STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	02/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on February 6, 2017 and completed on February 9, 2017 the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. An extended survey subsequent to the standard survey was completed on 02/22/2017.	F 000		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 12 of 27 sampled residents (Resident #1, #4, #6, #9, #12, #13, #16, #20, #21, #22, #23, #25) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors and wait for a reply before entering a resident's room to ensure privacy during cares (Resident #16), ensure a resident's turning/toileting schedule (ability/inability to remain continent) remained confidential (Resident #4, #6, #9, #12, #13, #20, #21, #22, #23, and #25), feed residents in a dignified manner, ensure removal of a resident's soiled clothing (Resident #1), does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of	F 241	Resident #16: Staff was educated to knock and wait a little longer, for the resident or staff to give them permission to enter. The resident turning schedule has been revised to remove w/d and continent, and is now placed on the inside of the resident bathroom door, including residents #4,6,9,12,13, 20,21,22,23,and 25. Education to all staff was done on the proper way to feed a resident; which means sitting with the resident and not standing to feed them. All staff also educated on the importance of insuring residents dignity is preserved in providing	3/15/17

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

Electronically Signed | 03/17/2017

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

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F 241	Continued From page 1 embarrassment or emotional harm. Findings include: The facility failed to provide a policy regarding dignity per request. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY(S) COMPLETED ON 03/10/16 AND 10/13/16. KNOCKING/ANNOUNCING ONESELF PRIOR TO ENTERING A RESIDENT ROOM - Observations during the initial tour, on 02/06/17 at 10:15 a.m., showed the following: * On two occasions, an unidentified nurse knocked on the door as she entered a resident's room without announcing herself and/or waiting for permission to enter the room. * An unidentified CNA knocked on the door as she entered a resident's room without knocking/announcing himself or waiting for permission to enter the room. - Observation on 02/08/17 at 9:40 a.m. showed two CNAs (#27 and #33) assisted Resident #16 with personal cares. During cares, a CNA (#30) knocked on the door and immediately entered without waiting for permission. TURNING SCHEDULES Observations during the initial tour, on 02/06/17 at 10:15 a.m., showed "Resident Turning Schedules" posted on the outside bathroom doors in eight resident rooms on the 3 South Unit. The "Turning Schedules" identified the time direct care staff repositioned the residents, and	F 241	care to residents, including making sure that all residents clothes are clean, and if become soiled for any reason the clothes are to be changed immediately. All residents have the potential to have their dignity and respect violated if staff do not knock on doors and wait for a response. If residents are not able to see who is feeding them, this is a dignity/respect issue and all residents have the potential to be affected. All residents have the potential to have their dignity and respect violated if they have their pants removed during the day while they are taking a nap. All residents have the potential to have their dignity and respect violated if they are not in clean clothing at all times. It is staffs' responsibility to insure that resident clothing is changed immediately if the clothing should become soiled. Staff meetings were held on February 22, 2017 and March 1, 2017 for all nursing staff to address the deficiencies, including this deficiency. Copies of the education for correction of the deficiencies were also placed on all of the nursing units as inservices, and staff has been educated through this read and sign process. Observations will include proper procedure when entering resident rooms, checking placement of all turn schedules and insuring the schedules do not contain any information which may violate the dignity of the residents, monitoring	

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F 241	Continued From page 2 whether the residents had been "w" (wet) or "d" (dry) at the time of repositioning. Observations during the survey, February 06-09, 2017, showed a "Resident Turning Schedule" posted in the following sampled resident rooms, Resident #4, #6, #9, #12, #13, #20, #21, #22, #23, and #25. The "Turning Schedules" identified the time direct care staff repositioned the residents and whether the residents had been "w" (wet) or "d" (dry) or continent "y" (yes) or "n" (no) at the time of repositioning. This form hung in various places in the visible to all visitor and residents. residents' room, on the closet door, on the wall, and either on the front door of the room or room side of the bathroom door, and staff did not cover the forms, making them accessible and visible to all visitors and residents. FEEDING A DEPENDENT RESIDENT Observation on 02/08/17 at 8:15 a.m., showed a nurse (#13) standing between two dependent residents seated next to an assisted table in the dining room. The nurse took turns feeding each resident. REMOVING SOILED CLOTHING Observation on 02/09/17 at 9:30 a.m., showed a certified nursing assistant (CNA) (# 14) emptying Resident #1's catheter bag. The CNA (#14) stated, "Oh my, I made a little mess," after she accidentally dribbled urine across Resident #1's pants. The CNA (#14) completed Resident #1's toileting cares, pulled up her soiled pants, assisted her back into her wheelchair, and	F 241	residents who are laid down during the day to insure that they are fully dressed, monitoring of dining rooms to insure that all staff are sitting when feeding residents, and observations of residents to insure that clothes are clean. These deficiencies will have specific QA's for the areas cited under F241. QA audits will be done on each unit 5 times/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. If there are any incidents in which resident rights/dignity is not being met, staff will be once again given the education and we will follow the progressive discipline process as outlined in our policies. The DON is responsible to assure that this POC is followed.	

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F 241	Continued From page 3 transported her to the activity in progress in the resident lounge.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide reasonable accommodation of individual needs regarding wheelchair positioning for 2 of 12 sampled residents observed in a wheelchair (Resident #17 and #25). Failure to provide proper wheelchair positioning may result in pressure ulcers, falls, discomfort, contractures, and loss of mobility. Findings Include: - Review of Resident #25's medical record occurred February 05-06, 2017. Diagnoses included depression, weakness, malaise, fatigue, chronic pain, osteoarthritis, age-related osteoporosis, and peripheral vascular disease. The Care Guide, dated 02/09/17, stated ". . . Ambulation: Non-ambulatory, Uses manual wheelchair . . . Ensure foot pedals in use, Ensure footwear worn, Place calf pad over leg rest to support legs. . . . Safety: Resident assessed at	F 246	Immediate Actions Were Taken for the resident(s) found to have been affected include: Resident #17 □ T. K. □ Resident□s leg rests were shortened to provide support to her feet and a foot board was added to prevent feet from dropping between leg rests to avoid a possible injury. Resident #25 □H. J. □ This resident was sliding down in her wheelchair because the foot rests were not positioned correctly. Resident□s leg rests were shortened to shortest position and foam blocks were added to provide support her feet. A foot board was placed behind her calves and feet to provide support to her feet and prevent her legs from slipping between leg rests to avoid a possible injury. All residents have the potential to be affected if they do not have properly	3/17/17

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F 246	Continued From page 4 risk for falls . . ." Observation on 02/08/17 at 8:00 a.m., showed Resident #25 sitting at the dining room table. The resident's feet dangled in the air behind the foot pedals and calf pads. Resident #25 yelled for assistance and an administrative nurse (#1) came to assist the resident. When the nurse (#1) removed Resident #25 from the table, she placed the resident's legs on the calf rests and her feet failed to reach the foot pedals. The nurse (#1) returned Resident #25 to the dining room table at 8:20 a.m. The resident's feet were supported by a pillow placed across the calf rests and her feet failed to rest on the foot pedals. Observations on 02/09/17 showed the following: * 8:05 a.m., Resident #25 sat in her wheelchair at the dining room table. The resident sat toward the front of her wheelchair without her back against the backrest. * 9:55 a.m., Resident #25 sat in her wheelchair at the nurse's station and the resident's legs/feet dangled between the leg rests. * 10:20 a.m., Resident #25 sat in her wheelchair against a wall across from the nurse's station. The resident had slid down in her wheelchair and her feet dangled with the toes of one foot on a pedal and the side of the other foot rested against the other foot pedal. - Review of Resident #17's medical record occurred February 06-09, 2017. Diagnoses included Alzheimer's disease osteoporosis, and weakness. The quarterly MDS, dated 11/06/16, identified extensive assistance for transfers. Observation on 02/08/17 at 9:50 a.m. showed	F 246	adjusted leg rests on their wheelchair or if the are not positioned properly in their wheelchair. Facility will ensure all residents will be fit with leg rest of proper length and support and all residents were assessed for proper wheelchair positioning. All residents affected by improperly fitting leg rests will be corrected to appropriate position. Actions taken/systems put in place to reduce the risk of future occurrence include: On 2/14/17, all residents were screened for improperly fitting leg rests and proper wheelchair positioning. On 2/15/17, residents identified with improperly fitting leg rests were adjusted appropriately and foot board was added if appropriate. No other residents had positioning issues with their wheelchairs. New residents will be screen during PT evaluations for proper fit of leg rest and proper positioning to be ensured they are using a wheelchair that is appropriate for them. Also, any resident identified by other sources will be screened to ensure leg rests are properly fit and wheelchair is appropriate for resident. Education provided to staff on process for contacting Physical Therapy to do assessments on appropriate wheelchair positioning. Physical Therapy DM or designee will do	

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F 246	Continued From page 5 Resident #17's feet skimming the floor as two CNAs (#27 and #30) transported her via wheelchair. About half way to the resident's room, the CNAs stopped and the CNA (#30) attempted to place the resident's feet on the foot pedals. Resident #17's feet did not reach the foot pedals so the CNA left her legs elevated on the calf supports. During an interview on the afternoon of 02/09/17, an administrative staff member (#1) stated staff made a request for physical therapy to assess Resident #25's wheelchair positioning. An administrative staff member (#2) stated staff would look into a more appropriate wheelchair for Resident #17.	F 246	QA audits on each unit 5 times/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. Results of the audits will be reported monthly to the QAPI committee. This is the responsibility of the Physical Therapy DM and the DON.	
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and the physical, mental, and psychosocial well-being for 2 of 18 sampled	F 248	Resident #18 was discharged. Resident #17 will be provided individual visits and offered person appropriate activities of interest by Activities/Nursing staff with accurate documentation of involvement	3/16/17

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F 248	Continued From page 6 residents (Resident #17, and #18) dependent on staff for activities. Failure to provide activities that meet the residents' individual needs and interests, including one-to-one activities, limited the residents' ability to reach their highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the special care unit (4 West) activity calendar, dated February 06-09, 2017, occurred on 02/09/17. Activities included the following: * 02/06/17: Work Tasks; 9:30 Exercise and News Updates; 10:00 Reading and Reminiscing; Walks-off unit [outside weather permitting]; 1:30 Music video; Coffee Time and visits; 3:00 Bingo/Special event - 3 Center [unit] * 02/07/17: Work Tasks; 9:30 Bible Study; 10:00 Exercise and News Update then Sensations and visits; Walks-off unit; 1:30 Arts and Crafts [coloring]; 2:30 Puzzles and Games; Coffee Time and Visits; 3:00 Music * 02/08/17: Work Tasks; 9:30 Exercise and News Update; 10:00 Polish Nails then Sensations and visits; Walks-off unit; 1:45 Puzzles, Games, Movies; Coffee time and visits; 3:00 Music video/Movie * 02/09/17: Work Tasks; 9:30 Exercise and News Update; 10:00 Trivia and Word Games; 1:00 Reminiscing; 2:00 Catholic Mass-3 Center [unit]; Coffee time and visits; 4:00 Music - 4 East [unit]; Walks-off unit - Review of Resident #17's medical record occurred February 05-06, 2017. Diagnoses included Alzheimer's disease. The quarterly MDS, dated 11/06/16, identified both short and	F 248	daily. All residents in the facility have the potential to be affected. The facility will insure staff members engage 4W Special Care unit residents in person appropriate activities of interest when resident is accepting and able to participate by offering variety of different options. Colorful containers in organizer storage bins were installed and filled with hands on tasks, finger fidgets, etc. for staff to engage residents easily during the day/night. The 4W Special Care Unit Activities schedule was revised to reflect the need for more individual activities. In other activity areas person appropriate activities are provided as needed for residents. All Activities staff and 4West nursing staff were educated on how to interact with residents to engage them in activities of interest and the importance of accurate documentation was reviewed. This was completed on March 15-16, 2017. The Activities Director/Nurse Unit Manager will be responsible to ensure residents are engaged in activities with staff when residents are accepting and able to participate. Immediate education will be provided for non-compliance. QA monitoring of individual appropriate activities will be implemented by March 15 for residents who are dependent on staff to participate in activities. This	

