

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

PRINTED: 06/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/06/2010
NAME OF PROVIDER OR SUPPLIER TRINITY HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 305 8TH AVE NE MINOT, ND 58701		
(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 May 3, 2010, and completed on May 6, 2010, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000			06/01/2010
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or	F 156	1. Staff involved have been educated on the correct process for completing and documenting Notice of Medicare Provider Non-Coverage (aka Medicare Generic Notices) and Medicare Non- coverage Letters (aka Medicare Notice #5) (two separate notices). 2. Any residents receiving Medicare SNF/PPS services have the potential to be affected. Resident #15 signed the Medicare Notice #5 after a telephone conversation on 4/21/10 after which the form was sent out. But he did not check whether or not he wanted the claim submitted to Medicare. They did not sign the Notice of Medicare Provider Non- Coverage(aka "Generic Notice") that was also mailed out after the telephone conversation on 4/21/10. No claim has yet been submitted due to regulation of submitting in chronological order. Verbal indication from responsible party in conversation with business representative was that they did not wish to submit claim/appeal facility decision of Medicare decision. This was confirmed on 6/1/2010 by phone contact with the responsible party by Reimbursement Director. This is documented on a copy of Medicare Notice #5. Resident #32 signed and returned the Medicare Notice after it was mailed out on 7/1/09. They checked that they wanted to file a claim, begin the Medicare appeal process and this has been initiated. But all claims must be sent in chronological order to the Fiscal Intermediary so claim submission will occur at some time in the future.		

LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

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

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F 156	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter	F 156	Resident #33 Medicare Notice #5 was signed after being sent out on 10/19/09 after notifying responsible party. Responsible party indicated that they did not wish to submit claim to Medicare and begin appeal process for 10/21/09. Medicare Notice #5 was signed after being sent out on 1/14/10 after notifying responsible party. Responsible party indicated that they did not wish to submit claim to Medicare and begin appeal process for 01/17/10. Medicare Notice #5 was signed after being sent out on 4/16/10 after notifying responsible party. Responsible party indicated they did not wish to submit claim to Medicare and begin appeal process for 04/18/10. Generic Notice was not signed for any of the dates. 3. Staff involved will be inserviced on the need for specific documentation in the resident record to coincide with provision of the written notification of the Generic Notice and the documentation needed for the Medicare Notice #5 – and how to address and document the receipt of an unsigned Notice (either Medicare Notice #5 or Generic) to insure that resident/responsible party understands clearly what they are signing and that both distinct forms must be signed even though they are both notices of Medicare appeal but have different processes. 4. Date of Correction: June 1, 2010 5. Observations will be completed for every Medicare noncoverage decision. This will be reported monthly to the QA Committee until compliance is obtained. Once compliance is obtained, random observations with quarterly reporting will be done. The Reimbursement Director will be responsible for this process.		

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F 156	Continued From page 2 related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare records, review of professional literature, and staff interview, the facility failed to confirm the resident's or legal representative's decision regarding his/her right to a demand bill for 1 of 1 Resident (#15), and to an appeal for non-covered services for 1 of 1 sampled Resident (#15) and 2 of 2 supplemental Residents (#32 and #33). Failure to confirm the residents or legal representatives' decision regarding their rights to a demand bill and/or appeal, is an infringement of the residents' rights. Findings include:	F 156			

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F 156	Continued From page 3 The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding informing Medicare beneficiaries of their rights related to billing. The facility must provide a liability notice using either the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a Denial Letter to the resident or his/her legal representative in writing. The facility must also issue the Notice of Medicare Provider Non-Coverage (CMS form 10123, also called an Expedited Appeal Notice or a Generic Notice), when there is a termination of all Medicare Part A services for coverage reasons. This notice informs the beneficiary of his/her rights to an expedited review of Medicare benefit termination by the Quality Improvement Organization (QIO). These notices need to be provided to the resident or representative in writing and in a language the resident understands. CMS also outlined instructions regarding how to properly complete the Notice of Medicare Provider Non-Coverage form. According to the instructions, it states the beneficiary or the representative must sign the signature line, and must fill in the date that he or she signs the document. Review of Medicare billing records occurred the morning of 05/06/10 with an administrative staff member (#42). The denial letter issued to Resident #15 included a section required to be marked "yes" (indicating a request for a demand bill) or "no" (indicating no demand bill requested) by the resident or his/her legal representative. The letter lacked indication of either a request for or a refusal of a demand bill. During an interview on 05/06/10 at 9:50 a.m. with the staff member	F 156			

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F 156	Continued From page 4 (#42), she stated if the resident or legal representative failed to mark "yes" or "no" on the denial letter, the facility automatically issued the bill. Review of Residents #15, #32, and #33's Medicare records showed Notice of Medicare Provider Non-Coverage forms. Review of these notices showed the following: - For Resident #15, Medicare coverage ended 04/23/2010. - For Resident #32, Medicare coverage ended 07/03/2009. - For Resident #33, three separate notices issued regarding Medicare coverage which ended 10/21/09, 01/17/2010, and 04/18/2010. The five forms reviewed lacked a signature and date, which resulted in failure of the facility to confirm the resident's or his/her legal representative's decision to appeal for non-covered services.	F 156			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any	F 164	Staff employees involved have been counseled on waiting for a reply when knocking and using the privacy curtain when providing cares. All residents have potential to be affected. Staff will be inserviced on knocking & waiting for reply and using privacy curtains when providing cares. Random Observations will be made to insure staff is complying with these areas. Observations will be done weekly and reported monthly to the QA Committee until compliance is obtained. Once compliance is obtained, monthly observations with quarterly reporting will be done. The Director of Nursing will be responsible for this process.		6/1/10

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F 164	Continued From page 5 individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide privacy during personal cares for 3 of 27 sampled residents (Residents #5, #7 and #15). Failure to provide privacy during personal cares is an infringement on patient's rights and has the potential to affect the dignity of the resident, as well as cause unease to other residents in the vicinity of the involved resident. Findings include: - On 05/04/10 at 9:35 a.m., a nursing staff member (#16) provided a dressing change to both of Resident #7's lower legs. The dressing change included the nurse donning a gown and gloves, removing a stretch net gauze positioned below the knee on both of the resident's lower legs, assessing the resident's heels for wound healing, washing the resident's legs with wet clothes, applying a Band-Aid with bacitracin to the right heel, and reapplying new stretch net gauze. During this time, the nurse left the resident's	F 164			

