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	355074	A. BUILDING _____ B. WING _____	C 10/13/2016

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 unannounced complaint survey conducted October 12-13, 2016, the sample included six sampled residents, two closed records, and two supplemental residents for focused review.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 2 of 6 sampled residents (Resident #3 and #6) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors or wait for a reply before entering a resident's room does not promote residents' dignity or enhance their quality of life. Findings include: - Observation on 10/12/16 at 3:00 p.m., showed Resident #6 laying on her bed, exposed from the waist down, as two certified nursing assistants (#1 and #2) assisted her with cares. An unidentified physician knocked on Resident #6's door and, without waiting for permission, entered her room. He walked around the privacy curtain, observed staff provide Resident #6's pericares, turned around, and exited the room. The	F 241	Resident #6 has been discharged to home. DON has re-educated all staff regarding knocking on doors and waiting for resident to respond (if able) before entering room. Resident #3 was asked to let charge nurse know if staff does not follow this process, and Resident #3 will also be asked during routine audits if staff is following appropriate procedure. All staff are educated on privacy and importance of knocking on resident doors, waiting for a response, and identifying themselves when entering the resident room. This education is provided in orientation, and again in our C.N.A. training class. Dr. B. was also educated on this process, and staff and visitors have been re-educated. All residents could be affected by not	11/8/16

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

Electronically Signed | 11/08/2016

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F 241	Continued From page 1 unidentified physician re-entered Resident #6's room, without knocking or waiting for permission, and stood next to the bathroom. When questioned, he identified himself, turned, and exited the room for a second time. A few minutes later, a nurse (#1) knocked on Resident #6's door and, without waiting for permission, entered the room with a pain medication. Both failed to knock, announce themselves, and/or wait for a response from Resident #6 or the staff members attending her needs. - During an interview with Resident #3 on 10/12/16 at 2:10 p.m., an unidentified staff member opened the resident's door and entered her room without knocking or asking permission to enter. The staff member obtained the resident's bag of linen and exited the room. During an interview on the afternoon of 10/13/16, dignity issues were discussed with administrative staff members (#6 and #7). The staff members provided no additional information.	F 241	knocking and waiting for a response to enter, or waiting for a minute to enter if resident is unable to answer. A written inservice for staff to read and sign was given to each unit with the re-education of knocking on doors and waiting for responses to ensure residents rights and dignity are preserved. This written education was provided on November 9, 2016 to all nursing staff, and discussed at the monthly CNA/Nurse meeting on November 16th, 2016. Observations will include proper procedure when staff are entering rooms; and all violations will be addressed immediately with re-education to knock, wait, identify. These observations will be documented as they occur and any corrective measures that were taken to address concerns will also be documented. The Director of Nursing will share these observations with the Quality Assurance committee. The Director of Nursing, Assistance Director of Nursing, Nurse Managers and Nursing staff will observe 2 staff members per shift on each unit weekly for 4 weeks, and if compliance is obtained will do observations monthly for four months, and then quarterly. If we find incidents where staff members are not following the process, as stated above, the individual will be re-educated and we will have to follow the disciplinary	

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F 241	Continued From page 2	F 241	process if the same individuals are found not to be compliant with doing this for residents. Reporting will be done monthly to the Quality Assurance Committee. The DON will be responsible to make sure that this process is followed.	
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, review of facility policy and procedure, and staff interview, the facility failed to provide medically related social services to assist 1 of 2 sampled residents who experienced behaviors (Resident #1) to attain or maintain their highest practicable physical, mental, and psychosocial well-being possible. Failure to provide specific interventions for the resident's behaviors placed Resident #1, other residents, staff, and visitors at risk of injury and continued behaviors. Findings include: Review of the facility policy titled, "Care Planning" occurred on 10/13/16. This policy, revised July 2016, stated, ". . . CARE PLAN . . . B. Individual approaches for each resident. . . ."	F 250	Resident #1: Care Plan was revised and updated to assure behaviors are documented and individualized to meet resident needs. (Resident was discharged) All residents have the potential to be affected if appropriate individual interventions are not identified and are part of the plan of care with the resident. System of disruptive behaviors interventions and effectiveness of interventions: All disruptive behaviors, interventions and effectiveness will be documented as they occur. Problems and specific interventions will also be included on the care plan and care guide. This education was provided to staff with Read	11/8/16