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F 248	Continued From page 7 long term memory problems and extensive assistance for transfers and locomotion. The current Care Guide stated, "Activities: Inform & [and] invite resident re [regarding]: daily recreation activities, Escort, as needed, to & from activities, music on unit." Review of Resident #17's activity attendance record, dated February 06-09, identified the following: * February 06: visited at lunch * February 07: nothing documented * February 08: individual visit - resident passive; observed exercise/exercise games; passively observed music/sing-a-long; attended current events; passively observed trivia/word games; watch TV/movie * February 09: nothing documented Observations included the following: * 02/07/17 at 8:10 a.m. - Resident #17 seated in the activity area with her head down and eyes shut and Fox News on the television. * 02/07/17 at 8:27 a.m. - Two certified nursing assistants (CNAs) (#27 and #28) transported Resident #17 to her room and transferred her to bed. The resident remained in bed until the noon meal at approximately 11:00 a.m. * 02/07/17 at 1:25 p.m. - Resident #17 in the activity area. Music played both on the television and overhead speakers. At 1:30 p.m., two CNAs (#27 and #29) transported Resident #17 to her room and transferred her to bed. * 02/08/17 at 8:00 a.m. - Two CNAs (#27 and #30) transferred Resident #17 from bed to a wheelchair and transported her to the dining room for breakfast. At approximately 8:45 a.m., the CNA (#27) transported the resident to the	F 248	measure will be audited on all units weekly (x3 on 4 West Special Care unit) for total x9 residents/week until compliance obtained for 4 weeks, then monthly with report to the Quality Assurance Committee monthly until compliance obtained for 6 months then the study will be completed quarterly with quarterly reporting to QA committee. Reporting will be done monthly at the Quality Assurance Committee. The Activity Director will be responsible for this process.	

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F 248	Continued From page 8 activity area. * 02/08/07 at 9:50 a.m. - The CNA (#30) transported Resident #17 from the activity area to the beauty shop located off the unit. * 02/08/17 at 2:30 p.m. - Resident #17 asleep on her bed. * 02/09/17 at 9:55 a.m. and 12:20 p.m. - Resident #17 lying on her bed with her eyes shut. - Review of Resident #18's medical record occurred February 06-09, 2017. Diagnoses included dementia. The quarterly MDS, dated 12/31/16, identified severe cognitive impairment and able to move about the unit in a wheelchair with supervision. The current Care Guide stated, "Activities: Inform & invite resident re: daily recreation activities, Encourage participation in activities of interest, Escort, as needed, to & from activities, Individual visits as tolerated, tv, music, new [sic] on tv." Review of Resident #18's activity attendance record, dated February 06-09, 2017, identified the following: * February 06: individual visit; wandering in/out of reading/talking activity; observed exercise; observed coffee time; active in music/sing-a-long; attended news update/current events; TV/movie * February 07: individual visit; wandering in/out of reading/talking activity; refused exercise, music, and news update/current events; TV/movie * February 08: individual visit; refused bingo; wandering in/out of reading/talking activity; observed exercise, trivia, and coffee time; attended news update/current events; TV/movie * February 09: nothing documented Observations included the following:	F 248		

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F 248	Continued From page 9 * 02/07/17 from 7:55 a.m. to 10:15 a.m. - Resident #18 remained in his room lying on his bed with his eyes closed. * 02/07/17 at 10:15 - Two CNAs (#27 and #29) assisted Resident #18 with morning cares. At 10:40 a.m., the CNAs transported the resident via wheelchair to the entry way to the dining room. * 02/07/17 at 1:20 p.m. - Two CNAs (#27 and #29) transported Resident #18 to his room and transferred him to bed. * 02/08/17 at 8:05 a.m. - Resident #18 seated in the activity area in his wheelchair with his eyes closed. The television and music were both off. * 02/08/17 at 2:30 p.m. - Resident #18 lying on his bed with his eyes closed. Observation showed the following: * On 02/07/17 at approximately 10:00 a.m., an unidentified staff member sang songs with some residents and led exercises. Resident #18 watched from the hallway. At approximately 1:30 p.m., an unidentified staff member colored in a coloring book while one resident sat close by with her eyes shut. * On 02/08/17 at 10:00 a.m., an unidentified staff member polished the nails of a resident * On 02/09/17 at 9:55 a.m., an activity staff member (#35) read from the newspaper as a resident sat next to her with his eyes shut. After the newspaper, the staff member (#35) colored in a coloring book while a resident watched. At 10:30 a.m., five residents were seated in the activity area, no television or music playing, and four CNAs standing around the activity area. Observation showed no interaction between the residents and CNAs.	F 248		

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F 248	Continued From page 10 Observation showed neither Resident #17 or #18 attending activities except for 02/07/17 at approximately 10:40 a.m. when Resident #18 observed the activity from the hall. These observations contradict the activities documented in Resident #17 and #18's activity attendance records.	F 248		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		3/15/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

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F 278	Continued From page 11 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 3.0), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 3 of 27 sampled residents (Resident #6, #7, and #16). Failure to accurately complete Section G (Functional Status), Section M (Skin Conditions), and Section H (Bowel Patterns), does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: FUNCTIONAL STATUS The Long-Term Care Facility RAI Manual, revised October 2016, page G-24, stated, ". . . Bathing: . . . Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period. . . ." Resident #6's significant change MDS, dated 12/09/16, identified the resident had not received a bath in the last 7 days.	F 278	Immediate actions were taken for residents found to have been affected include: a. Resident #6 □ J.K. Section G □ 12/9/16 MDS was modified to include the fact that she had a bath on 2/13/17. Modified Assessment resubmitted. b. Resident #7 □ D.T. Section M □ Careplan and Careguide were updated to reflect an accurate picture of usage of pressure reducing device. A modified assessment has been completed and resubmitted. c. Resident #16 □ H.R. Section H □ 1/4/17 MDS was modified to a Code 0 (no constipation), from a Code 1 (constipation). Modified Assessment to be resubmitted in next batch. All residents have the potential to be affected if their assessments specific to their Functional Status, Skin Conditions, and Bowel Patterns are not accurately coded on the Minimum Data Sets (MDS). Facility will ensure all residents will be accurately coded on the MDS. All resident who have not have had a bath or were coded as constipated in a 7d lookback for a scheduled MDS, this	

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F 278	Continued From page 12 Review of Resident #6's medical record occurred February 06-09, 2017. A Questionnaire History form provided by an administrative nurse identified Resident #6 received a bath on December 06, 2016. During an interview on the afternoon of 02/09/2017, an administrative nurse (#16), identified staff should have coded Resident #6 for bathing in section G0120. SKIN CONDITIONS The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), page M-37, stated, ". . . M1200: Skin and Ulcer Treatments . . . PRESSURE REDUCING DEVICE(S). Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating . . . Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days. M1200A, Pressure reducing device for chair M1200B, Pressure reducing device for bed . . ." - Review of Resident #7's medical record occurred February 06-09, 2017. A quarterly MDS, dated 12/21/16, identified the use of a pressure reducing device for a chair. Observations on 02/07/17 at 9:00 a.m., 9:40 a.m., 10:38 a.m., 4:04 p.m., and on 02/08/17 at 8:30 a.m., and 10:35 a.m. showed Resident #7 sitting in chairs on the unit without a pressure	F 278	clinical timeframe will be thoroughly analyzed for accuracy of coding, and residents who were coded as having a pressure reducing device in their chair will be assessed to ensure coded device is present. Actions taken/systems put into place to reduce the risk of future occurrence include: a. On 2/9/17, immediate verbal education was provided. b. On 2/13/17, corrections to the inaccurate MDS□s were requested of staff. c. On 2/13/17, required all responsible staff to re-evaluate clinical for accuracy, and observe for coded devices. The MDS Coordinator, or designees will be responsible to monitor for accuracy of the coding of the MDS. The MDS Coordinator, or designee(s), will audit all applicable MDS's (applicable assessments defined as :coding of "8" (Activity did not occur) in Section G0120A; coding of "1" (Yes-Constipation Present) in Section H0600 completed for 4 weeks on Sections G & H. 4 weeks or until compliance attained. Auditing will be done on 8 applicable MDS Assessments monthly for 3 months and then 4 applicable assessments quarterly thereafter for one year. Results will be immediately reported to the DON and ADON. If concerns are identified, immediate corrective action will	

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F 278	Continued From page 13 reducing device. During an interview on the morning of 02/09/17 an unit manager (#1) confirmed Resident #7 does not use a pressure reducing device in a chair as he is ambulatory and only uses a wheelchair for long distances. BOWEL PATTERNS The Long-Term Care Facility RAI User's Manual (Version 1.14), page H-12, stated, "Definition: CONSTIPATION: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). * Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. * Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period." Review of Resident #16's medical record occurred February 06-09, 2017. The significant change MDS, dated 01/04/17, identified constipation. Review of the resident's bowel records identified four bowel movements during the 7-day assessment period.	F 278	be implemented. The MDS Coordinator Supervisor will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. This is the responsibility of the MDS/Medicare Supervisor and DON.	
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	F 280		3/17/17

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F 280	Continued From page 14 including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 280		

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F 280	Continued From page 15 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy, the facility failed to review and revise the comprehensive care plans for 4 of 27 sampled residents (Residents #4, #11, # 16 and #17). Failure to review and revise the	F 280	Care plans and care guides were reviewed and revised to eliminate any discrepancies for Residents' #4,#11,#16, and #17. Staff was educated to review all updates to care plans and care guides	

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F 280	Continued From page 16 residents' care plans limits communication of resident care needs between staff and does not ensure continuity of care for each resident. Findings include: The facility policy titled "Care Planning" occurred on 02/09/17. This policy, revised 07/2016, stated, ". . . To develop a concise, easily understood plan of care for each resident . . . Each nursing unit is responsible for the reviewing and updating of the resident care plans. . . . Care plans are to be revised according to the resident's condition. . . . On each shift the CNA's [certified nursing assistant] and Nurse review care plans and care guides so that each resident's care plan is reviewed by the three shifts monthly adding or deleting problems, goals and approaches as appropriate." - Review of Resident #4's medical record occurred February 06-09, 2017. Diagnoses included panic disorder, chronic pain, and weakness. The quarterly MDS, dated 11/09/16, identified moderate independence with decisions, able to make self understood, usually understands others, and occasional incontinent of urine and continent of bowel. Resident #4's current care guide stated: * "Toileting: . . . Assist to toilet every 2-4 hours and as requested by [Resident name]. Wears a pull-up . . ." * "Safety: . . . uses adaptive call light, . . . soft touch call light within reach. . . ." Observations identified the following: * 02/06/17 at 5:00 p.m.: A regular push button	F 280	and make sure that identified needs of the resident were being followed. All residents have the potential to not have the proper care provided if the care plan/care guide are not correct and if the approaches are not followed. All nursing staff, activities, OT, PT, Speech, Dietary, Social Workers have been provided with written instructions on completing/ revising care plans and care guides. This was completed through communication to all departments that these instructions are on each area in the Quick Look books. All new staff that are required to complete and revise care plans and care guides, will be provided with the appropriate education as part of their orientation. Until we are using the new Matrix system 100%, QA audits will be done on each unit 5 times/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. The results of the audits will be reported monthly to the QAPI committee.	

