Observation at 12:15 p.m. showed dietary staff failed to serve the resident fortified soup and yogurt for lunch. Failure to serve Resident #7 fortified soup and yogurt as recommended by the dietician may result in Resident #7 experiencing weight loss again.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		6/7/16

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F 327	Continued From page 33 This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/25/15 Based on observation and record review, the facility failed to offer fluids to 3 of 8 sampled residents (Resident #5, #6, and #7) during cares. Failure to offer fluids during cares increased the risk of dehydration, constipation, and urinary tract infections (UTIs) for these residents. Findings Include: - Review of Resident #5's medical record occurred on all days of the survey. Diagnoses included muscle weakness, difficulty walking, shortness of breath, rheumatoid arthritis, history of falling, congestive heart failure, acute kidney failure, and UTI. The resident's significant change Minimum Data Set (MDS), dated 03/30/16, identified set-up and supervision for eating. Review of Resident #5's current care plan stated, ". . . Focus . . . ADL [activity of daily living] Self care deficit as evidenced by need for physical assist related to physical limitations SOB [shortness of breath] and weakness from CHF [congestive heart failure]. . . . Interventions . . . assist with daily . . . oral care and eating as needed . . . cognitive loss . . . related to early state dementia. . . ." Observation on 05/02/16 at 10:26 a.m. showed a certified nurse assistant (CNA) (#8) assisted Resident #5 from the bed to her wheelchair into the bathroom for toileting. The CNA then assisted the resident with dressing and personal cares.	F 327	Staff were educated to provide Hydration with cares for Residents # 5 and #7. Residents #5 and #7 will be offered appropriate consistency fluids at cares in addition to regular meal and each shift fluid pass. Resident #6 no longer resides at the facility. Residents who require assistance with fluid intake or reminders to drink fluids have the potential to be negatively impacted by this practice. The DON educated nursing staff on May 11th , 12th , and 18th on the need to offer fluids with cares. The DON or designee will complete direct care observation and audits five times weekly for four weeks then twice weekly for four weeks then weekly for three months to validate hydration guidelines are being followed. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 327	Continued From page 34	F 327		

The CNA failed to offer fluids and no fluids were noted at the bedside.

- Review of Resident #6's medical record occurred on all days of the survey. Diagnoses included constipation, hypertension, shortness of breath, and UTI. The resident's admission MDS, dated 03/25/16, identified set-up and supervision for eating.

Review of Resident #6's current care plan stated, ". . . Focus . . . ADL self care deficit as evidenced by: non-verbal communication . . . Interventions . . . Assist with daily hygiene, grooming, dressing, oral care, and eating as needed. . . . transfer with 2 assist . . . Cognitive loss . . ."

Observation on 05/02/16 at 9:17 a.m., showed a two CNA's (#11 and #12) transferred Resident #6 to the bathroom, perform peri cares, and empty the foley catheter bag. The CNAs failed to offer fluids and no fluids were noted at the bedside.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia, and muscle weakness. The resident's quarterly MDS, dated 01/28/16, identified limited assistance of one staff member for eating.

Resident #7's current care plan stated, "Focus: Nutritional status as evidenced by recent wt [weight] loss. Has swallowing difficulty r/t [related to] Parkinsons. Need for altered texture food and fluids. Needs assistance with meals. . . . Interventions: . . . Encourage and assist as needed to consume foods and/or supplements and fluids.