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F 250	Continued From page 3 Review of the facility's "Behavior Charting Guidelines" occurred on 10/13/16. This guideline, revised October 2010, stated, ". . . Process . . . Consistency in following the careplan is as important as the careplan itself. You must know what interventions are used and use them. If they don't work, we need to develop new ones. . . ." The facility failed to provide a policy regarding behaviors. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, depression, and anxiety. The care guide stated, "Speak to resident calmly & with simple terms, Monitor wandering, Monitor verbal aggression, Monitor physical aggression, Monitor agitation/restlessness, Monitor resistance/refusal of care, Monitor risk for falling." The care plan stated, "Problem: BEHAVIOR - DX [diagnosis] of anxiety and depression. Verbal and physical abuse toward staff. Inappropriate with bodily waste. Not redirectable. Resistant to cares. Easily annoyed. Disruptive. Occasional wandering. . . . Approach . . . Monitor wandering, Monitor verbal aggression, Monitor physical aggression, Monitor agitation/restlessness, Monitor resistance/refusal of care, Monitor for inappropriate elimination, Monitor for pain and intervene prn [as needed], Monitor risk for falling, Explain all care/procedures in simple terms to promote compliance, Maintain consistent environment & routine . . ." The care plan failed to include specific and individualized interventions for Resident #1's behaviors. Review of the September through October 13, 2016 progress notes identified the following:	F 250	and Sign education given to each unit on November 4, 2015 and in CNA/Nurse meeting on November 16, 2016. The Behavior Policy is now in place to assure consistency in management of behavior. This was also included in the education. Social Workers were on the Behavior Documentation Policy on November 4, 2016. All residents with behaviors documented on the care plan/guide will be reviewed to ensure that interventions are individualized and the effectiveness of the interventions is documented. New interventions will be implemented and assessed if current interventions are unsuccessful. The care plans/care guides will be updated to reflect any changes. The Social Workers will review progress notes daily for instances of behavior documentation. If behavior documentation is found, the social worker will look for documentation indicating that interventions are being implemented and the outcome of these interventions. The care plan/care guide will be reviewed and updated to ensure interventions are current. Social Workers will be responsible for updating the care plans/care guides. Social Services Director and Social workers are currently monitoring seven resident charts daily (M-F) to make appropriate individualized approaches for	

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F 250	Continued From page 4 *09/05/16 at 2:23 p.m.: "Resident was yelling and trying to hit CNA when she was asked to take a shower." *09/30/16 at 10:35 a.m.: "Per report from NOC [night] shift, the resident was combative with cares at PM shift, crawled on the floor and sustained a small skin tear to the left han [sic], abrasion to the right knee and bruise to the right arm. . . ." *10/10/16 at 6:20 p.m.: "Resident observed combative with cares this morning. She was hitting, punching, spitting and kicking staff during shower. It took 3 person to help her shower. While she was being combative, she accidentally hit her lips and small bruises developed." Review of the September through October 13, 2016 "Behavior Tracking Intervention Assessment" identified the following: *Physical behavioral symptoms directed toward others occurred 14 times and included hitting, kicking, biting, scratching, grabbing and pushing. *Verbal behavioral symptoms directed toward others occurred 17 times and included screaming at others, cursing at others and threatening others. *Other behavioral symptoms not directed toward others occurred 5 times and included hitting or scratching self, screaming, disruptive sound, throwing or smearing food or bodily wastes, and pacing. The "Behavior Tracking Intervention Assessment" identified the following "comments" regarding Resident #1's behaviors: *09/05/16: "Resident refused to elevate legs this shift. Resident was observed wandering down hallway and attempting to go into other residents	F 250	residents with behaviors. These audits will continue until all residents charts have been reviewed and updated. The results of these audits are reported monthly to the Quality Assurance Committee monthly and are also being tracked daily to ensure that all resident care plans will be updated. Once all resident care plans/care guides are specific to resident, the Social Services department will review all residents charts monthly to make sure behavior logs and care plans/care guides are matching and complete. Director of Social Services is responsible for this process.	