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F 280	Continued From page 17 call light observed by the bed. * 02/07/17 at 9:35 a.m.: Resident's brief checked and identified to be dry and no toileting offered. Staff placed a regular push button call light within Resident's reach. * 02/07/17 at 4:00 p.m.: Resident's brief checked and identified soiled with urine, a new brief applied and no toileting offered. * 02/08/17 at 7:45 a.m.: Observation showed the call light as a regular push button call light. * 02/08/17 at 9:35 a.m.: Resident's brief checked and identified soiled with urine, a new brief applied and no toileting offered. - Review of Resident #11's medical record occurred February 06-09, 2017. Diagnoses included deep tissue injury to right lateral foot and blister on right lateral ankle area. A quarterly MDS, dated 11/26/16, showed Resident #11 at risk for pressure ulcers, but did not have pressure ulcers or other wounds at that time. The current care guide stated, "Skin . . . Dressing to Rt [right] knee, report to nurse if loose or missing." Observations showed Resident #11 lacked a dressing to her right knee on 02/07/17 at 7:43 a.m., 8:46 a.m., 10:15 a.m., 10:40 a.m., and 2:00 p.m., but did show a dressing to the right ankle. Observations on 02/08/17 at breakfast and noon meal; and on 02/09/17 at breakfast all showed a dressing to Resident #11's right ankle. The care plan and care guide lacked the correct information regarding a dressing to the resident's right ankle rather than right knee as identified in these documents. - Review of Resident #16's medical record	F 280	If we find incidents of staff members who not following the process as stated above, the individual will be re-educated and we will follow the disciplinary process if the same individuals are found not to be compliant. Each Director who is involved in the Care Plan process is responsible for they, or their designee, to update and revise the care plan as needed. The DON will take the final responsibility of the POC.	

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F 280	Continued From page 18 occurred February 06-09, 2017. Diagnoses included dementia. The significant change MDS, dated 01/04/17, identified extensive assistance for toileting. The current Care Guide stated, ". . . [Resident's name] will toilet himself at times . . . Urinal within reach. Encourage use of urinal at night . . ." Observation on 02/07/17 at 8:05 a.m., 02/08/17 at 9:40 a.m. and at 2:30 p.m., showed Resident #16 laying on his bed and the urinal in the bathroom. The facility failed to place the urinal within reach which may result in Resident #16 experiencing a fall while self-transferring to the bathroom. - Review of Resident #17's medical record occurred February 06-09, 2017. Diagnoses included Alzheimer's disease and weakness. The quarterly MDS, dated 11/06/16 identified both short and long term memory problems and extensive assistance for eating. The current Care Guide stated, ". . . Encourage self feeding, Deliver & [and] setup tray . . . Provide cueing for eating . . ." Observation on 02/07/17 at 7:55 a.m., 02/08/17 at 8:10 a.m., and 02/09/17 at 12:00 p.m., showed facility staff feeding Resident #17. On 02/08/17 at 8:30 a.m., the CNA (#27) stated Resident #17 has been unable to feed herself for "quite some time."	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		3/1/17

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F 281	Continued From page 19 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to meet professional standards of care for 1 of 1 (Resident #5) sampled residents with missed eye drops for 4 days. Failure to administer eye drops per physician orders may result in vision loss or blindness. Findings include: Review of Resident #5's medical record occurred February 06-09, 2017. Physician admission orders showed Resident #5 was on Timolol (anitglaucomal) eye gtts [drops] prior to admission on 01/06/2017. Physician orders identify, ". . . Timolol Maleate 0.5% 1 gtt ophthalmic solution daily to both eyes. . . ." Review of Resident #5's Medication Administration Record for January 01- February 05, 2017, identified that Resident #5 did not receive her Timolol eye gtts January 31 - February 03, 2017 (4 days). During an interview on 02/09/17 at 10:00 a.m., an administrative nurse (#18), stated the floor nurses do all the medication ordering and order according to which pharmacy the resident uses and when any medications are getting low. Review of the Pharmacy Refills Fax Form provided by an administrative nurse (#18),	F 281	Eye Drops were ordered for Resident #5 on February 3, 2017. She did start receiving her eye drops on February 4, 2017 as ordered. Resident was discharged on 2/9/2017. Staff were reminded to order the residents eye drops when they are getting low. All residents have the potential to be affected if their medications are not ordered in a timely manner. All nursing staff have been provided with instructions on ordering medications. This was completed through group training sessions on February 22nd and March 1st. Any staff unfamiliar with the process has been provided with education on ordering medications as needed prior to running out of the medication. All new staff that are required to order medications for residents will be provided with the appropriate education as part of their orientation. Each unit will have a QA completed making sure the medications are ordered appropriately as needed and are arriving on time prior to the last dose running out. QA was started on 2/13 for all units to	

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F 281	Continued From page 20 identified staff did not order Resident #5's Timolol eye gtts until 02/03/17. During an interview on 02/09/17 at 3:00 p.m., an administrative nurse (#18) stated after further investigation into Resident #5 not receiving her Timolol eye gtts for 4 days, the facility identified the nurse had failed to order them when the present bottle was low.	F 281	audit the MAR and ensure all medications were available and that they were being ordered appropriately. QA audits on MAR's (ensuring all medications are available)will be done on each unit 5 times/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. If we find incidents of staff members are not following the process as stated above, the individual will be re-educated and we will follow the disciplinary process if the same individuals are found not to be compliant. Reporting will be done monthly to the QAPI Committee. This process is the responsibility of the Nurse Managers for each unit and the Director of Nursing.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's	F 309		3/17/17

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F 309	Continued From page 21 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: CONSTIPATION 1. Based on record review and review of facility policy, the facility failed to provide the necessary care and services to manage constipation for 3 of 3 sampled residents (Resident #16, #17 and #22) with a diagnosis of constipation and frequent as needed (PRN) medications. Failure to document residents' bowel status, implement interventions	F 309	CONSTIPATION Immediate Actions Taken for the resident(s) found to have been affected include: For resident #16, staff ensured that he is/will continue to be receiving prune juice and prunes at every meal and is being	

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F 309	Continued From page 22 to manage constipation in a timely manner, and follow facility bowel protocol may result in resident discomfort and continued constipation. Findings include: Review of the facility policy titled "Bowel Protocol" occurred on 02/09/16. The undated policy, stated, ". . . On admission, all residents are put on every shift BM [bowel movement] monitoring. A BM list is kept in all nursing units and staff is to write any resident BM's on this list. At the end of each shift, the CNA [certified nursing assistant] is to review the clipboard and chart results on their assigned residents in the computer under monitoring for BM's. Nurses/med aides are to chart any interventions . . . in the computer under monitoring for BM's. . . . The day nurse/med aide will review the BM list and administer the appropriate intervention. If a resident is on day 2 of no BM, he/she is to receive prune juice, or a provider's standing order for bowel aide. On day 3 of no BM, the resident is to receive an oral laxative, such as MOM (Milk of Magnesia) or a provider's standing order for a bowel aide. Also a consult to dietary is to be completed. On day 4 of no BM, the resident is to receive a fleet's enema or Dulcolax suppository, depending on provider orders. . . ." - Review of Resident #16's medical record occurred February 06-09, 2017. Diagnoses included constipation. Medications to aide in bowel elimination included Senna Plus (laxative and stool softener) one tablet twice a day, and Miralax (laxative) twice a day. A dietary progress note, dated 01/04/17, stated,	F 309	encouraged to eat them. Staff was reminded to document bowel protocol accurately and follow it according to the day of no bowel movement. For resident #17, staff will ensure that she receives and eats her fruit ball at meals. Resident #17 does not like prune juice, so juice of choice is offered at meals and snacks. Resident #17 is on a pureed diet, and staff reminded to ensure that the blended fruit or applesauce is eaten and documented as part of the bowel protocol. Staff was reminded to follow bowel protocol and document accurately according to day of no bowel movement. Resident #22 was in the hospital from 12/7/16 to 12/12/2017. Staff had called residents MD on 12/14 about abdominal concerns and he had ordered an enema for the resident. Staff was reminded to follow and document the bowel protocol accurately. All residents had the potential to be affected by staff not following/documenting the bowel protocol accurately. The facility will ensure that all residents will have the bowel protocol followed and documented upon accurately in their medical record under the prn bowel protocol questionnaire. All residents affected by the bowel protocol will be monitored to ensure that	

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F 309	Continued From page 23 "Res [resident] is on BM list. Res sleeps through breakfast frequently, so dietary bowel aides are to be offered in other meals. Res is offered prune juice at lunch and dinner, fruit ball at lunch and prunes at dinner. Fresh fruit also offered at lunch and dinner. Offer prune juice as needed and encourage fluids. Res has bowel meds [medications] on board as well." Resident #16's medical record failed to show documentation staff offered the above interventions. Review of Resident #16's bowel records and medication administration record (MAR) from November 01, 2016 through February 08, 2017, identified the following: * BM on November 01, 02, and 04 (twice). Facility staff administered an as needed (PRN) Dulcolax suppository on the 5th even though the resident had a BM twice on 4th. * No BM on November 24, 25, 26, and 27. Facility staff administered MOM on the 27th with results of a BM on the 28th. * No BM on December 14, 15, and 16. The facility administered MOM on the 15th (2 days without a BM). The resident had a BM on the 17th. * No BM on December 18, 19, and 20. The facility administered MOM on the 18th and a Dulcolax suppository on the 19th. The resident had a BM on the 21st. * No BM December 22, The facility administered a Dulcolax suppository on the 23rd with results. * No BM on December 24, 25, 26, and 27. The facility administered a Dulcolax suppository on the 28th with results. The facility failed to administer an oral laxative on the 26th (day 3	F 309	the protocol is being followed by nursing and that they are receiving the dietary offerings as ordered by dietary at their meals. QA was started on 2/13/16 to monitor that bowel protocol is being followed and documented. QA audits will be done on 5 residents who are on the bowel protocol on each unit/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. Those staff who are not in compliance will be reeducated on bowel protocol and how to document it. The staff were educated in a group setting at the nurses meeting on 2/22 and 3/1. Results will be immediately reported to the DON or designee. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. This is the responsibility of the DON. ASPIRATION PRECAUTIONS	

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F 309	Continued From page 24 with no BM) and the suppository on the 27th (day 4 with no BM). * No BM December 31, January 01, 02, and 03. The facility administered a Dulcolax suppository on January 01 (day 2 with no BM). The resident had a BM on January 4th twice. The facility failed to follow their bowel protocol by documenting dietary interventions offered on day two of no BM, administer an oral laxative on day three of no BM, and administer a Dulcolax suppository on day four of no BM. - Review of Resident #17's medical record occurred on February 06-09, 2017. Diagnoses included constipation. Medications to aide in bowel elimination included Colace (stool softener) twice a day, Senna S (laxative and stool softener) twice a day, MOM PRN, Miralax PRN, and a Dulcolax suppository PRN. Review of Resident #17's bowel records and MAR from December 01, 2016 through February 08, 2017 identified the following: * No BM December 06, 07, and 08. The facility administered a Dulcolax suppository on the 9th with results. * No BM December 14, 15, and 16. The facility administered a Dulcolax suppository on the 17th with results. * No BM December 23, 24, 25, 26, and 27th. The facility administered a Dulcolax suppository on the 28th (day 6 with no BM) with results. * No BM January 12, 13, and 14. The facility administered a Dulcolax suppository on the 15th with results. * No BM January 20, 21, and 22. The facility administered a Dulcolax suppository on the 23rd	F 309	Immediate Actions Taken for the resident(s) found to have been affected include: Staff for Resident #1 were reminded that when offering fluids or food that the resident must be alert and in an upright/high-fowler□s position to prevent aspiration. This can be done by having the resident sit in an upright chair or at a 90 degree angle in bed. All residents have the potential to be affected by aspiration when not in the correct position for eating/drinking. Facility will ensure that all residents will be seated at a 90 degree angle prior to eating or drinking. All residents affected by aspiration risk will be seated at a 90 degree angle prior to eating or drinking. All residents will also be assessed for level of alertness. If the resident easily falls back asleep, the food or fluid will not be left with them, but staff will continue to try and arouse resident to waking state so they may consume the food or fluid being offered. QA audits will be done on proper positioning of residents by auditing 5 residents each unit/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The	