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F 164	Continued From page 6 bedroom door open which opens into the corridor directly across from the nurse's desk (station), and left the privacy curtain open between Resident #7's and Resident #15's bed (both residents resided in the same room). At 9:40 a.m. on 05/04/10, during the above dressing change, two certified nursing assistants (CNAs) (#17 and #18) accompanied and assisted Resident #15 in her wheelchair into the room while the nurse (#16) continued with Resident #7's dressing changes. The CNAs (#17 and #18) closed the door to the room, left the privacy curtain open between the two residents and transferred Resident #15 with the assistance of two from the wheelchair to a lift recliner. Observation showed the CNAs communicating with Resident #15 for cooperation during the transfer, and the presence of a urinary drainage bag suspended from Resident #15's wheelchair. An interview occurred with an administrative staff member (#6) on 05/06/10 at 9:00 a.m. The staff member agreed staff should close resident room doors, and pull privacy curtains between residents during cares. The staff member agreed anyone can easily observe Resident #7 and #15 from the nurses station with the door open. - On 05/04/10 at 4:40 p.m., a CNA (#25) assisted Resident #5 with personal cares which included changing a brief, oral hygiene, dressing for the day, and transferring to a wheelchair in her room. Observation identified a certified medication aide (CMA) (#5) entered the room without knocking or waiting for permission and/or giving the resident time to be aware of the CMA's intent to enter before opening the door. The CMA (#5) preceded to set up and administer Resident	F 164			

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F 164	Continued From page 7 #5's nebulizer treatment.	F 164		
F 221 SS=D	During an interview on 05/06/10 at 11:30 a.m., an administrative nurse (#4) confirmed facility staff should knock before entering a room. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility failed to ensure staff used physical restraints to treat medical symptoms and not for staff convenience, for 2 of 2 sampled residents (Resident #16 and #21) with lap buddies on their wheelchairs. Failure to ensure care planning and attempts at less restrictive interventions placed the residents at risk of loss of mobility and unnecessary physical restrictions. Findings include: Review of the facility policy and procedure, Physical Restraints, occurred on 05/06/10. This policy and procedure, revised 10/08, stated "POLICY: It is the policy of Trinity Homes to use the least restrictive device, for the shortest time period possible . . . Restraints will be released at least every two hours under supervision. . . . The resident will be free from any physical restraint imposed for purposes of discipline or convenience and not required to treat the	F 221	Facility denies allegation of non-compliance. Resident #16 is able to remove her lap buddy. A stranger (surveyor) asking a resident with dementia to remove the lap buddy and not having the resident remove it is not reason to conclude resident can't remove it. Restraint assessments address medical, reductions and alternatives. Resident #21 had restraint released every two hours for toileting meeting the standard despite not meeting the higher facility standard as set in facility policy. In the spirit of cooperation, please find the following: 10 minute inservice given on the policy May 19, 2010 on unit where situation occurred. Residents have restraints removed during meals and every two hours. All residents with restraints have the potential to be affected. Inservices have been given to all nursing staff May 25 & 26, 2010. Education provided to all new employees regarding regulations, policies and procedures on restraints, which includes using the least restrictive device. Electronic record changed to include release device and reassess resident every two hours and remove at meals, which will improve documentation.	6/1/10

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F 221	Continued From page 8 residents medical symptoms. PROCEDURE: . . . 3. Attempts will be made to find the least restrictive device. This is an ongoing, continual process to provide quality care and provide residents with appropriate alternatives to restraint usage. . . ." - Resident #16's medical record, reviewed on all days of survey, identified the facility admitted the resident in 11/03. Current diagnoses included dementia and previous stroke. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified short and long term memory problems, moderately impaired daily decision making, extensive assistance of one or more persons for all mobility activities, falls in the past 30 and 180 days, and a trunk restraint used daily. Resident #16's Falls Resident Assessment Protocol (RAP) Summary, dated 08/03/09, stated "Resident triggered falls related to . . . the use of a lap buddy in the last couple of days. . . . Resident was using a lap buddy to remind her to ask for assistance with ambulating, but she continually would take off the lap buddy. Staff is now trialing a merrywalker [sic] to ensure her safety. . . ." Resident #16's current care plan, dated 09/01/09, stated "Problem, SAFETY - potential for injury from falls - poor regard for own safety due to dementia . . . Approach . . . Merry Walker - release and assess q2h [every two hours] and at meals, q shift. (03/16/10), Lap Buddy - use lap buddy while up in w/c [wheelchair]. If resident attempts to remove several times, may uses merrywalker [sic] instead. . . . (03/19/10) . . ." The resident's Care Guide, dated 05/04/10, stated "Ambulation . . . up in w/c with lap buddy in	F 221	The Nurse Managers and DON will be responsible for monitoring and reporting monthly to the Quality Department. Random weekly audits/observations will be completed, to insure compliance with this regulation. Once compliance is obtained, audits will be done quarterly. The Director of Nursing will be responsible for this process.		

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F 221	Continued From page 9 attempt to reduce use of merrywalker [sic]. . . . Safety . . . lap buddy used while in w/c." Resident #16's medical record identified the resident used the merry walker for ambulation on the unit and facility staff have used the lap buddy on a trial basis on several occasions. The current period of use of the lap buddy began on 03/19/10. Observation, on May 04-06, 2010, identified the facility staff applied the lap buddy to the wheelchair each time they assisted the resident to the wheelchair. The lap buddy remained in place as long as the resident remained in the wheelchair, including when attended by staff during breakfast on all three days, during the noon meal on May 04 and 05, and during all activities attendance. Observation showed the facility staff failed to offer or consider removing the lap buddy. Observation showed Resident #16 did not make any attempt to remove the lap buddy. On request, the resident did not make any attempt to remove the lap buddy. - During the initial tour, on 05/04/10 at 11:00 a.m., a nursing supervisory staff member (#1) reported the facility received a physician's order, at the family member's request, for Resident #21 to use a lap buddy. Resident #21's medical record, reviewed on May 05-06, 2010, identified the facility admitted the resident in January 2001. Current diagnoses included dementia, anxiety, depression, and chronic pain. The resident's current MDS, dated 04/05/10, identified short and long term memory problems, moderately impaired daily decision making, falls in the past 31 to 180 days, and no restraints used.	F 221			

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F 221	Continued From page 10 Resident #21's Falls RAP Summary, dated 07/06/09, stated "Resident triggered falls related to her use of an antianxiety medication and her history of falls. Staff should monitor her for trying to transfer per self and assist as needed. She does have a chair & [and] bed alarm to alert staff for times when she is trying to stand or transfer per self. . . ." Resident #21's Initial Device Assessment, dated 04/30/10, stated "SECTION IV - PLAN, A. Identify the problem: falls B. When is it a problem? Times vary. Has had falls on al [sic] shifts. . . . G. Device to be applied? Lap Buddy . . . H. Assessment results/Plan, Trial of lap buddy done. Res. [Resident] unable to remove on request. Will notify MD [physician] of family request and obtain a MD order." Resident #21's current care plan, dated 04/01/09, stated "SAFETY - potential for injury from falls - has poor regard for own safety due to dementia . . . (08/14/09) . . . Approach . . . Lap Buddy - when up in w/c q shift (04/30/10)." The resident's Care Guide, dated 05/05/10, failed to identify the lap buddy. Resident #21's medical record identified seven falls during the period 11/15/09 to 04/24/10. Falls on 02/10/10 and 04/24/10 occurred from the resident's wheelchair when attempting independent transfers. The remaining falls occurred from her bed when attempting independent transfers. The medical record identified limited interventions, including the alarm and a toileting program, attempted by staff to	F 221			