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F 250	Continued From page 5 rooms four times this shift. Resident did not wish to go to bed but was taken back to her room/sofa." *09/10/16: "Resident hit and try to bit [sic] staff while giving her cares this moring [sic]. Resident threw food at staff during dinner time after changing her brief." *09/11/16: "resident hit staff and spit towards staffing [sic] while changing her during shift." *09/13/16: "resident had BM [bowel movement] an [sic] was very hard to wake up, upon waking up resident was cursing at staff trying to spit at them, pushing them away and was trying to grab at things to throw at staff members. . . ." *09/18/16: "resident didn't want cna to clean her up she was hitting scratching bitting [sic] pushing screaming spitting at cna" *09/27/16: "Resident was punching CNA repeatedly on the back, scratching and swinging at CNAs face, kicking at the CNA's, spitting in the CNA's face, hollering, pinching CNA's arms and hands, and trying to bite the CNA's." *10/01/16: ". . . biting and scratching, we were trying to clean the bowel movement she had all over clothes and all over her body, all over bedding. . . ." *10/02/16: "The resident resisted cares by scratching, hitting, kicking, screaming, crossing legs, and turning." *10/04/16: "Resident kicked CNA in chest, attempted to bite the nurse, and was screaming and spitting at staff." *10/07/16: "Resident was spitting, pinching, kicking, and hitting while CNA's where [sic] trying to reposition her." "Resident spit out siliva [sic] from her mouth to cna face several times" The medical record lacked interventions staff should utilize in response to Resident #1's	F 250		

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F 250	Continued From page 6 behaviors. During an interview on 10/13/16 at 8:45 a.m., a social worker (#13) stated at times Resident #1 is combative with staff during cares. The social worker (#13) provided no further information regarding specific individualized interventions for Resident #1's behaviors. Failure to develop and implement specific interventions for Resident #1's behaviors placed, other residents, staff, and visitors at risk of injury and continued behaviors.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		11/11/16

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the care plans for 1 of 6 sampled residents (Resident #1) and 2 of 2 closed record residents (Resident #7 and #8). Failure to review and revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity in care. Findings include: Review of the facility policy titled, "Care Planning" occurred on 10/13/16. This policy, revised July 2016, stated, ". . . PROGRESS RECORD . . . Care plans are to be revised according to the resident's condition. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and weakness. The care guide identified, ". . . Bed Mobility: Assist to reposition in bed . . . Safety . . . Enteric precautions . . ." The care plan identified, ". . . Problem: BED MOBILITY . . . able to participate with encouragement, extensive assistance (wt. [weight] -bearing) required . . . Approach: Independent in bed mobility . . . Staff help as needed . . . Problem: INFECTION PRECAUTION - Enteric precautions . . . Approach: Resident to be - on supervised outings to meals only Three times daily, Consult w/ [with] Infectious Disease MD [medical doctor] . . ."	F 280	Resident #1 Care Plan has been reviewed and updated to ensure continuity of care. Closed Records 7 & 8 were reviewed with staff. Both residents are now deceased. All residents have the potential to be affected if care plans are not reviewed and updated as resident needs change and if care plans/care guides are not accurate and consistent. All appropriate disciplines, including, but not limited to Therapy Services, Infection Control Nurse, Nutrition Services will attend the care plan conference for the residents that have specified needs in their areas. Social Services staff educated on October 14, 2016, Dieticians and dietary clerks educated November 4, 2016, Physical, Occupational and Speech Therapy staff educated on November 11, 2016, and nursing staff and Infection Control nurse had education done on November 11, 2016 and again on November 16, 2016. All education included updating the care plans and care guides as changes occurred in resident status and approaches. We also found that our current EHR was not deleting approaches as new approaches were entered. Staff educated on manual updates on all changes. We are in the process of getting a new EHR system which will be accurate and up to date with changes.	