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 _____	05/04/2016

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F 327	Continued From page 35 Observation on 05/02/16 at 2:30 p.m. showed two CNAs (#7 and #16) assisted Resident #7 from bed to her wheelchair. The CNAs failed to offer the resident fluids and no fluids were present in her room.	F 327		
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. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility	F 329	Resident # 7 had a medication review	6/7/16

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F 329	Continued From page 36 policy/procedure, and staff interview, the facility failed to monitor the use of an antipsychotic medication and as needed (PRN) anti-anxiety medication for 2 of 11 sampled residents (Resident #7 and #10) on psychotropic medications. Failure to document the clinical rationale for not attempting a gradual dose reduction (Resident #7) and failure to attempt non-pharmacological interventions prior to the administration of a PRN medication and document the results of the medication (Resident #10) may result in the residents receiving an unnecessary medication. Findings include: Review of the facility policy/procedure titled "Medication Administration-General Guidelines" occurred on 05/04/16. This policy/procedure dated, April 2014, stated, ". . . C. Documentation. . . . 2) When a PRN medications are administered, the following documentation is provided: . . . b) Complaints or symptoms for which the medication was given. . . . c) Results achieved from giving the dose and the time results were noted. . . . ." - Review of Resident #10's medical record occurred May 01-04, 2016. Diagnoses included Lewy body dementia with behavioral disturbance and generalized anxiety disorder. A quarterly Minimum Data Set (MDS), dated 04/12/16, identified short and long term memory loss, and severely impaired ability to make daily decisions. Review of Resident #10's medication administration record (MAR) for April 2016, identified lorazepam (anti-anxiety medication) 0.5	F 329	completed by the pharmacist and forwarded to the medical provider. The dose of Seroquel was reduced as a result of this audit. Resident #7 is being monitored for any adverse effect related to this reduction. Resident #10 no longer resides at the facility. Review of current residents was completed and those who experience behavior symptoms and receive psychotropic medications were identified as like residents who could be negatively impacted by this practice. Compliance with pharmacy review for these medications was validated. Behavior care plans were updated when needed to include non-pharmacological approaches. After completion of a full review for GDR needs and recommendations the DON or designee will monitor monthly for follow through and review of actions that will be presented at QA for ongoing analysis. The DON or designee educated licensed nurses and nursing assistants on May 11th , 12th , and 18th on behavior documentation and suggested interventions to be taken prior to administering PRN medications. The DON educated the interdisciplinary team on GDR requirements. The DON or designee will complete audits of use of psychotropic medication three times weekly for four	

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F 329	Continued From page 37 milligram (mg) by mouth once daily PRN for anxiety, changed to PRN twice a day on 04/22/16. The MAR identified nursing staff administered lorazepam 19 times in April. Nursing staff failed to document the behavior observed and/or the non-pharmacological interventions attempted prior to administering the lorazepam, and/or outcome related to the administration of the medication. During an interview on 05/04/16 at 11:40 a.m., an administrative nurse (#1) confirmed nursing staff should document the behaviors observed when administering a PRN anti-anxiety medication, identify the non-pharmacological interventions attempted, and the outcome of PRN anti-anxiety medications administered. Review of the facility policy titled "Psychotropic Gradual Dose Reduction (GDR) Guidelines" occurred on 05/04/16. This undated policy stated, "Antipsychotics: Frequency . . . After 1st year annually . . . Treatment of psychiatric disorder: GDR . . . Continued use is in accordance with relevant current standards of practice AND the physician has documented clinical rationale. The "Centers for Medicare and Medicaid Services," stated, "For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia . . .), the GDR may be considered contraindicated, if: *The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's	F 329	weeks, then twice weekly for four weeks then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 329	Continued From page 38 function or cause psychiatric instability . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and paranoid schizophrenia. Medications included Seroquel 250 mg at bedtime, initiated July 2014. Resident #7's quarterly MDS, dated 01/28/16, identified both long and short term memory problems and no behaviors exhibited during the seven day assessment period. The "Psychotropic Med [medication] Use Detail Report," dated April 2016, stated, ". . . 11/15 [November 2015] addressed by psyche [psychiatric] review committee - no change at this time." During an interview on the afternoon of 05/05/16, an administrative nurse (#1) stated the psychiatric review committee members consisted of the Director of Nursing, the Assistant Director of Nursing, the pharmacist, and the medical director when available. The nurse (#1) stated the physician recommended not to decrease Resident #7's Seroquel in 2012 due to her stability on the dosage (200 mg at that time). Failure to document the clinical rationale for why any attempted dose reduction would be contraindicated resulted in Resident #7 receiving the same dose of Seroquel since July 2014 and may have resulted in an unnecessary dose of medication.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		6/7/16