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F 221	Continued From page 11 prevent falls from the wheelchair. Observation, on May 04-05, 2010, identified Resident #21 seated in a wheelchair with an alarm and without a lap buddy. Observation, on 05/06/10 at 7:45 a.m., identified the resident seated in a wheelchair with an alarm and a lap buddy at the dining room table. Observation of the breakfast meal on 05/06/10 showed an unidentified staff member assisting the resident with the breakfast meal while the lap buddy remained in place. During interview, on 05/06/10 at 8:30 a.m., a nursing management staff member (#2) agreed facility staff should have removed Resident #16's and #21's lap buddies during meals and activities and reported staff may have implemented Resident #21's lap buddy at the family member's insistence. Additional information including care planning, approaches for staff, family member education, and rationale for Resident #21's lap buddy was requested, but not provided. The facility failed to develop care plan approaches for removal of the lap buddies at least every two hours or at other times when supervised and failed to remove the lap buddies when facility staff supervised them. The facility failed to implement less restrictive interventions after Resident #21's two falls from her wheelchair before using the lap buddy. These failures resulted in restraints used for staff convenience and placed the residents at risk of injury and further decline.	F 221			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225			6/1/10

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F 225	Continued From page 12 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and	F 225	Facility took immediate actions to protect residents during the investigations of alleged abuse. None of the allegations were substantiated by the state survey and certification agency. All staff will be educated on the Abuse and Neglect Policy. New policy will be given to all new employees, with education being provided in new employee orientation. All residents have the potential to be affected. Abuse policy and procedure has been updated, and all staff will be educated on the updates to insure allegations are faxed to NDSHD within 24 hours of being reported. Director of Nursing and Social Work Department Manager will be responsible to audit all abuse/neglect complaints to insure timeliness of reporting. Monthly audits will be done and reported to the Quality Assurance Committee, and once compliance is obtained will do quarterly audits.		

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F 225	Continued From page 13 procedure, review of professional literature, and staff interview, the facility failed to notify the state survey agency and administration within appropriate time frames for 3 of 4 abuse/neglect allegations (06/29/09, 11/21/09, and 03/20/10) involving physical and/or verbal abuse. Failure to immediately report all allegations of abuse and/or neglect has the potential to affect the quality of life for residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding reporting of abuse and neglect allegations. CMS states the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately (within 24 hours) to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Review of the facility policy titled "Investigation and Reporting of Abuse, Neglect, and Misappropriation of Resident Property" occurred on 05/04/10. This policy, dated January 2010, stated, "... Procedure: ... 1. All actual or alleged incidents of abuse, neglect ... will be reported immediately to your supervisor, charge nurse,	F 225			

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F 225	Continued From page 14 department manager, or manager on call . . . 2. The supervisor notified is responsible to initiate protective approaches to prevent further abuse, neglect . . . 3. The supervisor will then contact the Director of Nursing and/or Director of Social Services to initiate the investigation process. The Director of Nursing and/or Director of Social Services will report the alleged abuse, neglect, or misappropriation of resident property to the Administrator and/or their designee, the State Health Department [contact the State Health Department via phone Monday through Friday during normal business hours for initial reporting]. . . ." The facility policy conflicts with regulatory requirements regarding immediate reporting to the state survey and certification agency. Review of investigations of alleged abuse/neglect occurred on 05/04/10 at 11:30 a.m. with an administrative staff member (#43). Review of three of four investigation forms showed the following: - Physical abuse allegation dated 06/29/09, reported to the North Dakota State Survey Certification Agency (NDSSCA) on 07/06/09 - Physical abuse allegation dated 11/21/09, reported to NDSSCA on 11/23/09 - Verbal abuse allegation dated 03/20/10, reported to the administrator and NDSSCA on 03/22/10 Review of these allegations identified the facility failed to immediately report all of the allegations to the NDSSCA, and failed to immediately report the 03/22/10 allegation to the administrator. During an interview on 05/05/10 at 7:50 a.m., an	F 225			

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F 225	Continued From page 15	F 225			
F 241	administrative staff member (#33) confirmed the facility notified the NDSSCA of the above investigations during normal business hours.	F 241			
SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY				6/1/10
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide care and services to residents in recognition of their individuality regarding undergarments (Resident #12), plastic eating utensils (Resident #16), and toileting location and methods (Resident #16, #22, and #31), for 4 of 27 sampled residents. Failure to provide care in recognition of the residents' individuality placed the residents at risk of reduced self esteem and self worth. Findings include: - Review of Resident #16's medical record, occurred on May 04-06, 2010. Resident #16's current diagnoses included dementia and depression. The resident's current Minimum Data Set (MDS), dated 04/18/10, identified short and long term memory problems, moderately impaired daily decision making, and extensive assistance of two or more persons for toileting and eating. Resident #16's Activities of Daily Living (ADL) Functional Rehabilitation Potential Resident Assessment Protocol Summary (RAPS), dated		Facility denies the allegation of non-compliance for plastic spoon for resident #16 and under garments for resident #12. Regulations state "day to day use of plastic cutlery". Resident #16 is served silverware with all of her meals. The resident had dropped her spoon, so the resident was given a plastic spoon out of the kitchenette to replace the one she dropped. Residents, staff, and visitors also have access to plastic spoons which are available with hot chocolate. Resident #12 has complained of discomfort in the past from being uncomfortable with any type of undergarment, and the results have been the same in the past; continues to be incontinent even with his toileting schedule. Resident drinking from milk carton able to pour own milk and reach straw, which were on the table. This resident is independent with all meals and has the ability to reach a straw and pour her milk into a glass. Staff involved in the deficiencies with resident toileting and commodes have been educated to: 1) Use a toilet instead of a commode if it is the resident's wishes, 2) Always use the resident's personal bathroom and/or commode when able, and 3) Do not have resident's facing the wall when they are using the commodes.		

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F 241	Continued From page 16 08/03/09, stated "... Staff have been feeding her part of her meal. Encourage her to participate with feeding self. ... Staff toilet her every 2-3 hours ..." Resident #16's current care plan, dated 09/01/09, stated "Problem, ELIMINATION ... requires extensive assistance ... Problem, NUTRITION/FEEDING ... Starts to feed self, staff assist prn [as needed] by nursing staff. ..." The resident's Care Guide, dated 05/04/10, stated "Eating, Fed by CNA [certified nursing assistant] or nurse only - feeds self some ... Toileting ... Staff toilets every 2-3 hrs [hours]." Observation, on 05/04/10 at 7:55 a.m., showed Resident #16 seated in a wheelchair at the dining room table with a cup of coffee and a plastic spoon. The resident alternately stirred the coffee with the spoon and sucked on the spoon as if trying to use the spoon as a straw. At 8:05 a.m. an unidentified staff member provided her breakfast meal of hot cereal, eggs, juice, and milk, in addition to the coffee. The resident began eating, using the plastic spoon to feed herself. An unidentified staff member assisted the resident, feeding her with a metal spoon, and Resident #16 continued to feed herself at times with the plastic spoon. The staff member failed to attempt to replace the plastic spoon with a metal spoon. Observation, on 05/04/10 at 12:10 p.m., showed Resident #16 seated in a wheelchair at the dining room table with her pureed meal items of meat, sweet potato, peas, and pudding. The resident fed herself part of the meal with a plastic spoon and a CNA (#7) prompted her and fed her the remainder of the meal with a metal spoon. The staff member (#7) failed to attempt to replace the	F 241	All residents have the potential to be affected. Education provided to the staff on promoting dignity and self respect by giving resident choices in personal needs, including using resident's bathroom and not leaving residents unattended if their condition warrants staff stay with the resident. Inservices given to all employees May 26th & 27th. Random observations will be made by staff and nurse managers to ensure an environment that promotes and maintains residents well being and dignity. Reports will be submitted to Quality Assurance Committee monthly, and once compliance is obtained will do quarterly audits.		