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F 309	Continued From page 25 with results. * No BM February 03, 04, and 05. The facility administered a Dulcolax suppository on the 6th with results. The facility failed to follow their bowel protocol and administer a less invasive intervention such as dietary interventions and oral laxatives for constipation before administering a Dulcolax suppository. - Review of Resident #22's medical record occurred on February 09, 2017. Diagnoses included constipation. Medications included Bisacodyl (laxative) one tablet daily, Colace two times daily, FiberCon (fiber therapy) two tablets daily, and Mineral Oil daily PRN. Review of Resident #22's bowel movement record and MAR, dated December 06-14, 2016, identified the following: * 12/06/16: Large loose BM * 12/07/16: No BM * 12/08/16 - 12/12/16: No documentation. * 12/13/16: Large loose BM * 12/14/16: Large loose BM times two. * Resident's MAR identified staff did not administer PRN bowel medications during this time frame. Review of Resident #22's medical record identified a note dated, 12/14/16 at 2:00 p.m., which stated, "Abdomen distended. Bowel sounds active x [times] 4. Abdomen hard to palpation. Order for enema. Given with large amount soft excrement expelled. Abdomen then soft." THIS IS A REPEAT DEFICIENCY FROM THE	F 309	QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. Results will be reported to the DON or designee. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. This is the responsibility of the Nurse Managers and the DON. RENAL DIALYSIS Resident #26 and #27 had Monitor Dialysis Shunt started immediately as a task. All nursing staff were instructed to check the dialysis fistula daily on residents who receive kidney dialysis daily. This is to be documented in the EHR under the task Monitor Dialysis Shunt. An agreement was drawn up and signed between Trinity KDU and Trinity Homes. This was completed and signed on 3/16/2017. All residents receiving kidney dialysis have the potential to be affected. Facility will ensure all residents receiving	

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F 309	Continued From page 26 SURVEY COMPLETED ON 10/13/16 ASPIRATION PRECAUTIONS 2. Based on observation, record review, review of professional literature, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 2 sampled residents (Resident #1) observed being fed in a reclined position received the care and services necessary to maintain safe oral intake. Failure to ensure a resident demonstrating signs/symptoms of dysphagia was alert and properly positioned prior to being fed placed Resident #1 at a higher risk of aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc (2007), pages 9 and the educational handouts, identified, ". . . Signs and symptoms of dysphagia . . . wet gurgling voice after swallowing . . . throat clearing . . . coughing . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ." Review of the facility policy titled "Feeding and Residents at risk for aspiration" occurred on 02/09/17. This policy, revised August 2015, stated, " . . . Refer to care plan/care guide for feeding instructions. . . ." - Review of Resident #1's medical record	F 309	kidney dialysis will have their fistulas checked daily. The facility also has a contract agreement in place now and will provide the appropriate information as needed. QA's will be done for the 3 residents that have fistulas; the QA is for checking daily for thrill and bruit and this will be monitored daily. QA audits will be done on the 3 residents weekly X 4 weeks, then 2 X monthly 24 months and then quarterly for one year. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. Reporting of all QA audits will be done monthly to the Quality Assurance Committee. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. This is the responsibility of the DON.	

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F 309	Continued From page 27 occurred February 06-09, 2017. Diagnoses included dementia and gastro-esophageal reflux disease. The current care plan addressing Resident #1's individualized nutrition/feeding needs failed to address appropriate positioning for safe oral intake. The current care guide identified, ". . . Ensure resident sitting upright in appropriate chair, Monitor for chewing/swallowing problems . . . Assist to finish. . . ." Observation showed the following: * 02/07/17 at 8:42 a.m., showed two certified nursing assistants (CNAs) (#19 and #20) provided Resident #1's cares as she laid flat in bed with a pillow behind her head. Afterwards, one of the CNAs (#20) offered her a plastic glass containing water. Resident #6 sipped water from the straw, presented with a wet gurgly vocal quality when she responded to a question, and then softly cleared her throat/coughed. The CNA failed to ensure Resident #1 was seated in an upright position (90 degrees) before offering her liquids, and failed to recognize the signs/symptoms of dysphagia (wet gurgly vocal quality and throat clearing/coughing) she presented. * 02/08/17 at 9:40 a.m., showed a CNA (#14) offered Resident #1 a morning snack. The CNA (#14) exited the room and returned with a cup of yogurt. Resident #1 fell asleep soon after the CNA exited the room. The CNA (#14) re-entered Resident #1's room, raised her bed to an approximate 35 degree angle, and gave her a bite of yogurt before handing her a plastic glass containing water. Resident #1 took two sips of water from the straw and handed the glass back	F 309		

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F 309	Continued From page 28	F 309		

to the CNA. The CNA (#14) then handed her the cup of yogurt and exited the room. Resident #1 fell asleep holding the cup of yogurt. The CNA failed to ensure Resident #1 was alert and seated in an upright position (90 degrees) before offering her foods/liquids.

During an interview on 02/09/17 at 10:20 a.m., a managerial nurse (#18) provided no additional information regarding positioning/swallow safety issues.

RENAL DIALYSIS

3. Based on record review, review of professional literature, resident interview, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 2 of 2 sampled residents (#26 and #27) who received dialysis at another location. Failure to obtain an agreement with the dialysis provider which included all aspects of how to manage the resident's care has the potential to result in complications related to the residents' health and decreases his/her quality of life and well-being.

Findings include:

The American Nephrology Nurses' Association (ANNA) "Vascular Access Fact Sheet," dated 2013, stated:
". . . Caring for a Fistula or Graft [dialysis access site]: Good fistula or graft care will help maintain the patency of the vascular access. There are measures that can be taken to prevent clotting or infection to the access. Feel the 'thrill' or vibration of blood through the access, or use a

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F 309	Continued From page 29 stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access and site rotation. The access should be kept clean and free of injury. Inspect the access for signs of infection, including pain, tenderness, swelling, and redness to the area. . . . The access needs to be protected from injury or restriction to prevent clotting of the access. *Avoid tight clothing, jewelry, or pressure on the access area. . . . *Avoid lying on the access site when sleeping. *Do not allow blood to be drawn from the access arm. *Do not allow blood pressure to be taken in the access arm. . . ." - Review of Resident #26's medical record occurred on 02/09/17. Diagnoses included Chronic Renal Disease Stage 5. Physician's orders included hemodialysis three days a week. Resident #26's quarterly Minimum Data Set, dated 01/21/17, identified the resident as cognitively intact. During an interview on 02/09/17 at 10:00 a.m., Resident #26 stated she has a fistula in her left arm. The resident stated facility staff do not check her fistula site and that she checks it herself every day. During an interview on 02/09/17 at 10:15 a.m., a staff nurse (#21) stated she thinks the nurse on the evening shift checks the fistula when Resident #26 comes back from dialysis, but is not sure where to find this documentation. Review of Resident #26's nursing progress notes showed one entry on 07/18/16, addressing the status of the resident's fistula. During an interview on 02/09/17 at 2:45 p.m., an	F 309		

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F 309	Continued From page 30 administrative staff nurse (#18) stated there is a section in the electronic record titled "Monitor Dialysis Shunt" for staff to document they have checked the resident's fistula daily. Resident #26's medical record, reviewed with the staff member, showed no documentation of staff monitoring the fistula, and the facility had activated/started the section "Monitor Dialysis Shunt" on 02/06/17. - Review of Resident #27's medical record occurred on 02/09/17. Diagnoses included Chronic Renal Disease with physician's orders for hemodialysis three days a week. Review of the medication record with an administrative staff member (#18) occurred on 02/09/17 at 2:55 p.m. Resident #27's medical record showed staff documented monitoring of the fistula daily until 12/17/16, when staff discontinued the monitoring. During an interview on 02/08/17 at 5:30 p.m., an administrative staff member (#2) stated the facility does not have an agreement with the dialysis provider. The facility failed to have an agreement between the facility and the dialysis provider to ensure the coordination of safe care and services, and failed to ensure monitoring/documentation of Resident #26 and #27's fistula sites.	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section.	F 311		3/17/17

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F 311	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to provide residents with the appropriate treatment to maintain their highest practicable level of physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #3) care planned for a walking program. Failure to provide planned services did not provide Resident #3 the opportunity to maintain her range of motion, balance, strength, endurance, and mobility. Findings include: The facility failed to provide a policy regarding their walking program per request. Review of Resident #3's medical record occurred February 06-09, 2017. Medical diagnoses included dementia, cerebrovascular accident (stroke), hemiplegia (paresis on one side of the body), and weakness. The annual Minimum Data Set (MDS), dated 01/21/17, identified intact cognition and supervision/assistance of one person required for walking in room/corridor. The current care plan addressing Resident #3's individualized ambulation needs identified, ". . . Approach: . . . Distance walking 2 x [times] daily. . . ." The current care guide failed to address Resident #3's walking program. Observation during the initial tour, on 02/06/17 at 10:15 a.m., showed Resident #3 seated in her wheelchair in her room with the lights off. She stated, "I can't get better. Nobody walks me."	F 311	Resident #3 is offered the opportunity to walk at least twice a day as ordered and documented. All residents who are on a specified walking program have the potential to not maintain or improve their specific ability if the residents aren't walked as designated for their specific needs. All staff is educated to follow provider□s orders regarding ambulation and walking program. This education is provided during nursing orientation. A group in-service was completed during the Monthly Nurse meeting on February 22, 2017 and March 1, 2017. A written in-service for staff to read and sign was also given to each unit with the re-education of offering fluids during cares. This written education was provided on March 1, 2017. Observations will include proper offering of ambulation according to provider□s order; and all violations will be addressed immediately with re-education. QA audits will be done each unit looking for all residents being walked who are on the walk list. 15 residents who are on the walk list will be audited weekly X 4 weeks, then 10 residents monthly for 4 months and then 20 residents until compliance is sustained. The QA audits will be done by	

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F 311	Continued From page 32 Observations on all days of survey showed facility staff offered to walk Resident #3 on one occasion (02/07/17 at 8:50 a.m.). The "Distance Walked" log, dated January 09-February 07, 2017, identified staff failed to walk Resident #3 on 4 of 30 days, and walked her once a day on 13 of 30 days. During an interview on 02/09/17 at 12:20 p.m., a managerial nurse (#18) reported, "Staff walk [Resident #3] per her request. There is no schedule. Staff should be walking her two times daily."	F 311	designated nursing staff and monitored weekly by the DON and ADON. The Director of Nursing, Assistant Director of Nursing, Nurse Managers and staff will assess ambulation for four weeks, and if compliance is obtained will do observations monthly for four months, and then quarterly. The Director of Nursing will share these observations with the Quality Assurance Committee. If we find incidents where staff members are not following the process, as stated above, the individual will be re-educated and we will follow the disciplinary process. Reporting will be done monthly to the Quality Assurance Committee. The DON will be responsible to make sure that this process is followed.	
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 314		3/16/17