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F 332	Continued From page 39 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure and staff interview, the facility failed to ensure a medication error rate of less than 5% during 2 of 4 observations of medication administration on 05/02/16; and failed to ensure 1 of 1 closed resident record (Resident #19) reviewed received scheduled medications. Failure to ensure staff administered medications as ordered resulted in a medication error rate of 10% and Resident #19 not receiving medications scheduled for bedtime. Findings include: Review of the facility policy/procedure titled "Medication Administration-General Guidelines" occurred on 05/04/16. This policy/procedure dated, April 2014, stated, ". . . B. Administration . . . 2) Medications are administered in accordance with written orders of the attending physician. . . . 9) Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered, based on meal times. . . . C. Documentation. 1) The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and	F 332	Resident #21 had orders reviewed and MAR updated to reflect current orders. MD was notified of incorrect vitamin being given and missed eye drops. Resident #20 no longer resides at the facility however it is noted that nursing notified the MD of the error during the survey and the MD updated the order to read administer medication BID as this was what the resident was maintained on prior to a recent hospitalization. Resident #19 no longer resides at the facility. Residents who reside in the facility and receive medication have the potential to be impacted by this practice. A review of current orders to MAR has been initiated and will be completed by June 1, 2016. Physicians have been/will be notified, orders clarified, and MARs updated if indicated. The DON or designee provided education to licensed nurses on May 11, 12, and 18th regarding the process for validating orders with two licensed nurses reviewing monthly orders and admission orders. A 24 Hour Report sheet has been developed and implemented in the facility to and new orders are recorded on this form to ensure follow up and validation of	

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F 332	Continued From page 40 documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. . . . 6) Residents are identified before medication is administered. Methods of identification include: a) Checking identification band. b) Checking a photograph attached to the medical record. c) Asking the resident to state their name. d) If necessary, verifying resident identification with other facility personnel. . . . 3. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter does of antibiotic is needed), it is noted on the MAR and an explanatory note is entered in the area of the record provided for this documentation. If vital medications are withheld or refused, the physician is notified. . . ." Review of the facility policy and procedure titled "Medication Administration-General Guidelines" occurred on 05/04/16. This policy and procedure dated, April 2014, stated, ". . . B. Administration . . . 2) Medications are administered in accordance with written orders of the attending physician. . . . C. Documentation. 1) The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. . . ."	F 332	transcription is completed. This will be an ongoing process in the facility. The DON or designee will complete audits of transcription from MD order to MAR/TAR five times weekly for four weeks then twice weekly for four weeks and then weekly for three months. Results of audits will be forwarded to the QA committee for review and recommendations.	

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F 332	Continued From page 41 - Observation of medication pass occurred on 05/02/16 at 8:22 a.m. A licensed nurse (#5) attempted to administer a multivitamin with minerals to Resident #21 as indicated on the MAR. The medication cart failed to contain a bottle of multivitamins with minerals and the nurse (#5) obtained the needed medication from the stock medication storage. The nurse (#5) then delegated the administration of Resident #21's multivitamin with minerals, eye drops, and inhaled medication to another licensed nurse (#6). Observation at 8:45 a.m. showed the nurse (#6) prepared the multivitamin with minerals and the inhaled medication and administered them to Resident #21. The nurse (#6) failed to administer eye drops th the resident. Review of Resident #21's medical record on the afternoon of 05/02/16 showed the physician order stated, "multivitamin", not "multivitamin with minerals" as stated on the MAR. During an interview on 05/02/16 at 4:25 p.m., a licensed nurse (#5) confirmed Resident #21's physician's order was for a "multivitamin" and staff failed to administer the eye drops as ordered. The nurse (#5) identified the MAR is printed by the facility pharmacy and checked by two facility nurses. Facility staff failed to identify the transcription error related to the multivitamin. The nurse also confirmed staff failed to administer the ordered eye drops. -Review of Resident #20's medical record showed a physician order, dated 04/27/16, stated, "Keppra [levetiracetam] 750 mg 1 [tablet] PO [by mouth] daily." Resident #20's MAR	F 332		