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F 241	Continued From page 17 plastic spoon with a metal spoon. It is unknown how or where Resident #16 obtained the plastic spoons. Use of the plastic spoons and failure of staff to replace them with metal spoons did not enhance or respect the resident's dignity or individuality. Observation, on 05/04/10 at 3:20 p.m., identified CNAs (#11) and (#12) assisting Resident #16 with toileting in the unit's tub room. The CNAs assisted the resident to stand with a gait belt and a wall rail in front of her, lowered her pullup and slacks, removed the wheelchair from behind her, moved a commode behind her, and the resident sat on the commode. After voiding, the CNAs assisted Resident #16 to stand from the commode with the gait belt and wall rail, provided perineal care while the resident stood, changed the resident's brief, pulled up her slacks, removed the commode from behind her, moved the wheelchair behind her, and the resident sat in the wheelchair. During interview, at completion of this episode of care, CNA (#11) reported the staff used the commode instead of the toilet (as observed two times earlier in the day) because the resident is "hard to turn" for the pivot transfer to the toilet. Observations of toilet transfers showed the resident and staff had no difficulty and use of the commode was a staff convenience. Observation, on 05/05/10 at 9:35 a.m., identified CNA (#13) preparing to toilet Resident #16 in the unit's tub room. CNA (#13) waited in the hall with the resident for approximately five minutes before CNA (#14) arrived and entered the tub room with the resident. After transferring Resident #16 to	F 241			

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F 241	Continued From page 18 the toilet, CNA (#13) called out to Resident #22 "Are you doing O. K. back there?" When questioned, CNA (#13) reported Resident #22 was behind a drawn cubicle curtain. Observation showed Resident #22 seated on a commode, positioned facing a low wall, with her knees flexed, and her knees and toes touching the wall. CNAs (#13) and (#14) did not provide a reason for Resident #22 using the commode in this position. It is unknown how long Resident #22 sat on the commode unattended in this position. It is known CNA (#13) waited in the hall outside the tub room approximately five minutes for CNA (#14), during which no staff members left or entered the tub room. - Observation in the unit's tub room, on 05/06/10 at 8:30 a.m., accompanied by a nursing management staff member (#2), identified Resident #31 seated on a commode positioned facing a low wall, with her knees flexed, and her knees and toes touching the wall. At this time the unit's residents were eating breakfast in the dining room and there was no evidence of facility staff in the tub room or the hall outside the tub room. The staff member (#2) immediately summoned a staff member from the dining room to remove Resident #31 from the commode and tub room. It is unknown how long Resident #31 sat on the bedside commode unattended in this position. During interview, at the completion of the observation regarding Resident #31 on 05/06/10 at 8:30 a.m., nursing management staff member (#2) agreed facility staff should have replaced the	F 241			

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F 241	Continued From page 19 plastic spoons with metal spoons, facility staff should toilet Resident #16 using the toilet, and facility staff should not toilet Resident #22 and #31 on the commode in the tub room. - Observation on 05/04/10 at 7:59-8:10 a.m., showed a CNA (#29) assisted Resident #12 to toilet. While in the bathroom, Resident #12 verbalized to a CNA (#29) his discomfort concerning the type of incontinent undergarment he wore and stated, "I have suffered all morning." Observation showed Resident #12's incontinent undergarment dry and the resident voided. As a CNA (#29) raised Resident #12's incontinent undergarment, the resident stated "Don't put these [referring to the incontinent undergarment] on me." Observation of Resident #12's groin area showed no redness or open areas. CNA (#29) applied barrier ointment on Resident #12's groin area. This CNA informed the resident he needed to wear this incontinent product "for protection" and stated she would not pull the incontinent undergarment up too tight. CNA (#29) stated staff used to place "pull-ups" (a brand name of a type of incontinent undergarment) on Resident #12 but changed to the current undergarment because the resident developed redness and rash to his groin area. Observation on 05/04/10 at 10:00 a.m. showed a CNA (#28) assisted Resident #12 to toilet. Observation of Resident #12's incontinent undergarment showed it to be dry. Resident #12 voided and while seated on the toilet rubbed his groin area and verbalized discomfort with the incontinent undergarment he wore. Observation on 05/05/10 at 8:00-8:10 a.m. showed a CNA (#40) assisted Resident #12 to	F 241			

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F 241	Continued From page 20 toilet. Observation of Resident #12's incontinent undergarment showed it to be dry. Resident #12 voided and verbalized displeasure with the type of incontinent undergarment he wore. Review of Resident #12's medical record occurred on all days of survey. Resident #12's current significant change Minimum Data Set (MDS), dated 02/09/10, identified the resident required extensive assistance of two or more persons for toilet use and transfer, occasionally incontinent of bladder, and usually continent of bowel. During interview on 05/05/10 at 3:45 p.m., administrative nursing staff member (#2) stated his unawareness of Resident #12's verbal complaints with the use of the incontinent undergarment. Administrative nursing staff member (#2) stated staff frequently toilet Resident #12 to improve continence. When asked to provide information on interventions or alternatives the facility implemented in response to Resident #12's verbal discomfort with his current incontinent undergarment, administrative nursing staff member (#2) failed to provide further information. Failure of the facility to provide an incontinent undergarment in recognition of Resident #12's individuality does not enhance or promote this resident's dignity.	F 241			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of	F 246	Resident #16 is served silverware with all of her meals. The resident had dropped her spoon, so the resident was given a plastic spoon out of the kitchenette to replace the one she dropped. Residents, staff, and visitors also have access to plastic spoons which are available with hot chocolate.		6/1/10