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F 314	Continued From page 33 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/10/16 Based on observation, record review, facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure ulcers for 3 of 9 sampled residents (Resident #1, #2, and #11). Failure to implement preventative measures resulted in Resident #2 and #11 developing pressure ulcers on their heels, and placed Resident #1 at risk of developing an ulcer. Findings include: Review of the facility policy titled "Pressure Ulcer Prevention Protocol" occurred on 02/09/17. This policy, undated, stated, ". . . Elevate/Float heels off bed using pillows . . . Staff member must be able to pass hand freely between mattress and heel . . . without touching once pillows . . . are in place. . . . Use pressure reduction cushion while resident in . . . chair. . . ." - Review of Resident #2's medical record occurred February 06-09, 2017. Diagnoses included dementia, depression, diabetes, peripheral vascular disease, history of pressure ulcers (bilateral buttocks, coccyx, and left heel), and current pressure ulcers (top of left ankle/foot and deep tissue injury to left heel). The quarterly Minimum Data Set (MDS), dated 12/28/16, identified moderately impaired cognition, limited assistance of one person required for transfers,	F 314	Resident #2 had a cushion placed in her recliner and knee immobilizer discontinued. Resident #11-Swim buddies were removed and a concave mattress was provided to the resident. Resident #1-pillow removed from directly under feel and care plan updated to reflect adaptive device or pillow used to keep heels floated and prevent contact with bed. All residents have the potential of risk for developing pressure ulcers or pressure ulcers not improving if braces, cushions, and adaptive devices not used as ordered. Education provided to RNs and LPNs at the Nurse meeting held February 27th and March 1, 2017. Nurse managers verbally educated all nursing staff and a read and sign was placed on each unit with the education of proper use of adaptive equipment, and the importance of having the care plan and care guide reflecting the approaches to be used for each resident. The weekly decubitus rounding was increased from weekly to twice weekly. Heel floatation has been added to treatment sheets. QA on dressing changes will be done as follows: 10 observations per week X 4 weeks, and then 20 observations monthly	

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F 314	Continued From page 34 dressing, and toileting, unhealed Stage 3 pressure ulcer, pressure reducing device for chair/bed, and ointments/medications. The progress notes identified the following: * 09/11/16 at 8:19 a.m., ". . . Resident was able to move left foot but complained of moderate to severe pain with movement of left leg. . . . order received to send to ER [emergency room] for evaluation." * 09/11/16 at 1:36 p.m., "Returned to facility at 1305 [1:05 p.m.] . . . Knee immobilizer in place to left leg and to be worn when resident is out of bed . . ." * 09/13/16 at 9:41 a.m., "Resident is up in wheel chair . . . resident stated '. . . it [is] just uncomfortable with this brace on' . . ." * 09/28/16 at 7:30 a.m., ". . . resident . . . stated 'my left hip pop [sic] out again,' resident left foot and knee was [sic] inverting inward, but was able to move her toes . . . order resident to ER for eval [evaluation] of the left hip . . ." * 09/28/16 at 1:29 p.m., "Resident return [sic] from ER with no new orders . . ." * 10/13/16 at 5:22 p.m.,"Wound care note: Assessed a stage II pressure ulcer to top of left ankle/foot area measuring 0.5 x [by] 0.5 x 0.1 cms [centimeters]. Wound bed is covered with a thin red scab. . . . The ulcer is on a bony prominence of the foot and the pressure is from the leg brace resting on it. Staff is now aware of the importance of making sure is in proper placement on the left leg. . . ." * 10/19/16 at 3:22 p.m., "Wound care note: . . . Resident has an area on her left top foot, .5 x .5, resident stated 'that's where this brace is rubbing' . . . Assessed a deep tissue injury to left heel measuring 2.5 x 3.3 cms. Wound bed is deep	F 314	X 4 months, and then 20 observations quarterly. QA on heels floated and cushions in place are as follows: 20 observations per week X 4 weeks or until compliance obtained throughout the facility, then 40/month X 4 months and then 40/quarterly. QA results will be reported to the QAPI team monthly. This is the responsibility of the Nurse Managers, Wound care Nurse and DON.	

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maroon and spongy to palpation. . . . Resident does not wear shoes on that foot. Her leg immobilizer was lower than it should be and her foot was resting on it. Leg immobilizer taken off. Staff educated on proper application of leg immobilizer. . . ."

Review of the "Ulcer Management History," dated 10/13/16-02/09/17, described the following:
* 10/13/16 - "A round Stage II pressure ulcer to the top of the left foot/ankle, wound bed covered 100% by a thin, red scab, measuring 0.5 x 0.5 x 0.1 cm, with dark red/purple erythematous periwound. . . . 02/09/17 - An irregular Stage II pressure ulcer to the dorsal left foot, wound bed 100% red, measuring 0.8 x 0.4 x 0.1 cm, with intact periwound."
* 10/13/16 - "An elongated, unstageable pressure ulcer to the left heel, wound bed covered 100% by thin, black eschar, measuring 0.3 x 0.2 cm with an unknown depth/tunneling, with intact periwound. . . . 02/09/17 - An irregular shaped, unstageable pressure ulcer to the left heel, wound bed covered 100% by black eschar, measuring 2.4 x 2.5 cm with an unknown depth/tunneling, with intact periwound."

During an interview on 02/09/17 at 8:57 a.m., when asked if the facility educated staff on how to properly apply Resident #2's leg immobilizer prior to her developing two pressure ulcers, the managerial nurse (#18) stated, "I don't believe education was provided prior to the ulcer[s], no."

Failure to provide staff education and failure to ensure staff correctly applied Resident #2's leg immobilizer resulted in her developing two pressure ulcers, a Stage II ulcer to the top of her

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left foot/ankle and an unstageable ulcer to her left heel.

The "Bed Mobility Assistance" assessment, dated 12/15/16, identified Resident #2 required assistance to reposition herself in bed and "likes to sit in her recliner in room."

Both the current care plan addressing Resident #2's skin integrity and the current care guide identified, ". . . Approach: . . . cushion to recliner . . . at all times. . . ."

Observation showed the following:
* Early afternoon on 02/08/17, Resident #2 sat in her recliner, with no cushion visible.
* 02/09/17 at 8:25 a.m., Resident #2 sat in her recliner, with no cushion visible.

During an interview on 02/09/17 at 9:25 a.m., a CNA (#24) confirmed Resident #2 did not have a cushion in her recliner.

During an interview on 02/09/17 at 10:20 a.m., a managerial nurse (#18) reported, "[Resident #2's] cushion is being laundered. We don't have any extras to replace the one in laundry between cleanings."

Failure to ensure staff placed a cushion in Resident #2's recliner "at all times" per her care plan/guide placed her at risk of developing a pressure ulcers to her buttocks/coccyx.

- Review of Resident #11's medical record occurred February 06-09, 2017. Diagnoses included a blister to the right lateral ankle with deep tissue injury, dementia, and weakness. A

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quarterly MDS, dated 11/26/16, identified short and long-term memory problems, moderately independent daily decision making, supervision with one person assist for bed mobility, walking in room and corridor, at risk for pressure ulcers, no unhealed pressure ulcers, no pressure relieving devices for her bed, and no skin problems.

A progress note, dated 02/02/17 at 2:20 p.m., stated, "Wound care note: Resident seen as per concerns of [named two nursing staff members]. Assessed a deep tissue injury to right lateral foot in the inferior ankle area measuring 3 x 4 cms. Area is black underneath soft skin. The deep tissue injury is part of a drained and unroofed [partially opened] blister measuring 4 x 7 cms. Nursing staff says the area had drained a large amount of serous drainage earlier today. Scant amount of serous drainage noted now. No odor. Periwound to the area is pink and blanchable. Resident denies pain. Resident has "swim buddies [swimming noodles]" in her bed and it is possible that she rested her foot against a swim buddy in her sleep causing excessive pressure to the area. Floor nurses will see about getting a perimeter mattress for resident to eliminate the need for "swim buddies". Discussed with [above nurses] the use of Prevalon Boots or heel protectors but they were concerned that resident would walk in them and end up falling. Resident is not aware of her own safety needs. . . ."

A "General Maintenance Request", showed the facility requested a perimeter mattress for Resident #11 on 02/03/17.

An "Ulcer Management" record, dated 02/07/17, stated ". . . location - lateral/foot heel . . . %

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Wound Black - 100% black under intact skin . . . Wound Length (in cm) - 3, Wound Width (in cm) - 4 . . . Drainage Amount - Moderate (dressing saturated, involves 25-75% or [sic] dressing) Drainage Color - Serous, Odor - No, Pain - No, Periwound - Edema 2+ . . . Comments: Deep tissue injury [DTI] remains in the center of a mostly unroofed blister. Some clear fluid build up is noted in the blister. The DTI is slightly boggy with palpation. Periwound of the blister is pink and intact. Resident pulls away and verbally reacts during wound assessment and dressing change but denies painwhen [sic] she is asked and states "It's maybe [sic] anticipatory".

During an observation, on 02/07/17 at 2:00 p.m., a nurse (#26) completed an assessment and a dressing change to Resident #11's right lateral heel. Observation showed Resident #11 continued to have "swim buddies" in place in her bed. The "swim buddy" on the exit side of the bed did not follow the edge of the mattress, but angled into the bed and the resident's left leg went over the "swim buddy".

During an interview, on 02/07/17, immediately following the dressing change, the nurse (#26) identified staff are not using protective boots for Resident #11 due to fall risks but she did direct staff to remove the "swim buddies" as she felt they may have contributed to the pressure wound. When informed the "swim buddies" remained, the nurse (#26) went back into the room, confirmed the "swim buddies" were there, and indicated she expected staff to remove them from Resident #11's bed on 02/02/17.

Failure to remove the "swim buddies" from

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Resident #11's bed after the development of a pressure area may contribute to the development of other pressure areas. Observation of the resident laying on the "swim buddy" demonstrated the continued possibility of unrelieved pressure from the "swim buddies".

- Review of Resident #1's medical record occurred February 06-09, 2017. Diagnoses included dementia, peripheral vascular disease, and restless leg syndrome. The annual MDS, dated 11/15/16, identified severely impaired cognition and extensive assistance of one or more persons required for Activities of Daily Living (ADLs).

The "Bed Mobility Assistance" assessment, dated 01/12/17, identified Resident #1 required assistance to reposition herself in bed.

The current care plan addressing Resident #1's skin integrity failed to address appropriate positioning when in bed. The current care guide identified, ". . . pillows under feet and float heals. . . ." Placing pillows directly under Resident #1's feet contradicts the preventative measure of floating her heels.