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F 280	Continued From page 8 During an interview on 10/13/16 at 10:45 a.m. an administrative nurse (#9) stated Resident #1 had clostridium difficile and placed on enteric precautions. The care plan failed to consistently reflect Resident #1's assistance required with bed mobility and failed to state why enteric precautions were implemented. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia, weakness, and a history of falls. The care plan identified, "Problem: AMBULATION - walks independently, has a cane in room but does not use it . . . Approach: Ambulatory - Walks independently. Has a cane in room to use if needed. . . . Problem: TRANSFERRING - independent - no supervision required . . . Approach: Stand-by Assistance with Transfers, Cue resident before & [and] during transfers, Uses cane and/or walker, Give verbal cues as needed before/during transfer for sequencing and direction - Independent uses cane . . ." A physical therapy discharge summary, dated 02/22/16, stated, ". . . Functional/physical status on discharge: 2/22/2016 [Resident #7] has attended PT [physical therapy] 3 times a week for there ex [sic], transfers and gait. He is limited by his confusion and retention of instructions. He is transferring with SBA/CGA [stand-by assistance/contact guard assistance] to the walker and he is ambulating with CGA using the	F 280	The care plans will be updated as needed by each department, and this information will also be updated on the care guide. If there is a change in the resident that needs to be addressed on the care plan in between care conferences, the person who addresses the change on the care plan will use the daily communication form to document the change and will also inform the nurse at the same time that there is a change in the plan of care. Social Services is auditing seven resident care plans/care guides daily and will continue to do this until compliance is achieved for all resident records. Once compliance is achieved, social services will do monthly audits on all residents. These audits will be presented to the Quality Assurance Committee monthly. Physical, Occupational and Speech Therapy have completed audits on all current residents receiving therapies. All current residents receiving treatment have had all old approaches removed from the care plans/care guides (EHR glitch). PT and OT Department Directors are auditing two resident care plans/care guides for each area; PT,OT,Speech(six in total) weekly until compliance is achieved. These audits will be presented to the Quality Assurance Committee monthly. Dieticians and Dietary Clinical clerk will assess all residents per requirements and	

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F 280	Continued From page 9 caddy walker. He is not safe to ambulate without assist. . . ." During an interview on 10/12/16 at 4:46 p.m. a physical therapist (#8) stated Resident #7 needed verbal cues and someone close by. He did not need physical assistance, he needed SBA/CGA. The care plan failed to accurately reflect the assistance Resident #7 required with ambulation and transfers. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included chronic subdural hematoma, dementia, dysphagia, osteoarthritis, recurrent falls, and left hip fracture. A nutritional care plan, dated 02/26/16, identified, ". . . setup tray . . . Pureed - Nectar thickened liquids . . . Supplement - Ensure, Glucerna or Mighty Shk [shake] . . . Provide cueing for eating, Feed self independently . . . Encourage scheduled high kcal [kilocalorie] snacks . . . Monitor for chewing/swallowing problems . . . coughing/choking. . . ." The progress notes identified the following dietary interventions: * 02/20/16, "whole milk for added calories" * 03/09/16, "high protein foods" * 04/04/16, "raisin bran, fruit, and prune juice" * 05/18/16, "special cereal, glucerna, diet power pudding, ensure, large meat portions, adaptive utensils, and assist at meals" * 05/24/16, "added another supplement and offered additional items at meals"	F 280	put interventions on the care plan as needed. These audits will be presented to the Quality Assurance Committee monthly. Infection Control Nurse reviewed resident with enteric precautions (currently one). Infection Control Nurse will monitor IC practices by observations and report to Quality Assurance Committee monthly until compliance is achieved and them quarterly. These audits will be presented to the Quality Assurance Committee monthly. Nurse Managers are reviewing two care plans per unit (14) weekly and updating as changes occur. These audits will continue until compliance is achieved, and then ongoing random checks will be done. These audits will be presented to the Quality Assurance Committee monthly. Physical Therapy, Occupational Therapy, Director of Nutrition Service, Director of Clinical Excellence and Director of Nursing are responsible for this process.	