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F 246	Continued From page 21 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY OF 06/11/09. Based on observation, record review, and staff interview, the facility failed to ensure each resident received reasonable accommodations of individual needs and preferences, for 5 of 27 sampled residents regarding sitting position in a wheelchair (Resident #16, #18, and #21), dining room seating position (Resident #18 and #34), and failure to toilet on request in a timely manner (Resident #12). Failure to accommodate wheelchair seating positions placed residents at risk of pain and pressure ulcers; failure to accommodate dining room seating position placed residents at risk of reduced meal intake and nutritional risk; and, failure to accommodate toileting in a timely manner placed the resident at risk of unnecessary incontinence, loss of independence, and reduction of self esteem. Findings include: - Resident #21's medical record, reviewed on May 05-06, 2010, identified the facility admitted the resident in January, 2001. The resident's current diagnoses included dementia, chronic pain, chronic airway obstruction, spinal stenosis, and myalgia. The most recent Minimum Data Set (MDS), dated 04/05/10, identified short and long term memory problems, moderately impaired daily decision making, extensive assistance of	F 246	Resident #12 has complained of discomfort in the past from being uncomfortable with any type of undergarment, and the results have been the same in the past; continues to be incontinent even with his toileting schedule. Resident drinking from milk carton able to pour own milk and reach straw, which were on the table. This resident is independent with all meals and has the ability to reach a straw and pour her milk into a glass. Staff involved in the deficiencies with resident toileting and commodes have been educated to: 1) Use a toilet instead of a commode if it is the resident's wishes, 2) Always use the resident's personal bathroom and/or commode when able, and 3) Do not have resident's facing the wall when they are using the commodes. All residents have the potential to be affected. Education provided to the staff on promoting dignity and self respect by giving resident choices in personal needs, including using resident's bathroom and not leaving residents unattended if their condition warrants staff stay with the resident. Inservices given to all employees May 26th & 27th. Random observations will be made by staff and nurse managers to ensure an environment that promotes and maintains residents well being and dignity. Reports will be submitted to Quality Assurance Committee monthly, and once compliance is obtained will do quarterly audits.		

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F 246	Continued From page 22 two or more persons for bed mobility and transfers, and pain less than daily, at times excruciating in areas described as "other." Resident #21's Activities of Daily Living (ADL) Functional Rehabilitation Potential Resident Assessment Protocol (RAP) Summary, dated 07/05/09, stated "... continued to need extensive assist of one staff for bed mobility. ... needs extensive assist of one staff for dressing. She will try to assit [sic] with lifting her arms. ..." Resident #21's current care plan, dated 04/01/09, stated "Problem, BED MOBILITY & [and] ROM [Range of Motion] - able to participate with encouragement, self care deficit - requires extensive assistance (10/11/07), Goal ... Resident will turn & position successfully w/ [with] physical help. ..." Observations of Resident #21 seated in her wheelchair included: *05/04/10, 12:25 p.m. - At the dining room table, leaning to her left, her trunk against the left wheelchair arm rest. Certified nursing assistant (CNA) (#9) fed the resident the noon meal and failed to reposition the resident. *05/05/10, 8:10 a.m. to 8:35 a.m. - At the dining room table, leaning to her left, her trunk against the left wheelchair arm rest. Licensed nurse (#1) and CNA (#36) fed the resident the breakfast meal and failed to reposition the resident. *05/05/10, 9:50 a.m. - In the Lounge during a newspaper reading activity, leaning to her left, her trunk against the left wheelchair arm rest. Unidentified facility staff reading the newspaper and in the area failed to reposition the resident. Failure to reposition Resident #21 placed the	F 246			

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F 246	Continued From page 23 resident at risk of increased pain and reduced meal intake. - Resident #16's medical record, reviewed on all days of survey, identified the facility admitted the resident in 11/03. The resident's current diagnoses included dementia, degenerative disc disease, and a stage II coccyx pressure ulcer (healed on 04/27/10). The resident's current MDS, dated 04/18/10, identified short and long term memory problems, required extensive assistance of two or more persons for transfers and bed mobility, and a stage II pressure ulcer. Resident #16's Activities of Daily Living (ADL) Functional Rehabilitation Potential Resident Assessment Protocol (RAP) Summary, dated 08/03/09, stated "... needed extensive assist of one staff to lift her feet in and out of bed. ... monitor her for sliding down in bed and assist to pull her up. She needed extensive assist [sic] of one staff to transfer in an out of her wheelchair. ..." Resident #16's current care plan, dated 09/01/09, stated "Problem, BED MOBILITY & [and] ROM [Range of Motion] - self care deficit - requires extensive assistance (11/22/09), Goal ... Resident will turn & position successfully w/ [with] physical help. ... Problem, SKIN INTEGRITY - potential for skin impairment related to incontinence & needing more help with mobility ... Problem, TRANSFERRING - self care deficit - requires extensive assistance ... " The resident's Care Guide, dated 05/04/10, stated "Skin ... potential for breakdown r/t [related to] decreased mobility ..." Observation of facility staff members providing	F 246			

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F 246	Continued From page 24 care and completing transfers for Resident #16 identified the resident seated in a wheelchair with her hips and trunk rotated to the right after each transfer. Facility staff failed to reposition the resident to a sitting position without hip or trunk rotation after the transfers or during meals, as follows: *05/04/10, 9:20 a.m. - CNAs (#7) and (#8) completed assisted toileting for the resident and transferred the resident to a wheelchair. *05/04/10, 10:50 a.m. - The resident remained rotated in the wheelchair. CNAs (#9) and (#10) completed assisted toileting for the resident and transferred the resident to a wheelchair. *05/04/10, 12:10 p.m. - The resident remained rotated in the wheelchair. CNA (#7) assisted the resident with the noon meal at the dining room table. *05/04/10, 3:20 p.m. - CNAs (#11) and (#12) completed assisted toileting for the resident and transferred the resident to a wheelchair. *05/05/10, 7:53 a.m. - CNAs (#7) and (#13) completed morning cares for the resident and transferred the resident to a wheelchair. *05/05/10, 8:10 a.m. - The resident remained rotated in the wheelchair. CNA (#7) assisted the resident with the breakfast meal at the dining room table. *05/05/10, 9:35 a.m. - The resident remained rotated in the wheelchair. CNAs (#13) and (#14) completed assisted toileting for the resident and transferred the resident to a wheelchair. Failure of facility staff to ensure Resident #16's sitting posture in the wheelchair, without hip and trunk rotation, did not accommodate her individual needs to reduce the risk of recurrence of the coccyx pressure ulcer.	F 246			

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F 246	Continued From page 25 - Random observations on the resident care unit and the unit dining room, on May 04-06, 2010, identified the following positioning issues: *Resident #34 - seated in a wheelchair with her forearms resting on the arm rests and the upper arms positioned out to her sides away from her trunk. The resident could not maintain her upper arms at her trunk and her elbows at a right angle. At the dining room table, Resident #34's wheelchair arm rests were at the level of the table top. The arm rest prevented the wheelchair from moving under the table top. With the resident seated in the wheelchair, she leaned forward to access some items and reached to full arm's length to access others. *Resident #18 - seated in a wheelchair at the dining room table, the wheelchair arm rests at the level of the table top. The arm rest prevented the wheelchair from moving under the table top. With the resident seated in the wheelchair, she leaned forward to access some items and reached to full arm's length to access others. Failure to provide wheelchair seating for Resident #34 to allow proper upper extremity positioning did not accommodate her individual needs and placed her at risk of experiencing pain and fatigue related to improper positioning. Failure to provide easy access to meal items for Resident #34 and #18 limited their dining experience, placed the residents at risk of reduced meal intake, and placed the residents at risk of reduced self esteem if food dropped on their clothing. During interview, on 05/06/10 at 8:30 a.m., a nursing management staff member (#2) agreed facility staff should have repositioned Resident	F 246			