Observation showed the following:
* 02/07/17 at 8:42 a.m., showed two CNAs (#19 and #20) provided Resident #1's cares as she laid in bed. The CNAs (#19 and #20) placed a pillow under her knees/calves, resulting in Resident #1's heels resting directly on the mattress.
* Early afternoon on 02/07/17, Resident #1 laid in bed with a pillow placed under her knees/calves, resulting in her heels resting directly on the

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F 314	Continued From page 40 mattress. * 02/07/17 at 3:10 p.m., Resident #1 laid in bed with her heels resting directly against the foot board. * 02/08/17 at 9:40 a.m., showed two CNAs (#19 and #20) provided Resident #1's cares as she laid in bed. The CNAs (#14 and #24) placed a pillow under her knees/calves, resulting in Resident #1's left heel resting directly on the mattress. * 02/08/17 at 10:15 a.m., Resident #1 laid in bed with her left heel resting directly on the mattress. During an interview on 02/09/17 at 10:20 a.m., a managerial nurse (#18) offered no additional information. Failure to ensure Resident #1's heels floated per her care guide placed her at risk of developing a pressure ulcer to one or both heels.	F 314		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		3/17/17

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F 323	Continued From page 41 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: CLEANING SOLUTION HAZARDS 1. Based on observation, staff interview, and review of manufacturer's labels, the facility failed to maintain a safe environment (chemicals used by housekeeping staff) when cleaning the facility. The practice of leaving the housekeeping chemicals unattended placed cognitively impaired/wandering residents at risk for accidents and injury. Findings include: Observation on 02/07/17 at 8:20 a.m. showed an unattended (for approximately seventeen minutes) cleaning cart in the hallway between two resident rooms on the 3 South Unit. The cart contained the following cleaning chemical: * an open bucket on top of the cart contained a mixture of water and Coverage Plus NPD Disinfectant (a disinfectant that may be harmful if inhaled or absorbed through the skin and may cause moderate eye irritation), * an open plastic jug and mop bucket on the lower level contained a mixture of water and Coverage Plus NPD.	F 323	Chemicals Within one hour of being notified of a potential IJ for Cleaning Hazard solutions, all mop buckets and cleaning cloth buckets were removed from each cart. The mops were replaced with mops that require the cleaning solutions be placed in the handle of the mop, and the cleaning cloth buckets were removed from the top of the cart. All solutions that were diluted with chemicals were placed inside the cart, and the carts were locked. Smoking Hazard Within one hour of being notified of a potential IJ a sign out/sign in sheet was created for the 3 residents that smoke. We also instituted guidelines for these residents, which instructed each of them that they must notify staff and use the log to sign out and in each time they left the unit to smoke. We also added to the guideline that the residents were to take their cell phones or a walkie talkie with them when they went outside to smoke. This agreement was reviewed with each	

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F 323	Continued From page 42 During an interview on 02/07/17 at 8:41 a.m., the nurse (#13) on duty reported having one wandering resident on the unit. The observation showed the unattended cleaning cart parked outside the wandering resident's room. Observation on 02/07/17 at 9:46 a.m. showed an unattended (for approximately six minutes) cleaning cart in the hallway on the 3 East Unit. The cart contained the following cleaning chemical: * an open bucket on top of the cart contained a mixture of water and Coverage Plus NPD, * an open plastic jug and mop bucket on the lower level contained a mixture of water and Coverage Plus NPD. During an interview on 02/07/17 at approximately 9:49 a.m., an unidentified nurse reported having one wandering resident on the unit. She stated, "[Resident] wanders. We're trying to get him placed in 4 North, the locked unit." Observation on 02/07/17 at 10:11 a.m. showed an unattended (for approximately eight minutes) cleaning cart in the hallway on the 4 North (locked Alzheimer's) Unit. The cart contained the following cleaning chemical: * an open bucket on top of the cart contained a mixture of water and Coverage Plus NPD, * an open plastic jug and mop bucket on the lower level contained a mixture of water and Coverage Plus NPD. During this observation, a resident exited a resident room on the right side of the hallway, walk over to the unattended cleaning cart, and stared at the items on the top of the cart before	F 323	resident by the Social Worker and the agreement was signed by both the resident and the Social worker. All residents who are cognitively impaired or wander have the potential to be at risk if they should have access to chemicals that could harm them if ingested or used inappropriately. All residents who smoke have the potential to have their well-being compromised if they are outside without staff's knowledge and are unable to contact staff for assistance. The changes made for the chemicals were made the day of being notified of the potential IJ; all buckets removed and all chemicals are kept locked up in the housekeeping carts. Automatic locks were placed on all housekeeping carts. Education given to all housekeeping staff on 2/07/17 and 2/08/17. Education for smoking hazards given to the 3 residents, and education to new guidelines were given to all staff on 2/07/17 and 2/08/17; also education given at the monthly RN/LPN meetings held February 27th and March 3rd, 2017. A read and sign for these changes were placed on every unit, and nurse managers reviewed these guidelines with employees. We immediately started a QA process to check housekeeping carts: All carts were checked daily for 2 weeks, now are checked weekly on each unit for 4 weeks or until compliant, and then all carts will be checked 2 X monthly for one year.	

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F 323	Continued From page 43 entering another resident room on the left side of the hallway. SMOKING HAZARDS During the standard recertification survey on 02/07/17, the team determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from an observation at approximately 9:00 a.m. when observation showed Resident #3 outside, smoking in potentially hazardous weather conditions. After observation and interview with the facility staff, the survey team met at 11:00 a.m. and determined corrective action needed to occur. At 11:07 a.m., the team contacted the managerial staff at the State Agency (SA) to report the findings and to discuss a potential IJ situation. At 12:20 p.m., the survey team notified the facility administrator of the IJ and that they must develop a plan for abatement. At 4:38 p.m., the facility provided a written plan of correction for the IJ. The team reviewed and accepted the written plan. At 4:55 p.m., the team determined the IJ situation abated, reduced the scope and severity level to "D," and informed the administrator of this action. 2. Based on observation, record review, and resident/staff interviews, the facility failed to ensure 1 of 1 sampled resident (Resident #3) who utilized her wheelchair to leave the facility campus to smoke could do so safely. Failure to identify how she would acquire assistance from staff (if needed) once she had left the facility may	F 323	QA's are done weekly on the 3 residents that smoke to make sure that they are following the guidelines that were set up for them, which will ensure their safety. Audits will be done weekly for 4 weeks until compliant, and then 2X monthly X 4 months, and then 4X quarterly for one year. The results will be reported to the QAPI committee monthly. This is the responsibility of the DON and Department Director of Housekeeping.	

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F 323	Continued From page 44 result in an avoidable accident with/without injury. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included alcohol-induced persisting dementia, cerebrovascular accident (stroke), hemiplegia (paresis on one side of the body), weakness, and tobacco use. The annual Minimum Data Set (MDS), dated 01/21/17, identified Resident #3 as cognitively intact and supervision of one person required for transfers, walking in room/corridor, and locomotion on/off unit. Even though the facility identified Resident #3 as non-interviewable, they determined she was "safe to smoke independently," on her "Smoking Questionnaire," dated 01/15/17. Resident #3's physician's orders failed to address her tobacco use. The current care guide addressing Resident #3's safety identified, ". . . goes outside to smoke in designated area. . . ." Observation showed the following: * 02/07/17 at 8:50 a.m., Resident #3 held a cigarette in one hand as she self propelled her wheelchair through the dining room. She was wearing a hat and unfastened coat. An unidentified certified nursing assistant (CNA) stopped Resident #3 and assisted her with the snaps on her coat. When asked where the designated smoking area was located, the CNA stated, "off property. They [residents] are not supposed to smoke." Resident #3 added, "I stay	F 323		

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	355074	A. BUILDING _____ B. WING _____	02/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOMES	305 8TH AVE NE MINOT, ND 58702

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F 323	Continued From page 45 close to the building. If I go to where I'm supposed to, I will never make it back in. An electric wheelchair would make it through the snow. I'd be slipping and sliding all over the place." Resident #3 then rode the elevator to the first floor, put on one glove, and exited the building through a set of doors on the east side of the building. (At 8:54 a.m. the temperature in Minot registered at -6 degrees Fahrenheit with a wind speed of 10 mile per hour. In those conditions, frostbite can occur within ten-to-thirty minutes.) At the same time, an unidentified maintenance staff member was observed cleaning the sidewalk in front of the doors with an enclosed, riding snow blower. Resident #3 self propelled her wheelchair next to a table and chairs to the right of the door, lit her cigarette, and began smoking. She then propelled her wheelchair to the left of the door and finished her cigarette. * 02/06/17 at approximately 9:00 a.m., The unidentified maintenance staff member was observed assisting Resident #3 with her wheelchair, before he pushed her back into the building. * 02/06/17 at 9:20 a.m., Resident #3 was sitting in her wheelchair in her room. When asked why the staff member had assisted her, she stated, "I was stuck in the snow, that's why he got out to help me. He knew I was stuck, and said 'Let me help you.'" When asked how she would have gotten back into the facility if he hadn't been present, she stated, "I don't know, maybe someone on the inside would have seen me and bring me back in. I'm too scared to go out where I'm supposed to." When asked if she requested her cigarette from the nurse and/or signed out prior to leaving the Unit, she stated, "I keep my	F 323		

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F 323	Continued From page 46	F 323		

own cigarettes and lighter in my dresser. No, I don't sign out."

During an interview on 02/07/17 at 11:45 a.m., when asked if Resident #3 requested her cigarette from the nurse and/or signed out before leaving the Unit, a nurse (#13) and certified medication aide (CMA) (#25) indicated Resident #3 keeps them herself. The nurse (#13) stated, "No, she doesn't have to check out to smoke unless she leaves the grounds. There is a spot outside the back doors, by the edge of the [parking] lot. There is an ashtray next to the parking lot." When asked how residents who smoke contact staff if they require assistance, the nurse (#13) stated, "They [residents] usually have walkie-talkies." The CMA (#25) contradicted her, by stating, "They don't have walkies. They were throwing them away. Most [residents] have cell phones. [There are] one or two that don't. If they are out there for a long time, we'd go check on them." When asked how would you know to check on the resident, if you were unaware they had left the facility to smoke, the staff members (#13 and #25) failed to respond.

During an interview on 02/07/17 at 12:20 p.m., an administrative staff member (#2) reported, "We encourage residents and families to have a phone. I'm not sure if [Resident #3] has a phone. We do have walkie-talkies too."

Observation showed the following:
* 02/07/17 at 1:20 p.m. Resident #3 held a cigarette in one hand as she self propelled her wheelchair towards the exit. She was wearing a hat and coat, with only one snap secured. When asked if she had a cell phone or walkie-talkie on

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F 323	Continued From page 47 her person, she stated, "I don't have the right charger [for my phone]. No, no walkie-talkie. I told you they don't do that." Resident #3 exited the building through the set of doors on the east side of the building. Facility staff had cleared the sidewalk to the north, but the sidewalk to the south remained covered in snow. * 02/07/17 at approximately 1:40 p.m., Resident #3 finished her cigarette, pushed the handicapped button near the door, held onto the door frame, and rocked her chair two-to-three times before passing over the transition strip between the sidewalk and building. The facility failed to ensure Resident #3 received the care and services necessary for personal safety while smoking. The facility failed to ensure (given her diagnoses of hemiplegia and weakness) Resident #3 was capable of self-propelling her wheelchair through the snow to/from the designated smoking area. The facility failed to identify/care plan how Resident #3 would acquire assistance from staff (if needed) once she'd left the facility.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,	F 325		3/16/17