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F 280	Continued From page 10 * 06/06/16, "adding butterball and mighty shake" The safety care plan, dated 03/14/16, identified, ". . . at risk for falls . . . Call light within reach . . . hourly rounds with offering toilet and fluids . . . PT/OT [physical therapy/occupational therapy] . . ." The progress notes identified the following fall interventions: * 02/19/16, ". . . hourly rounds . . ." * 02/24/16, ". . . PT, OT, and call light within reach . . ." * 03/01/16, ". . . added to walk list . . ." * 03/04/16, ". . . unable to comprehend use of the call light . . ." * 05/12/16, ". . . bed low and 2 side rails . . ." * 06/11/16, ". . . first in bed after meals and up before meals . . ." During an interview on the afternoon of 10/13/16, administrative staff members (#6 and #7) provided no additional information regarding the nutritional and safety care plans. Resident #8's current care plan failed to reflect the changes made, including the addition of 2 side rails, adaptive utensils, additional items offered at meals, additional supplements, assistance at meals, bed low, butterball, diet power pudding, first in bed after meals and up before meals, fruit, high protein foods, inability to comprehend use of the call light, large meat portions, prune juice, raisin bran, special cereal, walk list, and whole milk.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		11/11/16

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F 309	Continued From page 11 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 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 4 sampled residents (Resident #6) and two supplemental residents (Resident #9 and #10) observed during cares and/or medication pass, received the necessary care and services. Failure to provide proper positioning has the potential to affect the residents' overall swallow safety, putting them at risk of aspiration. Findings include: Review of the facility policy titled "Feeding the Impaired Resident" occurred on 10/13/16. This policy, revised December 2015, stated, " . . . Position resident appropriately . . . Elevate head of bed if in bed . . . Use drinking straw . . . for liquids. . . ." Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 9 and 125 and the educational handouts, identified, ". . . Signs and symptoms of dysphagia . . . drooling . . . coughing/choking . . . During the oral intake of . . . liquids, it is optimal for a patient to	F 309	Resident #6 was discharged to home 11/11/2016. Resident #9 deceased 10/23/2016. Ongoing monitoring of resident #10 is being done for proper positioning for food and fluid intake. All staff educated on proper positioning of residents while offering fluids. Resident's #6, 9, and 10 did not suffer adverse effects of not being repositioned for fluid intake; staff was educated. All residents have the potential of adverse problems if not positioned correctly while the resident is eating or drinking fluids. Staff re-educated on proper positioning of residents when offering fluids or eating. This education was provided by a read and sign inservice placed on all of the units on November 9, 2016 and again in the CNA/Nurses meeting November 16, 2016. HOB will be elevated optimally 90 degrees or as high as resident tolerates for safe and optimal food/fluid intake. Perry & Potter Edition 8, 2014, p.771 states "Position patient in upright (90 degrees or highest position allowed by	

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F 309	Continued From page 12 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 Resident #6's medical record occurred on all days of survey. Diagnoses included weakness. The care guide, dated 10/12/16, identified, ". . . Encourage self feeding, Deliver & [and] setup tray. . . . Encourage intake of fluids. . . ." Observation on 10/12/16 at 3:00 p.m., showed two certified nursing assistants (CNAs) (#2 and #3) provided Resident #6's cares as she laid in bed. Afterwards, the two CNAs (#2 and #3) raised the head of her bed to an approximate 20 degree angle and offered her a plastic glass containing water. Resident #6 almost spilled the water as she sipped from the glass. She stated, "I should have a straw." Approximately fifteen minutes later, a nurse (#1) administered Resident #6's pain medications and offered her the plastic glass containing water. Resident #6 drooled as she sipped from the glass. - Review of Resident #9's medical record occurred on 10/13/16. The current CNA care guide stated, ". . . Eating . . . Ensure resident sitting upright in appropriate chair, Encourage intake of fluids . . ." Observation on 10/12/16 at 12:38 p.m. showed two CNAs (#4 and #5) transferred Resident #9 into bed. After assisting with cares, a CNA (#4) raised the bed to an approximate 50 degree	F 309	medical condition during meals)." Speech Therapist will be consulted if resident has difficulty swallowing or chokes easily, pockets food or any unexplained elevated temp, congestion or symptoms related to aspiration. DON, Nurse Managers and Nurses will do weekly rounds and monitor 5 residents being offered fluids/foods on each unit weekly. The monitoring will continue to be weekly until 100% compliance is achieved for four consecutive months. The DON will report the compliance of these audits monthly at to the Quality Assurance Committee monthly until 100% compliance is achieved for four consecutive months. The DON is responsible for this process.	