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F 246	Continued From page 26 #21 and #16. This staff member did not provide additional information regarding positioning or wheelchair alternatives attempted for Resident #34 and #18. The staff member (#2) agreed facility staff should evaluate Resident #34's and #18's wheelchair and dining room positions. - Observation on 05/04/10 at 7:39 a.m. showed Resident #12 seated in a wheelchair in the 3rd Unit West living room. Resident #12 verbally requested assistance to utilize the toilet and stated, "Hurry up, otherwise I'm going to have an accident." A certified medication aide (#35) present in the same area verbally heard and acknowledged Resident #12's request and stated staff "were on their way" to help him. Observation at 7:59 a.m., (20 minutes after requesting assistance to toilet), a CNA (#29) transported Resident #12 from the living room into his room and assisted the resident. Review of Resident #12's medical record occurred on all days of survey. Resident #12's current significant change MDS, dated 02/09/10, identified short and long term memory problems, moderately impaired in daily decision making, required extensive assistance of two or more persons for toilet use and transfer, occasionally incontinent of bladder, usually continent of bowel, history of accidents/falls within the past 30-180 days and fracture (rib) within the last 180 days. During interview on 05/05/10 at 3:45 p.m., administrative nursing staff member (#2) stated he expected the average time for staff to respond to a resident's need for assistance with toileting to be between 7-9 minutes. When informed of the above observation on 05/04/10, involving Resident #12's request for toileting assistance, an	F 246			

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F 246	Continued From page 27 administrative nursing staff member (#2) stated twenty minutes "is too long for a resident to wait for help/assistance with toileting."	F 246			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to provide medically-related social services to meet the necessary psycho-social needs of 1 of 2 sampled residents (Resident #11) identified as a new admission within the last month on the roster provided by the facility. Findings include: - Review of Resident #11's medical record occurred on May 04-06, 2010. The resident's medical diagnoses included left ankle osteomyelitis with a wound vacuum, depression, and fatigue/malaise. The resident's current medications included Lorazepam (anti-anxiety), Percocet (pain relief), Acetaminophen (pain relief), Ertapenem Sodium intravenously (IV) (antibiotic), and Daptomycin IV (antibiotic). Resident #11's admission Minimum Data Set (MDS), dated 04/16/10, identified no short or long term memory problems, independent in daily decision making, able to make herself understood and able to understand others.	F 250	Facility denies this allegation of non- compliance. Hospitalist noted reason for prescribing anti-anxiety medication on discharge history and physical. Resident was discouraged with medical problems and having to stay in nursing home for 6 weeks. Her at home activities matched her activities in the facility. Shortly after admission, facility was able to meet her need of a private room after which her need for anti- anxiety medication decreased. Resident was discharged home on 5/17/2010. In the spirit of cooperation, please find the following: Social Services staff will read all resident progress notes and identify residents that are unhappy with placement or current situation. Residents that choose to spend all, or most, of their time in their room will be identified and social worker will meet with resident and document resident choices. This has the potential to affect all residents. Social Service educated on assessments and complete documentation. Social Workers will do assessments on residents who choose to isolate themselves and do assessments to insure that all psycho-social needs are being met. QA will be monitored monthly and reported monthly until in compliance and reported quarterly thereafter. The Social Service Department Manager will be responsible for this process.	6/1/10	

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F 250	Continued From page 28 The Resident Assessment Protocol Summary (RAPS), dated 04/14/10, included the following: * "Problem area - Psychosocial well-being - Resident #11 is alert and oriented times three, establishes her own goals, and is independent in daily decision making. Her goal is to return to her own home as soon as possible. * Problem area - Falls - Triggers with using Lorazepam for anxiety-used x 1 this week. Monitor for side effects including dizziness. Offer support and reassurance. * Pressure ulcers - . . . She prefers to stay in her room. . . * Psychotropic drug use - Triggers with using prn [as needed] Lorazepam for anxiety. She has a depression dx [diagnosis]. Staff monitor for significant changes in her mood/behavior and update her Md [medical doctor] as needed." Resident #11's care plan identified the following problem and interventions: "Problem: Psycho-social activities - enjoys socializing 1:1, independent in activity and social choices, prefers self-directed activities. Goal: Read and watch TV weekly." The care plan failed to identify specific interventions to address the Resident #11's anxiety, frustration, and difficulty dealing with current illness, unhappiness, and isolating behavior. The resident's Care Guide [CNA care plan] stated: Behavior Approaches - Help with adjustment to floor & routine changes, Spend 1:1 time with resident. Review of Resident #11's nursing progress notes identified nursing staff administered Lorazepam 0.5mg (milligrams) on five occasions between April 04-24, 2010 for anxiety. Alternative interventions identified were "decrease	F 250			

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F 250	Continued From page 29 environmental stimulation, relaxation technique, pain management." The record failed to identify the source of the anxiety. In addition, the nursing progress notes identified the following: * 04/07/10 at 4:08 p.m. - "... Resident c/o frequent diarrhea and urgency in voiding. States "I've been in the bathroom ten times already today." * 04/08/10 at 3:56 p.m. - "Resident c/o not feeling well/nauseated." * 04/08/10 at 10:28 a.m. - "diarrhea" * 04/09/10 at 1:38 a.m. - "... on antibiotic [Cipro] for UTI." * 04/11/10 at 1:29 a.m. - "on antibiotics for ankle infection and loose stools." * 04/14/10 at 8:51 a.m. - "... She's in her room most the time." * 04/14/10 at 9:00 p.m. - "c/o upper left back and left chest pain. Tender to touch @ [at] left lower rib cage. c/o upset stomach. Has had several loose stools." * 04/20/10 at 9:15 a.m. - "... Resident very unhappy in general." * 04/20/10 at 10:24 p.m. - "Res [resident] unhappy with new antibiotic regimen. Res states she is just so frustrated with all her medical issues." * 04/21/10 at 8:10 p.m. - "Res remained in room entire shift. ... As of now, no c/o." * 04/22/10 at 3:00 a.m. - "... stated [resident] some right side muscle discomfort from laying in bed so much, given Tylenol." * 04/22/10 at 6:39 p.m. - "[Resident #11's physician] faxed back regarding ... res poor appetite." * 04/22/10 at 6:48 p.m. - "... Res remained in her room entire shift, staff offering her different foods to help with suppressed appetite." * 04/23/10 at 6:24 p.m. - "Res stayed in her room	F 250		
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F 250	Continued From page 30 entire shift. . . . Res states that she is not happy with her stay here and is frustrated with her slow healing process. Res appears depressed and lonely, but she denies that she is. . . ." * 04/24/10 at 3:00 a.m. - ". . . had loose stool and small green emesis, crying, stated so tired of feeling sick and weak." * 04/25/10 at 10:23 p.m. - "Resident remains on IV [intravenous] antibiotics. c/o nausea and coughing up yellow mucous, states her side hurts. Low grade fever noted. Faxed MD [medical doctor] with update." * 04/26/10 at 10:05 p.m. - ". . . Res c/o being tired. Remained in her room entire shift." * 04/28/10 at 4:14 a.m. - ". . . only c/o was that she stated that she was just overly tired, but states that it may be the rainy weather. . . ." * 05/04/10 at 10:15 a.m. - ". . . [Resident #11] is a very unhappy lady, we try so hard to please her." Review of Resident #11's social services progress notes indicated the following: * 04/07/10 at 10:59 a.m. - "I visited with [Resident #11] to do a social history. She reports enjoying her private room." * 04/21/10 at 9:58 a.m. - "Care plan review: Resident/family did not attend the care plan meeting. [Resident #11] is independent with most cares. She prefers her own room most of the time. She watches TV and enjoys visiting. She is eating fairly well. Her family is attentive. Needs addressed at this time." * 04/21/10 at 1:11 p.m. - "[Resident #11's family member's name] left a message regarding concerns he had regarding [resident's] meals. I requested that dietary staff follow up with [Resident #11] regarding her likes and dislikes. . . ." * 04/23/10 at 10:56 a.m. - "There has been no	F 250		