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F 332	Continued From page 42	F 332		

stated, "Levetiracetam 750 mg tab [tablet] . . . Take 1 tab by mouth twice a day for seizure . . . 8 AM [morning] . . . 8 PM [evening] . . ." The MARs (April and May 2016) showed nursing staff administered the levetiracetam twice a day at 8:00 a.m. and 8:00 p.m.

Observation of medication pass occurred on 05/02/16 at 7:52 a.m. A licensed nurse (#3) administered Levetiracetam 750 milligram (mg), one tablet, to Resident #20 as indicated on the MAR.

During an interview on the afternoon of 05/02/16, an administrative nurse (#1) stated staff failed to identify the transcription error related to the Levetiracetam. This error resulted in Resident #20 receiving Levetiracetam twice daily rather than daily.

- Review of Resident #19's closed medical record occurred on 05/03/16. Medications ordered at bedtime included Donepezil (dementia), melatonin (sleep aid), calcium, ICAP (multivitamin), Symbicort inhaler, and Tylenol. The progress note, dated 11/18/15 at 11:52 a.m., stated, "[physician] notified of medication error. HS [night] medications were not given last evening. . . ."

Resident #19's incident report, dated 11/17/15, stated, ". . . HS medications signed out on MAR but still in blister packs. Not administered. . . ." The report identified a nursing staff member documented the medications given, however failed to administer the resident's medication as ordered.

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F 332	Continued From page 43 During an interview in the morning of 05/04/16, an administrative nurse (#1 lacked evidence of an investigation to determine the causative factor and corrective action of the medication error.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		6/7/16

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F 356	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post accurate nurse staffing data on 1 of 4 survey days (05/01/16). Failure to post accurate nurse staffing data denied residents and visitors the opportunity to be informed regarding the staffing levels. Findings include: Observation on 05/01/16, at approximately 9:30 a.m. showed the staff posting data for 04/29/16. During an interview on the afternoon of 05/04/16, an administrative nurse (#1) confirmed the facility failed to change the staff posting data since 04/29/16.	F 356	The requirement for daily posting is meant to identify sufficient and consistent accuracy of staff to provide for the needs of the residents. The staffing coordinator or designee posts the weekend schedule behind the Friday schedule for daily updates. The weekend Manager on Duty or Charge Nurse is responsible to make sure the current day is posted and updated. All Residents have the potential to be impacted by this practice. The Administrator provided education to the management team/ weekend managers on May 18th on the need to update staff hour postings each shift. The DON or designee will complete audits of posted hours five times weekly for four weeks then twice weekly for four weeks then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	
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		6/7/16