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F 309	Continued From page 13 angle and offered the resident a drink of water. Resident #9 took a drink of water and immediately coughed after swallowing. - Review of Resident #10's medical record occurred on 10/13/16 and identified a diagnoses of dysphagia. The current CNA care guide stated, ". . . Eating . . . Ensure resident sitting upright in appropriate chair, Monitor for chewing/swallowing problems, Encourage intake of fluids, Pureed textures, nectar thick liquids . . ." Observation on 10/12/16 at 10:25 a.m. showed a CNA (#4) raised Resident #10's bed to an approximate 50 degree angle and offered her a drink of thickened water, which the resident swallowed. Staff failed to raise Resident #6, #9, and #10's beds to an approximate 90 degree angle prior to offering liquids, placing them at risk of aspiration. During an interview on the afternoon of 10/13/16, positioning/swallow safety issues were discussed with administrative staff members (#6 and #7). The staff members provided no additional information.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		11/16/16

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: FALL PREVENTION 1. Based on information received from the complainants, observation, record review, and staff interview, the facility failed to provide adequate supervision and assistive devices for 1 of 3 sampled residents (Resident #4) and two closed record residents (Resident #7 and #8) who fell/fractured. Failure to implement interventions correctly and consistently, evaluate the effectiveness of interventions, modify/replace interventions as needed, and evaluate the effectiveness of new interventions, resulted in Resident #8 experiencing additional falls with injury, and may have resulted in Resident #4 and #7 experiencing additional falls with/without injury. Findings include: Information submitted by the complainants identified the facility failed to reassess fall prevention interventions and make revisions as deemed appropriate resulting in Resident #8 experiencing numerous falls; two with serious injury. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included chronic subdural hematoma, dementia, osteoarthritis, recurrent falls, and left hip and left orbital and maxillary sinus fractures. The quarterly Minimal Data Set (MDS), dated 05/16/16, identified severely impaired cognitive skills, extensive assistance of two or more	F 323	Residents #4,7 and 8 are all deceased. Cases reviewed and nursing staff involved were all educated on read and sign inservice. Resident #1 was discharged. At times resident did refuse gait belt. All residents that require supervision and assistive devices have the potential to be affected. Residents with falls will be evaluated immediately and interventions implemented. All falls will be immediately reported to the nurse, and a nurse will assess the resident for injuries before the resident is moved. Staff will follow policy and use gait belts for transfers for patient safety. All falls are reviewed weekly at the falls meeting. During this meeting interventions will be evaluated for effectiveness, and if the interventions are not working, the team will identify and monitor new interventions. A staff huddle will take place after the fall for immediate interventions, monitoring of interventions and documentation of effectiveness. New falls interventions will be charted on for 1 week to evaluate the effectiveness of the intervention. Nurse Managers will monitor each fall to assure that the processes are in place	

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F 323	Continued From page 15 persons required for transfers, and history of falls. The safety care plan, dated 03/14/16, identified, ". . . at risk for falls . . . Call light within reach . . . hourly rounds with offering toilet and fluids . . . PT/OT [physical therapy/occupational therapy] as ordered . . ." An additional entry, made after the resident's fifth fall, dated 05/23/16, identified ". . . Physical Therapy - to encourage more movement. . . ." No other interventions were care planned despite the fact Resident #8 fell an additional ten times, sustained a left hip fracture, left orbital and maxillary sinus fractures, and a subdural hematoma. Review of Resident #8's "Falls Documentation" identified the following falls and interventions: * 02/19/16, "At [5:05 p.m.] . . . Resident fell. . . . Hallway of the unit. . . . Resident is restless, walks aimlessly around the unit. . . ." Response to fall - "Frequent rounding for this resident, redirection whenever he feels he is lost. Resident educated to always ask for help for needs. Hallway and room freed from clutter. All staff educated to keep a close eye on him being new to the unit." * 03/23/16, "At 11:00 a.m. . . . CNA calls for help, she found this resident sitting in [sic] the floor, beside bathroom door. Resident said he's trying to go to the bathroom but got off balance. . . . Resident's room . . . Weakness and balance problems. . . . Skin tears to left hand, right forarm and right elbow. Abrasion to right knee. . . ." Response to fall - "Resident was advised to use call light when needed [sic] help" * 05/01/16, "At 3:00 a.m. . . . Resident was found sitting on floor nearby resident bed. Resident	F 323	and interventions are appropriate. This information will be shared with the DON after each fall, and will also be shared weekly in the Falls Committee Meeting. Gait belts will be used for transfers. All staff re-educated on transfers, proper procedures with falls, and importance of immediate assessment by licensed nurse. A read and sign inservice was put on all of the units on November 9, 2016 and education was again provided at the CNA/Nurse meetings. Also included in the education are possible interventions to prevent/reduce falls, such as rounding frequently and offering fluids, toileting, repositioning, distraction activities, bringing resident to nurses station, etc. DON/ADON/Nurse Managers/Charge Nurses will do two observations of resident transfers per unit daily, which will include proper transfer techniques and use of a gait belt. These observations will be done until compliance is achieved and then audits will be done weekly X4 and then monthly X 4 to insure that compliance is maintained. This information will be presented to the Quality Assurance Committee monthly. The DON is responsible for this process.	