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F 250	Continued From page 31 further communication from [resident's family member] regarding dietary concerns [sic]." An interview with a nursing staff member (#21) occurred the afternoon of 05/04/10. The staff member stated Resident #11 is a very unhappy person and stays in her room. The staff member stated a confused resident wandered into Resident #11's room one day and Resident #11 became very upset and told the staff member (#21) she didn't know how to deal with "people like that" and appeared very anxious at the time. The staff member (#21) stated that is why Resident #11 wants her door closed at all times. An interview with a dietary supervisory staff member (#38) occurred on 05/05/10 at 11:00 a.m. This staff member (#38) stated the facility had been working very hard to find things Resident #11 would eat due to her poor appetite. The staff member stated the resident seemed to be having a very hard time adjusting to being at the facility and often seemed depressed and angry. An interview with a social services supervisory staff member (#39) occurred on 05/05/10 at 11:25 a.m. This staff member (#39) stated Resident #11 initially had issues of a double occupancy room but the facility resolved this by moving the resident into a private room. The staff member (#39) stated, "Most of [Resident #11's] issues surround the food here. I have been in contact with the dietary department regarding this. I have also talked to [Resident #11's] family member who left me a message complaining about the food. Those two really were the only issues [Resident #11] had." This staff member (#39) provided no additional	F 250			

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F 250	Continued From page 32 interventions/attempts to help Resident #11 adjust to her surroundings, deal with her anger, or current medical issues. The staff member stated no mental health referrals had been made. Staff member (#39) stated, "[Resident #11] liked being in her room watching television, reading or talking on the phone. It seemed every time I went to see the resident, she was talking on the phone." An interview with a nursing staff member (#20) occurred the afternoon of 05/05/10. The staff member (#20) stated Resident #11 refused to socialize with other residents and usually will not leave her room. The staff member (#20) stated the resident watches television or reads but does not participate in any activities. The staff member (#20) agreed Resident #11 often appears sad or irritable. Failure to provide medically-related social services may have contributed to Resident #11 experiencing unnecessary anxiety, depression, anger, isolation/withdrawal, and inability to cope.	F 250			
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	All raps for residents #11, #16, #17, and #21 have been redone. All staff involved in the MDS process educated on the Resident Assessment protocols. Individual education done with MDS/Care plan staff as well as Nutrition Staff. All residents have the potential to be affected Affected disciplines have been educated on need to follow through on Resident Assessment Protocols and the importance of identifying location of supporting documentation.		6/1/10

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F 272	Continued From page 33 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference review, and staff interview, the facility failed to conduct a comprehensive, accurate, and standardized reproducible assessment of the functional capacity of 4 of 27 sampled residents (Resident #11, #16, #17, and #21) regarding mood and behavior patterns (Resident #11), urinary continence (Resident #17), and documentation of summary information (Resident #11, #16, and #21). Failure to conduct comprehensive, accurate, and standardized reproducible assessments limited the facility's ability to develop and implement comprehensive accurate resident care plans. This failure may have resulted in delayed treatment of Resident #11's mood and behavior, may have limited treatment of Resident #17's urinary continence, and may have contributed to fluids not offered to Resident #16 and #21 (Refer to F327).	F 272	MDS Coordinator & Care Plan Coordinator will be responsible to audit all MDS's with Raps to ensure proper completion and location of information. Audits will be completed weekly to ensure completion and reports will be submitted to Quality Assurance Committee quarterly.		

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F 272	Continued From page 34 Findings include: "The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual," revised 02/09, Centers for Medicare and Medicaid Services . . . page 4-2 states ". . . Use the RAPs [Resident Assessment Protocols] to analyze assessment findings and then 'chart your thinking.' It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. A risk factor increases the chance of having a negative outcome, or complication. . . . The RAPs will give the interdisciplinary team a sound basis for the development of the resident's care plan. . . ." The RAI Minimum Data Set (MDS), Section V. RAP Summary, states ". . . 3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found. 4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. . . ." - Review of Resident #11's medical record occurred on May 4-6, 2010. The resident's medical diagnoses included left ankle osteomyelitis with a wound vacuum, depression, and fatigue/malaise. The resident's current medications included Lorazepam (anti-anxiety), Percocet (pain relief), and Acetaminophen (pain relief). Resident #11's admission Minimum Data Set (MDS), dated 04/16/10, identified no short or long term memory problems, independent in daily	F 272			

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F 272	Continued From page 35 decision making, able to make herself understood, and able to understand others. The RAPS, dated 04/15/10, included the following: * "Problem area - Psychosocial well-being - Resident #11 is alert and oriented times three, establishes her own goals, and is independent in daily decision making. Her goal is to return to her own home as soon as possible. * Psychotropic drug use - Triggers with using prn [as needed] Lorazepam for anxiety. She has a depression dx [diagnosis]. Staff monitor for significant changes in her mood/behavior and update her Md [medical doctor] as needed." Facility staff identified Resident #11's diagnosis of depression, anti-anxiety medication, adjustment difficulties, and anger. The facility staff failed to address these issues in the RAPS, dated 04/16/10. This failure limited development of a comprehensive accurate care plan for Resident #11 (Refer to F279) and may have contributed to or prolonged the resident's adjustment difficulties, anger and depression (Refer to F250). - Resident #17's medical record, reviewed on May 04-06, 2010, identified the facility admitted the resident in 10/09. The resident's current diagnoses included diabetes mellitus, dementia, and difficult urination. The resident's current medications included Pyridium 200 milligrams (mg), four times each day, as necessary, for painful urination, initiated on 03/04/10; and, Urecholine 25 mg, four times each day, for urinary retention, initiated on 04/09/10. Resident #17's significant change MDSs, dated 01/04/10 and 04/01/10 identified extensive	F 272			