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F 325	Continued From page 48 unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/13/16. Based on observation and record review, the facility failed to adequately assess the nutritional intake and follow interventions to restore/maintain adequate nutritional status for 1 of 6 sampled residents (Resident #4) who experienced weight loss. Failure to meet the resident's nutritional needs through diet, supplements, or other interventions may have contributed to the resident experiencing significant weight loss. Findings include: Review of Resident #4's medical record occurred February 06-09, 2017. Diagnoses included panic disorder, chronic pain, macular degeneration, dysphagia, and weakness. The quarterly Minimum Data Set (MDS), dated 11/09/16, identified short and long term memory loss, moderately impaired vision, supervision for eating, weight loss not physician prescribed and a weight of 90 pounds. The current care guide stated, " . . . Eating: . . . Offer encouragement, provide cueing for eating. Starts to feed self, staff finish feeding. . . . Encourage intake of fluids. . . ."	F 325	Staff were reminded to encourage resident #4 to eat her meals and drink her supplements. All residents have the potential to be affected if nutritional intake not assessed and residents not encouraged to take supplements.Facility will ensure all residents will be offered fluids, supplements as ordered, and encouraged to eat during meals. All residents who are on the 30, 90, or 120 day weight loss list will be added to the white board in the nurses station to identify to staff those residents that need extra attention at meal times, and staff is to encourage, assist or feed residents as necessary. These lists will be updated monthly. There is also a daily snack list for those residents who are to receive high calorie supplements throughout the day. This list will remind staff who is offered the high calorie supplements and also to encourage them to take the supplements. If a resident identifies the snack offered as something they do not like, staff will give an appropriate substitute as guided by the list. Staff	

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F 325	Continued From page 49 Review of Resident #4's weight record identified the following: May 2016 - 102.1 lbs. 06/27/16 - 98.8 lbs. 07/01/16 - 98.2 lbs. 08/15/16 - 97.5 lbs. 09/19/16 - 94.5 lbs. 10/04/16 - 90.9 lbs. 11/14/16 - 90.3 lbs. 11/28/16 - 87.6 lbs. 12/01/16 - 87.9 lbs. 01/02/17 - 84.0 lbs. 01/23/17 - 85.5 lbs. Dietary progress notes stated the following: * 11/09/16 - 2:16 p.m. " . . . Res [resident] feeds herself with setup. Res appetite slight decline since last assessment, currently averaging 47% of meals and 38% of fluids . . . Encourage intake of food and fluids. . . . Res had TID [three times a day] supplements of chocolate milk or high kcal item @ [at] 10 am, ice cream bar or ice cream @ 3 pm. At pm peanut butter toast. Average of all three supplements is 20%. Changing the PM supplement to chocolate ice cream for variety as intakes have decline of supplements taken. BMI 15.74 (underweight). . . . Averaging 47% of meals. Triggers for significant weight loss 3 & [and] 6 months. Continue to offer and encourage intake of high-calorie, protein-dense food and supplements. . . ." * 11/15/16 - 9:51 a.m. ". . . Res triggered for weight loss this month 3 and 6 month. . . . weight was 90.3# [pounds]. . . . Meal intakes averaging 47# (sic) of food. Res. is offered high kcal protein dense food and fluids. Res has scheduled supplements b/t [between] meals . . ." * 01/19/17 - 1:40 p.m. "6 month weight loss	F 325	education was provided March 22nd, and March 1st at the Nurses meetings, and then education provided on each individual unit on March 16th. Staff has be provided education on importance of offering encouragement at meals and supplements and charting accurately the residents intake. The nursing management team will review each weight report to ensure appropriate measurements are recorded and complete and to monitor weight fluctuations. The Director of Nursing Services (DON), or designee, will complete weekly chart audits on 5 residents per unit for four consecutive weeks, or until deficiency is in compliance, and then 10 residents per unit monthly X4, and then 5 residents per unit quarterly. The audits will be done by reviewing all weight reports and focusing on residents with weight change to ensure that changes are identified and appropriate interventions have been put in place. Residents who need assistance with feeding will also be included in this audit to ensure that the assistance is being given to those residents identified. Care plans will be reviewed for updated information to reflect these interventions. Audited records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the	

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F 325	Continued From page 50 assessment. . . . Res feeds herself with setup. Res appetite slight decline since last assessment, currently averaging 40% of meals and 38% of fluids. Encourage intake of food and fluids. . . . Res had TID supplements of chocolate milk or high kcal item @10 am and 3 pm and 8 pm averaging 33% intake. . . . intakes have declined. BMI 14.7 (underweight). . . . triggers for weight loss-14.2% significant. . . . Averaging 40% of meals. Triggers for significant weight loss 6 months. Continue to offer and encourage intake of high-calorie, protein-dense food and supplements. . ." Observations showed: * 02/07/17 at 8:25 a.m. showed Resident #4's breakfast tray served and setup. Staff failed to supervise, cue or assist Resident #4 with her meal. At 8:37 a.m. a certified nurse assistant (CNA) sat next to the resident but left at 8:40 a.m. At 8:40 a.m. the resident lifted an empty coffee cup to her mouth. Staff failed to give any further supervision, cueing or assistance with her meal. At 8:50 a.m. the staff pushed the resident in her wheelchair to the nurses' station area to sit. Resident #4's breakfast tray showed she had eaten approximately two bites of her peanut butter toast, 1/4 of a fried egg, 3/4 of juice, 1/4 of milk that was added to her hot cereal, 1/2 supplement, 3/4 hot cereal and 1/4 of bacon. * 02/09/17 at 8:35 a.m.: showed Resident #4's breakfast tray served and setup. Staff failed to give any assistance throughout the meal. Observation showed the resident ate approximately 3/4 of an egg, 3/4 of bacon, 1/4 toast, 1/2 hot cereal, sips only of juice and milk before the staff pushed her to the nurses' station to sit.	F 325	committee. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QAPI Committee at each scheduled meeting. This will be the responsibility of the Nurse Managers and DON.	

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F 325	Continued From page 51 Facility staffs failure to trial additional supplements when the resident refused current supplements, and failure to follow care guide interventions of offering encouragement, providing cueing, and assistance with eating, placed the resident at risk for continued weight loss.	F 325		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy, the facility staff failed to offer fluids to 2 of 7 sampled residents (Resident #4 and #17) who required assistance to access fluids. Failure to offer fluids during cares may increase the residents' risk of dehydration and constipation. Findings include: Review of the facility policy titled "Fluids" occurred on 02/09/17. This policy, revised December 2015, stated, ". . . Additional fluids should be given between meals and with medications. . . ."	F 327	Residents #4 and #17 are offered fluids during their cares. All staff is educated to offer fluids during cares. This education is provided during nursing orientation, and also provided during skills fairs and at nursing meetings. All residents who are not able to take fluids themselves are at risk for dehydration and constipation if fluids are not offered during cares, in between meals and with medications. A group in-service was completed during	3/16/17

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F 327	Continued From page 52 Review of Resident #4's medical record occurred February 06-09, 2017. Diagnoses included dysphagia and weakness. The quarterly Minimum Data Set (MDS), dated 11/09/16, identified short and long-term memory loss, moderately impaired vision and supervision with eating. The current care plan identified problem for weight loss and risk for dehydration. The Care Guide stated, ". . . encourage intake of fluids . . ." Dietary progress notes identified the following: * 11/09/16 at 2:16 p.m.: ". . . averaging 47% of meals and 38% of fluids . . . Encourage intake of food and fluids. . . . res [resident] to maintain improved meal intakes, skin to heal, and res to remain hydrated. . . ." * 01/19/17 at 1:40 p.m.: ". . . currently averaging 40% of meals and 38% of fluid . . . Encourage intake of food and fluids. . . . res to maintain improved meal intakes, skin to be intact, and res to remain hydrated. . . ." * 01/30/17 at 2:34 p.m.: ". . . continue to encourage fluid intake . . ." Observations identified the following: * 02/07/17 at 9:35 a.m. - Two certified nursing assistants (CNAs) (#10 and #11) transferred the resident from the wheelchair to the bed. The CNAs checked the incontinent product and identified to be dry. The CNAs failed to offer the resident fluids. * 02/08/17 at 7:45 a.m. - A nurse (#9) completed a skin assessment and failed to offer fluids. * 02/08/17 at 8:00 a.m. - Two CNAs (#10 and #12) transferred Resident #4 from the bed to her wheelchair. The CNAs failed to offer the resident fluids. * 02/08/17 at 9:35 a.m. - Two CNAs (#10 and	F 327	the Monthly Nurse meeting on February 22, 2017 and March 1, 2017. A written in-service for staff to read and sign was also given to each unit with the re-education of offering fluids during cares. This written education was provided on March 1, 2017. Observations will include proper offering of fluids during care; and all violations will be addressed immediately with re-education. The Director of Nursing, Assistant Director of Nursing, Nurse Managers and staff will assess offering fluids during cares with QA audits being done on 5 residents each unit/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. The Director of Nursing will share these observations with the Quality Assurance Committee. If we find incidents where staff members are not following the process, as stated above, the individual will be re-educated and we will follow the disciplinary process. Reporting will be done monthly to the Quality Assurance Committee. The DON will be responsible to make sure that this process is followed.	

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F 327	Continued From page 53 #12) pivot transferred Resident #4 from her wheelchair to the bed and provided incontinent care. The CNAs failed to offer the resident fluids. * All days of survey identified a form titled "Resident Turning Schedules" hanging in Resident #4's room that stated, "Please Offer Fluids When Turning." - Review of Resident #17's medical record occurred on February 06-09, 2017. Diagnoses included Alzheimer's disease, constipation, and weakness. The quarterly MDS, dated 11/06/16, identified both short and long term memory problems, and extensive assistance of one staff member for eating. Resident #17's Care Guide stated, ". . . Encourage intake of fluids . . ." Observation showed the following: * 02/07/17 at 8:27 a.m. - Two CNAs (#27 and #28) transferred Resident #17 from a wheelchair to bed. The CNAs failed to offer the resident fluids. * 02/07/17 at 1:30 p.m. - Two CNAs (#27 and #29) transferred Resident #17 from a wheelchair to bed. The CNAs failed to offer the resident fluids. * 02/08/17 at 9:50 a.m. - Two CNAs (#27 and #30) transferred Resident #17 from one wheelchair to another and the CNA (#30) transported the resident to the beauty shop. The CNAs failed to offer the resident fluids. * 02/09/17 at 12:20 p.m. - Two CNAs (#31 and #32) transferred Resident #17 from a wheelchair to bed. The CNAs failed to offer the resident fluids. The facility staff failed to offer fluids with cares which may result in dehydration and constipation.	F 327		

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F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 356		3/17/17

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F 356	Continued From page 55 (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post the actual hours worked per shift by registered nurses (RN), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift during 2 of 4 days of survey (February 6 and 8, 2016). Failure to post the nurse staffing data at the beginning of each shift denied residents and visitors the opportunity to be informed of current staffing levels. Findings include: Observations showed the following: * 02/06/17, The posting of staff for all three shifts (morning, evening, and night) was placed in a clear file-holder on the wall next to an exit on the north side of the building. The posting of staff for each shift was presented on a separate sheet of paper, with the posting for the morning shift prominately displayed. * 02/08/17, The posting for the 02/07/17 evening shift continued to be displayed at 6:00 p.m. The facility failed to post the nurse staffing data at the beginning of each shift.	F 356	The staffing sheet will be posted every shift, every day. every day. Visitors and residents potentially could be affected by this inadvertent omission because they would not be able to know the correct census and staffing for each shift. The Nurse staffing office was educated on process of posting daily: Facility name,current date,,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 Resident census and Posting requirements. Random audits of posting done each shift will be performed 3 times weekly for 4	

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F 356	Continued From page 56	F 356	weeks or until compliance obtained daily for 2 weeks, monthly for four months, and then quarterly. This will be the responsibility of the Nursing Service Supervisor and the Director of Nursing.	
F 373 SS=D	483.60(h)(1)-(3), 483.95(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT 483.60 (h) Paid feeding assistants- (h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. (h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help. (h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance	F 373		3/16/17