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F 371	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store and prepare foods in a safe and sanitary manner in 1 of 1 kitchen. Failure to label and date refrigerated foods properly and/or discard the expired foods placed the food at risk for contamination and failure to maintain the correct concentration of sanitizing solution does not allow the facility to effectively clean and disinfect food surfaces, which may result in food borne illness. Findings include: Review of the facility policy titled "Food Storage: Cold" occurred on 05/04/16. This policy, dated May 2014, stated, ". . . 5. The Food Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. . . ." During the initial tour of the kitchen on 05/01/16 at 9:55 a.m., a dietary staff member (#15) tested a sanitization bucket (used on food contact surfaces) sitting in the dish washing area. The solution tested less than 10 parts per million (ppm). During an interview on the morning of 05/03/16, an administrative dietary staff member (#14) confirmed when using a chlorine sanitizing concentration, the ppm needs to test at 50-100	F 371	The dietary staff has been educated about the use of a daily checklist of opening and closing systems that will ensure and includes all food items are labeled and dated are checked at the beginning and end of the day for recorded freshness. The checklist also includes chemical testing for accurate levels of sanitizer solution within range. The Dietary manager or designee will conduct weekly audits ongoing with initial schedule below followed by month review of 200ppm Quat or chlorine at 50 to 100ppm. Residents who reside in the facility have the potential to be affected by these practices. Education was provided by the Food Services Manager to dietary staff on May 18th, 19th, regarding the time frame in which foods must be used after opening. Audits will be completed by the Food Service Manager or designee of food storage areas three times weekly for four weeks, twice weekly for four weeks then monthly for three months. Results of audits will	

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F 371	Continued From page 46 ppm. Observation of the kitchen refrigerator on 05/01/16 at 9:55 a.m. showed the following: * A container labeled beef drippings with a use by date of 04/30/16. * A container of hot dogs labeled with a use by date of 04/25/16. * A container of cheese slices labeled with a use by date of 08/28/15. * A mug of coco wheat (cooked cereal) uncovered with no label or date. * Four containers of peach puree with no label or date. * A package of bologna lunch meat slices wrapped in an open plastic wrap with no label or date. * A pitcher of juice with no label or date. * A stainless steel container of roast beef puree with no date. During an interview on the morning of 05/3/16, an administrative dietary staff member (#14) confirmed all food should be covered, labeled, and dated. She stated that foods should be discarded by the expiration date.	F 371	be forwarded to the QAPI committee for review and recommendations.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. A facility must provide pharmaceutical services	F 425		6/7/16

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F 425	Continued From page 47 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 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. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to ensure the removal of expired medications in 2 of 2 units. Failure to dispose of medication by the recommended time frame has the potential to affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "STORAGE OF MEDICATIONS" occurred on 05/04/16. This policy, dated April 2014, stated, ". . . M. Outdated, contaminated, or deteriorated medications . . . are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy . . ." Observation on 05/04/16 at 9:00 a.m. of medication cart #1 located on the second floor identified: * Atorvastatin tablets expired 04/03/15 * Furosemide tablets expired 04/30/15	F 425	No residents were identified as being impacted by this practice. Residents who receive stock medication have the potential to be impacted by this practice. An audit of each medication cart and each medication storage area was completed and expired medications were removed from stock. A night shift duty list was developed to include routine check of medication cart, medication storage, and EKit for expired medications. The DON provided education to licensed nurses and the ancillary clerk on management of stock medication on May 11th , 12th , and 18th . Education included checking expiration dates on stock medications and EKIT contents. The DON or designee will complete audits of stock medication twice weekly	

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F 425	Continued From page 48 * ProAir inhaler expired 04/30/15 * Levothyroxine tablets expired 04/30/15 Observation on 05/04/16 at 10:50 a.m. of medication cart #14 located on the first floor identified: * 2 packs of Odanestran tablets expired 09/22/15 * Simethicone tablets expired January 2016 * 1 bottle of aspirin tablets expired July 2015 * 1 bottle of vitamin E expired April 2016 * 1 bottle of aspirin tablets expired March 2016 Observation on 05/04/16 at 11:14 a.m. of medication cart #67 located on the first floor identified: * 1 bottle of travel sickness tablets expired January 2016 * 1 Dulera inhaler expired 01/08/16 * 1 bottle of aspirin tablets expired March 2016 * 1 bottle of ferrous gluconate tablets expired March 2016 * 1 bottle of vitamin B-12 tablets expired April 2016 * 1 bottle of vitamin B complex expired January 2016 * 1 bottle of iron tablets expired October 2015 * 1 bottle of vitamin C tablets expired February 2016	F 425	for four weeks then weekly for four weeks then monthly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		6/7/16