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F 323	Continued From page 16 stated he tried to go to bathroom by himself. . . . Abrasion to bilateral knees. Skin tear to left forearm and left hand. . . ." Response to fall - "Educated resident to use call light for help and wait for staff to come assist." * 05/01/16, "At 11:50 a.m. . . . Resident found sitting on butt on floor on the side of the bed by CNA. . . . [room number] . . . resident was getting up on his own. . . . skin tear to left forearm and c/o [complained of] again of pain to his left hip area. . . ." The corresponding "Incident Report" identified, ". . . Sent to . . . and admitted to Hospital. Resident will be evaluated when returns after surgery. . . ." Response to fall - "reminded resident to use call light for assistance." The "Emergency Documentation" from the hospital, dated 05/01/16, identified, ". . . The patient presents following fall. The onset was had [sic] an unwitnessed fall early this morning and then had another unwitnessed fall around noon. . . . Left hip. The character of symptoms is pain . . . severe, 10/10 . . . and loss of mobility . . . discoloration of skin over left forehead and around left eye. . . ." The "Discharge Documentation," dated 05/09/16, identified, "He was identified to have a left hip fracture. . . . the surgery went forward on May 5 . . . Patient being discharged back to [Nursing Home] . . ." Review of Resident #8's "Falls Documentation" also identified the following falls and interventions: * 05/21/16, "At [1:30 p.m.] . . . staff found him in	F 323		

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F 323	Continued From page 17 the bathroom drying [sic] to get on toilet. he started to fall and staff quided [sic] him to the floor, sitting in postion [sic] . . . he was trying to go to the bathroom . . ." The "Fall Prevention [Hourly Rounds]" form, dated 05/21/16, identified staff monitored Resident #8's whereabouts at 12:00 p.m. and 2:48 p.m. The form identified Resident #8 at "lunch" at 12:00 p.m. and staff had no concerns at 2:48 p.m. Response to fall - "just monitor. Re educated resident not to get up without help" * 06/02/16, "At [7:10 p.m.] . . . He was seated on his wheelchair next to his bed. Apparently he stood up by himself without asking help from his CNA who was preparing stuff for his night cares, lost balance and fell. . . . He got a skin tear to his upper arm. . . ." Response to fall - "Resident reeducated to always ask for help esp [especially] with transfers as he is still unsteady. Staff also reminded to always tell resident to wait for help. Room freed from clutter, call light within reach, toileting needs always offered during roundings." * 06/03/16, "At [4:00 p.m.] . . . Resident was found by CNA on the floor lying on his right side. He said he went to his closet to grab a new shirt, lost his balance & [and] fell. He denied hitting his head, he does not have any pain complaints at this time. No new injury was found. . . . confusion . . ." Response to fall - "Resident reminded to use his call light for his needs. Frequency of roundings." * 06/07/16, "At 10:50 a.m. . . . resident said he's trying to get to his bed but he slipped from his W/C [wheelchair] down to the floor . . . Resident	F 323		

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trying to get into his bed without asking for help or forget [sic] to use his call light. . . ."