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F 373	Continued From page 57 only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. 483.95 (h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.60 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to determine the appropriateness and care plan for a Paid Feeding Assistant (PFA) for 2 of 2 residents (Resident #20 and #21). Failure to adequately assess a resident with aspiration precautions (#20) and failure to address a PFA in a care plan (#21) can place residents at risk and limits staff knowledge regarding PFA. Findings include: During an observation on 02/08/17 at 8:30 a.m., a PFA staff member (#22) assisted feeding Resident #20 breakfast and verbally cued	F 373	Resident #20 is no longer fed by PFA. Resident #20 and #21's care plans updated to reflect the feeding needs of the residents. All residents have the potential being fed by someone who had not had the proper training to feed them. Initial feeding assessments are completed by a licensed nurse and a Speech Therapist will also complete a feeding assessment for residents that have issues with choking. Feeding assessments are done quarterly. Each unit identified residents who need	

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F 373	Continued From page 58 Resident #21 to eat more of her meal. Upon interview, the staff member (#22) reported Resident #20 received thickened liquids and has assisted both Residents #20 and #21 at mealtime. Review of the facility policy titled "Paid Feeding Assistants" occurred on 02/09/2017. This policy, dated 01/20/2016, stated, "Policy: Paid Feeding Assistants feed only residents who have no complicated feeding problems (i.e.. difficulty swallowing, recurrent lung aspiration . . .) . . . The use of a Paid Feeding Assistant to feed a resident must be included on that resident's plan of care. . . . Procedure: . . . 3. the nurse will place on the care plan that a Paid Feeding Assistant can feed the resident following the assessment. a. the assessment will include identifying: Special orders for Speech Pathology. Resident . . . prone to aspiration. . . ." - Review of Resident #20's medical record occurred on February 8-9, 2017. A quarterly Minimum Data set (MDS), dated 01/17/17 identified extensive assist of one person for eating. Resident #20's current care plan stated, ". . . Encourage self feeding, Totally fed as needed., Provide cueing for eating, Starts to feed self, Staff finish feeding . . . Monitor for chewing/swallowing problems, . . . May be fed by paid feeding assistant. Nectar thick liquids. . . ." Current physician's orders stated, ". . . Thickened Liquids - Nectar consistency continuous Jun [June] 01, 2016, Aspiration Precautions q [every] shift continuous Nov [November] 09, 2016 . . ."	F 373	assistance with feeding and residents who can be fed by PFAs. The care plans were updated, and a list is now posted on each unit that identifies which residents can be fed by a PFA. Education on the importance of having the residents assessed for the appropriate feeding needs has been provided to all staff who assist with feeding residents. This education was provided at the RN/LPN meetings in February and March, and to all staff in the Read and Sign educations. Each resident who can be fed by a PFA is identified and placed on a list which is posted in the nurses station. QA audits will be done on 5 residents each unit/weekly X 4 weeks, then 10 X monthly on each unit for 4 months and then 20 X quarterly on each unit until compliance is sustained. The QA audits will be done by designated nursing staff and monitored weekly by the DON and ADON. All QA will be presented to the QAPI committee monthly. This is the responsibility of the DON and Speech Therapist.	

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F 373	Continued From page 59 Review of a Speech Therapy (ST) assessment dated 05/18/16, stated, ". . . Mod [moderate] to severe oropharyngeal dysphagia [swallowing disorder] characterized by coughing on all consistencies . . . " Review of Feeding Assessments for Resident #20 identified the following: *10/12/16 - Diet order (blank), Diet texture (mechanical soft), History of aspiration (yes), As result of assessment, is the resident able to be fed by paid feeding assistant? (yes) *01/11/17 - Diet order (blank), Diet texture (regular), History of aspiration (no), Does the resident require assistance with feeding? (no) This assessment conflicts with the physician's order, previous feeding assessment, and ST assessment. - Review of Resident #21's medical record occurred on February 8-9, 2017. A quarterly MDS, dated 11/08/16, identified extensive assist of one person for eating. Resident #21's current care plan lacked an intervention that included could be fed by a PFA. Current physician's orders stated, ". . . Diabetic continuous texture as tolerated (with a start date of) Feb [February] 15, 2012. Review of Feeding Assessments for Resident #21 identified the following: *11/03/16 - Diet order (blank), Diet texture (mechanical soft), History of aspiration (no), Does the resident require assistance with feeding? (no) *02/08/17 - Diet order (blank), Diet texture	F 373		

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F 373	Continued From page 60 (regular), History of aspiration (no) Does the resident require assistance with feeding? (yes) As result of assessment, is the resident able to be fed by paid feeding assistant? (yes). During an interview at 2:50 p.m. on 02/09/17 a nurse PFA instructor (#23) confirmed facility should care plan the PFA for Resident #21 and Resident #20 "probably shouldn't be fed by a PFA."	F 373		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		3/16/17

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F 431	Continued From page 61 (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to store all medications in a secure manner on 4 of 6 nursing units (2 East, 2 West, 3 East, and 4 East). Failure to store all medications securely may result in unauthorized access to medications. Findings include: The facility failed to provide a policy related to	F 431	Immediate education provided to all nurse managers and nurses to lock treatment carts and keep locked at all times when not in attendance. All residents could be affected by not locking the treatment carts. All nursing staff is educated on locking the treatment carts when not in use. This education is provided during nursing	

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F 431	Continued From page 62 medication storage. Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing, Concepts, Process, and Practice", 10th ed., Pearson Education, Inc., New Jersey, page 770, stated, "Medication Dispensing Systems . . . Medication cart . . . The nurse either carries a key for the medication cart or enters a special code to open the cart, because it must be kept locked when not in use. . . ." Observation of the medication storage areas occurred on 02/09/17 from 9:45 a.m. to 11:40 a.m. and identified unlocked treatment carts on 2 East, 2 West, 3 East, and 4 East. The carts contained various topical creams used for pain and infection, insulin pens, scissors, and metal nail files. During an interview on 02/09/17 at 10:30 a.m., a nurse (#34) stated staff have never locked the treatment carts.	F 431	orientation. An in-service was given to the staff during the Monthly Nurse meeting on February 22, 2017 and March 1, 2017. A written in-service for staff to read and sign was also given to each unit with the re-education of locking the treatment carts when not in use. This written education was provided on March 1, 2017. Observations will include proper procedure on locking the treatment carts when not in use; and all violations will be addressed immediately with re-education. The Director of Nursing, Assistant Director of Nursing, Nurse Managers and Nursing staff will check all treatment carts daily on each unit to ensure that carts are kept locked at all times when there is not a staff member in attendance. Weekly audits will be done on all 6 carts for four weeks, and if compliance is obtained will do observations of all six carts monthly for four months, and then quarterly for one year. The Director of Nursing will share these observations with the Quality Assurance Committee. If we find incidents where staff members are not following the process, as stated above, the individual will be re-educated and we will follow the disciplinary process. Reporting will be done monthly to the Quality Assurance Committee. The DON will be responsible to make sure that this process is followed.	
F 441	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,	F 441		3/16/17

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F 441 SS=D	Continued From page 63 PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		

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F 441	Continued From page 64 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 03/10/16. Based on observation, record review, facility policy review, and staff interview, the facility failed to follow infection control practices for 2 of 2 sampled residents (Resident #13 and #14) observed during dressing changes. Failure to follow infection control practices related to hand	F 441	Residents #13 and #14-all staff have been re-educated to wash hands after removing gloves and before putting on clean gloves during dressing changes. This is education that is ongoing with all of our staff. Resident #13: staff failed to sanitize hoyer lift after using it on this resident. As soon as management was notified, staff were again educated to	

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F 441	Continued From page 65 hygiene during and after dressing changes and cleaning of equipment (mechanical lifts) has the potential to spread infection to other residents, staff, and visitors. Findings include: Review of the facility policy "Dressing Change Guideline" occurred on 02/19/17. This policy, dated April 2015, stated, ". . . H. Using gloved hands, remove soiled dressings. . . . Remove gloves and perform hand hygiene . . . K. Place new dressing over wound and secure. . . . P. Perform hand hygiene. . . ." Review of Resident #14's medical record occurred February 06-09, 2017 and identified the resident currently receiving two intravenous antibiotics daily for infection and on Contact Isolation. A progress note from an Infectious Disease physician, dated 02/06/17, identified Resident #14 has ". . . Left heel osteomyelitis involving the calcaneus bone due to MRSA (methicillin resistant Staphylococcus aureus) and pseudomonas. . . ." Observation on 02/07/17 at 9:45 a.m. showed a nurse (#3) donned a gown and gloves and removed the soiled dressing from Resident #14's heel. The nurse discarded the dressing, removed her gloves, and without washing or sanitizing her hands, donned a new pair of gloves. The nurse (#3) then applied a new dressing to the wound and wrapped the resident's foot with gauze. The nurse removed her gloves, donned a new pair of gloves and removed dressings from three wounds on Resident #14's right amputation stump. The nurse discarded the dressing,	F 441	follow facility guidelines (not a policy)with all equipment for sanitization, which includes disinfecting equipment between each resident use. All resident have the potential of increased infection if proper procedures are not used for hand sanitation and equipment disinfection. Education was given to all nursing staff on February 20, 2017; with instructions for staff regarding procedure techniques and disinfectant products to be used on all multi-use equipment. All nursing staff are given this education as part of orientation and twice annually as part of our facility skills fair; which includes a module on infection which covers the area of deficient practice identified. Staff also have mandatory annual education on infection control as part of Trinity Health's Mandatory education. All RN's and LPN's were educated at the mandatory nurse meetings on February 27th and March 1, 2017, on the practice of glove removal followed by hand hygiene, per our guidelines. "Read and sign" minutes and education were given to each nursing unit. All new nursing staff (RN's and LPN's) attend orientation by Infection Control & Prevention Coordinator and an orientation checklist is completed; including these same staff spending individual time with the Wound Care and Ostomy Nurse.	

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F 441	Continued From page 66 removed her gloves, and without washing or sanitizing her hands, applied a new pair of gloves. - Review of Resident #13's medical record occurred February 06-09, 2017 and identified MRSA and vancomycin resistant enterococci (VRE). Observation on 02/07/17 at 10:15 a.m. showed two certified nurse assistants (CNA) (#6 and #7) transferred Resident #13 from the shower chair to the bed with a full body mechanical lift (Hoyer). The CNA (#6) brought the shower chair out of Resident #13's room to the tub/shower room and sprayed the shower chair with a disinfectant. The CNA then wheeled the Hoyer lift from the resident's room to a storage room. When asked if she needed to disinfect the mechanical lift, the CNA (#6) stated no, she only needed to take the lift pad to the laundry. Observation on 02/07/17 at 1:15 p.m. showed a nurse (#3) changed a dressing on Resident #13's buttocks, removed her gloves, applied new gloves, and gave Resident #13 a drink of water. The nurse failed to wash or sanitize her hands after removing her gloves and before donning new gloves to give the resident water. During an interview on 02/09/17 at 4:00 p.m., an administrative infection control staff member (#8) confirmed staff should wash/sanitize hands after removing gloves and should disinfect the Hoyer lift if it has been in a contact isolation room.	F 441	Observations of dressing changes, 2 dressing changes per unit, specifically noting glove removal followed by hand hygiene will be completed weekly for 4 weeks, or until compliance is sustained, then 4 X/month for 4 months, and then 6 times quarterly until compliance is sustained. We will also follow the same outline of audits for the disinfection of equipment between resident use. These audits will be completed by nursing and will be reported monthly to the QAPI committee. Re-education will occur with non-compliance and disciplinary action would ensue if an individual continues to be non-compliant despite repeated educational opportunities. Responsibility for this POC is the DON and Infection Control Nurse.	