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F 428	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's consulting pharmacist failed to recommend a gradual dose reduction (GDR) to the attending physician for 1 of 11 sampled residents (Resident #7) on psychotropic medications. Failure to notify the physician related to Resident #7's continued use of a psychotropic medication has the potential for this resident to receive an unnecessary dose of medication and experience adverse side effects. Findings include: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included paranoid schizophrenia and dementia. Medications included Seroquel 250 milligrams (mg) at bedtime. When asked for the monthly pharmacy reviews, an administrative nurse (#1) provided a "Psychotropic Med [medication] Use Detail Report," dated April 2016. This report stated, ". . . dx [diagnosis] - schizophrenia. 11/12 [November 2012] - admit on 200 mg HS [hour of sleep]. 7/14 [July 2014] - increased to 250 mg HS. 11/15 [November 2015] addressed by psyche [psychiatric] review committee - no change at this time." During an interview on the afternoon of 05/05/16,	F 428	Resident # 7 had a psychotropic medication review completed by the pharmacist and forwarded to the medical provider. The medical provider has reviewed and signed the recommendations. Residents who receive psychotropic medications have been reviewed and appropriate review and follow up have been validated. The DON provided education on May 19th to the nurse managers and social services staff regarding GDR requirements and follow up. The DON or designee will complete audits of psychotropic medications for review and follow up of recommendations twice weekly for four weeks, then weekly for four weeks, then monthly on an ongoing basis. Findings of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 428	Continued From page 50 an administrative nurse (#1) identified the psychiatric review committee members consisted of the Director of Nursing, the Assistant Director of Nursing, the pharmacist, and the medical director when available. The nurse (#1) stated Resident #7's physician does not attend the committee meeting and the committee does not provide the physician with a copy of the report. The Nurse (#1) stated the physician recommended not to decrease Patient #7's Seroquel in 2012 due to her stability on the dosage (200 mg at that time).	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		6/7/16

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F 441	Continued From page 51 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/25/15 Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 6 of 16 sampled residents (Resident #2, #3, #4, #5, #8 and #16) and 2 of 9 supplemental residents (Resident #22 and #28). Failure to follow infection control practices related to soiled linens (Resident #2, #3, #4, #5, and #28) and proper glove use/hand hygiene (Resident #3, #8, #16, and #22) has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 05/04/16. This undated policy, stated, ". . . 6. Wash hands with soap . . . and water for the following situations: When hands are visibly	F 441	Residents # 2, 3,4,5, 16 and 22, 28 were reviewed and did not develop any untoward effects related to the observations by the survey team. Resident # 22 has discharged from the facility. The identified residents above are dependent on staff for removing soiled linens without contact to the floor. Staff corrected the deficient practice when identified, and have been educated and monitored for ongoing compliance. Resident #3,#8,#16,and 22 were identified to have personal cares provided without proper hand washing and glove use between care processes. These residents are dependent on staff for proper infection control and hygiene. The residents identified have been correctly assessed for dependent care and all	