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F 272	Continued From page 36 assistance of one person for toileting, occasional urinary incontinence, and urinary incontinence improved (01/04/10) and unchanged (04/01/10). Resident #17's RAP Summaries identified the following: *01/06/10 - ADL (Activities of Daily Living) Functional Rehabilitation Potential, "... Staff provide good pericare [perineal care] after incontinent episodes. She toilets herself and staff help her adjisut [sic] her clothes as needed. . . ." - Urinary Incontinence Indwelling Catheter, "Triggers with occasional urine incontinence and wearing a pullup. Refer to ADL RAP 01/16/10. Staff provide good peri care after each incontinent episode. Staff monitor for signs and symptoms of UTI [urinary tract infection] with referral to MD [physician] for UA/C&S [urinalysis/culture and sensitivity] and treatment if indicated. Staff encourage fluids at and between meals. Proceed to care plan." *04/02/10 - ADL Functional Rehabilitation Potential, "... Staff help her transfer on/off the toilet, adjust her clothes and do pericare. Encourage her to participate in her ADL's as able." - Urinary Incontinence Indwelling Catheter, "Triggers with occasional urine incontinence and wearing a pullup. Refer to ADL RAP 04/02/10. Staff provide good peri care after each incontinent episode. Staff monitor for signs and symptoms of UTI with referral to MD for UA/C&S and treatment if indicated. Staff encourage fluids at and between meals. Proceed to care plan." Resident #17's medical record included multiple nurse's notes regarding the resident's difficulty with urination. The medical record included initiation of the medication Pyridium and results of	F 272			

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F 272	Continued From page 37 a urinary bladder cystogram, dated 03/12/10, which recommended follow-up studies. The follow-up cystourethrogram, dated 04/07/10, identified inability to urinate. The resident's physician prescribed the medication Urecholine after this examination. During discussion with a nursing management staff member (#2) regarding this issue, on 05/06/10 at 11:30 a.m., additional information was requested but not provided. The RAP dated 04/02/10 failed to identify Resident #17's difficulty with urination, the addition of the medication Pyridium, the results of the cystogram, and the follow-up recommendations. Failure to identify this information in the RAP limited the facility's ability to develop a comprehensive accurate care plan for Resident #17. (Refer to F279.) - Resident #16's most recent MDS which included the RAP, dated 08/01/09, identified the resident consumed insufficient fluids. The RAP Summary identified the Nutritional Status and Dehydration/Fluid Maintenance RAPs triggered for this Assessment. The RAPs information provided by the facility staff failed to identify the location of the RAP Summary information, failed to include RAPs addressing these two areas, and failed to show the facility staff care planned for these two areas. Refer to F279. - Resident #21's most recent MDS which included the RAP, dated 07/04/09, identified the resident consumed insufficient fluids. The RAP Summary identified the Nutritional Status and Dehydration/Fluid Maintenance RAPs triggered for this Assessment. The RAPs information	F 272			

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F 272	Continued From page 38 provided by the facility staff failed to show the location of the RAP Summary information, failed to include RAPs addressing these two areas, and failed to show the facility staff care planned for these two areas. Refer to F279. - Resident #11's most recent RAPS, dated 04/16/10, triggered for the resident with a psychosocial well-being problem. The RAPS report identified the psychosocial well-being triggered for this assessment. The RAPS information provided by the facility staff failed to show where the RAPS information is located and failed to show the facility staff care planned for psychosocial well-being. Refer to F279.	F 272			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Care plans for residents #9, #16, #20, #21, and #25 have been re-done. Are guides have been re-done to match care plans. Resident care plans are developed based on information obtained from current resident assessment and needs of the resident to provide optimum level of care. Care guides will follow care plans. All residents have the potential to be affected. Professional nursing staff and Care Plan Coordinator will review all resident care plans to insure all potential risks are addressed and interventions are in place to prevent potential risks. Education provided to nursing staff to follow plan of care and care guides for all residents. Education included offering/encouraging fluids and always having fluids within residents reach.	6/1/10	

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F 279	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop, review and revise the residents' comprehensive plan of care for 5 of 16 sampled residents (Resident #9, #16, #20, #21 and #25) requiring assistance to obtain fluids. Failure to develop a written care plan with specific interventions to provide fluids to residents requiring assistance could result in inconsistency of care and may result in resident decline in physical health, and hydration. Findings include: - Observations on May 04-05, 2010, showed throughout the survey facility staff failed to offer fluids with cares to Resident #9. Refer to F327. Resident #9's medical diagnoses included constipation, chronic kidney disease, depression, and cerebral vascular accident (CVA), and a history of stage I left heel ulcer healed on 11/23/09. The resident's current Minimum Data Set (MDS), dated 04/21/10, identified the resident required total assistance with transfers, locomotion, and toileting, and extensive assistance with bed mobility, dressing, eating, and personal hygiene. The Resident Assessment Protocol Summary (RAPS), dated 04/19/10, stated "... insufficient fluid ... diuretic ... monitor for s/s [signs and symptoms] of dehydration weekly ...". The resident's medication administration record included Lasix (diuretic) daily, KCL (potassium) daily and a multivitamin with iron. Resident #9's current care plan, dated 09/01/09,	F 279	Weekly observations and random review of care plans and care guides will be done to insure residents receive adequate hydration and have fluids within their reach. Date Completed: June 1, 2010 The DON, Nurse Managers and Care Plan Coordinator will be responsible to monitor all results. The Care Plan Coordinator will submit a report of the monitoring results to the QA Committee monthly.		

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F 279	Continued From page 40 stated "Problem: Potential for Dehydration-related to occasionally leaving 25% or more of fluids offered, and Diuretic use. (01/19/10) . . . Approach: Monitor for S&S dehydration every week on W [Wednesday], Lasix 40mg [milligrams] daily . . ." Resident #9's CNA Guide (a form located in each resident room which provides a brief description to the direct care staff of assistance the resident required), dated 05/04/10, also failed to identify any interventions for facility staff regarding encouragement of fluids. - Observations on 05/05/10 showed, throughout the survey, facility staff failed to offer fluids with cares to Resident #25. Refer to F327. Resident #25's care plan, dated 02/11/10, indicated "Problem: Potential for Dehydration-Occasionally leaves 25% of fluids at meals, Goal: Remain Hydrated, Approach: Monitor for S&S dehydration every week on W [Wednesday] . . ." Resident #25's Care Guide, dated 02/22/10, also failed to identify any interventions for facility staff regarding encouragement of fluids. The facility identified on the MDSs Resident #9 and #25 consumed insufficient fluids and identified the residents are at risk of dehydration. The facility failed to fully assess the residents' dehydration risks in the RAPs (Refer to F272) and failed to develop, review, and revise the residents' care plans to provide facility staff with approaches for these potential risks. These failures placed the residents at risk of complications related to fluid and nutritional risks, including recurrent pressure ulcers. - Review of Resident #16's medical record	F 279			