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F 441	Continued From page 52 soiled; and After contact with a resident with infectious diarrhea . . . 7. Use an alcohol-based hand rub . . . for the following situations: . . . Before and after direct contact with residents; . . . Before moving from a contaminated body site to a clean body site during resident care; . . . After removing gloves; . . ." Review of an untitled and undated facility policy, provided by an administrative nurse (#1) stated, ". . . 7. Linen a. Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments . . . " GLOVE USE AND HAND HYGIENE - Observation on 05/02/16 at 9:10 a.m. showed a certified nursing assistant (CNA) (#21) donned gloves and provided incontinence cares (stool) for Resident #8. After cares, and with the same gloves, the CNA (#21) applied lotion to the resident's buttocks and back. The CNA removed the soiled gloves, donned new gloves, and provided frontal pericares. The CNA (#21) removed his/her gloves and exited the room. The CNA (#21) failed to remove his/her gloves and perform hand hygiene after providing incontinence cares and before applying lotion to Resident #8 and failed to perform hand hygiene before exiting the room. - Observation on 05/02/16 at 9:50 a.m. showed a CNA (#8) placed Resident #3's catheter bag on the bathroom floor, then picked it up off the floor	F 441	personal care staff have been educated to proper hand washing and glove use. Resident #16 is dependent for intake and was subject to poor hygiene when a staff member coughed into their hand, and blew nose without washing prior to resuming assistance. Continued education and monitoring of proper hygiene will be reinforced through orientation and monitoring during meal service. After the survey exit, the deficient practices were discussed, however the education and identification did not occur until the next day in preparation for formal and ongoing education sessions. Residents who require staff assistance with linen and clothing changes and those who require assist with pericare as well as residents who require medications have the potential to be impacted by the identified practice. The DON or designee provided education on May 11th, 12th , and 18th to licensed nurses and nursing assistants on proper handling of linens, hand hygiene, and glove use. Education was provided on the same dates by the DON or designee on handling of medication to licensed nurses and to licensed nurses and nursing assistants on glove use and hand hygiene when providing pericare or treatments to perineal area.	

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F 441	Continued From page 53 and placed it into the privacy bag hanging from his wheelchair. The CNA failed to ensure Resident #3's catheter bag did not come in contact with an unsanitary surface. - Observation on 05/02/16 at 4:50 p.m. showed Resident #3 incontinent of stool. A staff nurse (#3) performed perineal cares and with donned gloves, the nurse applied a barrier cream to the resident's coccyx. The nurse removed her gloves and washed her hands. The nurse (#3) failed to perform hand hygiene after providing incontinence cares and before applying barrier cream to Resident #3. - Observation on 05/02/16 at 8:15 a.m. showed a staff member (#22) assisted Resident #16 with his meal. During the meal, the staff member coughed into her hands and blew her nose. The staff member (#22) continued to assist the resident with his meal and failed to perform hand hygiene. - A random medication pass observation on 05/04/16 at 9:57 a.m. showed a nurse (#10) prepared Resident #22's medications. The nurse ejected the pills directly into her ungloved hands, placed the pills into a medication cup, and administered the medication to Resident #22. The nurse failed to use proper hygiene when handling medications. SOILED LINENS - During the initial tour on 05/01/16 at 9:36 a.m., observation showed the following: * Resident #28: Used linens on the floor in the middle of the room.	F 441	The DON or designee will complete direct care observation audits of infection control compliance five times weekly for four weeks then three times weekly for four weeks then weekly for three months. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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F 441	Continued From page 54 * Resident #2 and #3's room: Used linens on the floor near the bathroom door. - Observation on 05/02/16 at 9:49 a.m. showed a CNA (#13) performed morning cares for Resident #4. The CNA (#13) removed Resident #4's clothing and tossed the soiled clothing on the floor. The CNA then performed perineal cares with a washcloth and towel, removed the bed linens, and tossed the washcloth, towel, and linens on the floor. The CNA then picked up the pile of used linens and clothing from the floor and placed them into a bag. The CNA (#13) failed to place used linens into a plastic bag and not on the floor. - Observation on 05/02/16 at 10:26 a.m. showed a CNA (#8) performed morning cares for Resident #5. The CNA (#8) removed the resident's clothing and tossed the soiled clothing on the floor. The CNA then removed the resident's bed linens and tossed them on the floor. When the CNA (#8) finished the resident's morning cares, she picked up the used linen and clothing and placed them into a bag. The CNA (#8) failed to place used linens into a plastic bag and not toss them on the floor. During an interview on 05/04/16 at 1:27 p.m., an administrative nurse (#1) stated she expected linens and soiled clothing to be placed in a bag and not on the floor.	F 441		