Response to fall - "lay resident down in his bed after every meal or activity. Place on hourly rounding"

* 06/08/16, "At [4:40 p.m.] . . . Resident was found by CNA laying on his back in his room. When asked regarding what happened, he said he tried to reach for something from the table. Was helped back up to his wheelchair. A skin tear on his left hand was found upon assessment. . . . confusion . . . Left hand skin tear . . ."

Response to fall - "ReOrientation on call light use. Resident on hourly rounding."

* 06/11/16, "At 11:35 a.m. . . . Resident was found on the floor sitting beside hois [sic] bed. Resident says he tries to get up and slipped on the floor. . . . Resident was confused, that he had a fractured hip and still weak and needs assistance when getting up . . ."

Response to fall - "on hourly rounding. First to lay down after meals and first to get up for meals."

* 06/21/16, "At [4:30 p.m.] . . . Resident attempts to stand at nurses desk indepdently [sic] and falls to floor onto left side . . ."

Response to fall - "encourage resident to stay in w/c and ask for assistance to stand."

* 06/24/16, "[4:00 p.m.] . . . Resident was found by CNA on Left side-lying position on the floor in his room. When asked regarding what happened, resident said he did not know. . . . confusion & dementia . . . Bruising & Swelling on Left eye, Nosebleed on Left nare, Abrasions on Left knee, redness on neck. . . ." The "Fall Prevention [Hourly Rounds]" forms, dated 06/24/16, identified staff monitored Resident #8's

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whereabouts/needs at exactly 4:00 p.m. with no concerns noted.

Response to fall - "Frequent reOrientation on call light use on roundings & reminded to ask for assistance on needs, still on hourly roundingd [sic]."

The "Emergency Documentation" from the hospital, dated 06/24/16, identified, ". . . The patient presents following Fall. . . . with c/o left eye and facial swelling and bruising . . . Pupil: Both eyes . . . unreactive. . . . Pt [patient] is also reported to have had recurrent falls. . . . Acute left orbital and maxillary sinus fracture as described above. . . . Scattered acute subarachnoid hemorrhages . . . Right medial temporal lobe contusion . . ."

Review of Resident #8's "Falls Documentation" also identified the following falls and interventions:

* 07/01/16, "At [4:05 p.m.] . . . Resident fell. . . . In the hallway, close to his bedroom. . . . Resident propelled his w/c, stood up without asking for help. . . . Skin tear to right cheek, bruise and abrasion to right shoulder. . . ."

Response to fall - "Resident reeducated to always ask help on transfer, neurochecks for 24-hr [hours], skin care protocol initite [sic], dressing to rt [right] cheek skin tear done. Hospitalist-on-call and family updated."

* 07/03/16, "At 7:00 a.m. . . . found him sitting on the floor on his buttock. Legs straight out. back against the bed side table . . . in his room . . . not sure he is very busy . . . Abrasions to: left knee measures 3 cm [centimeters] by 4 cm., left shoulder 4 cm by 4 cm. left buttock 4 cm by 3 cm . . ."

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F 323	Continued From page 20 Response to fall - "will monitor." * 07/11/16, "At 10:20 p.m. . . . Resident was found kneeling on floor nearby resident's bed. Resident has no injuries note [sic] . . . Resident stated he tried to get out of bed by himself. . . ." Response to fall - "Educated staff to check on resident frequently." The "Emergency Documentation" from the hospital, dated 07/12/16, identified, ". . . just discharged yesterday with the chief diagnosis of chronic subdural hematoma and possible aspiration pneumonia who at the nursing home today was checked on and was found to be short of breath, hypotensive . . . hypoxic, and bradycardic, and was transferred to the emergency room. . . . family has agreed to comfort care with limited measures. . . ." The progress notes, dated February 19-July 12, 2016, identified the following interventions: * 25 entries - call light within reach, educated to use call light, encouraged to use call light, reminders to use call light, reminded to ask for assistance when needed * 7 entries - hourly rounds * 7 entries - low bed * 5 entries - side rail * 3 entries - PT * 1 entry - first up before a meal and first in bed after a meal * 1 entry - walk list A progress note, dated 03/04/16, identified Resident #8 was unable to comprehend the use of the call light. Staff made this entry two weeks after Resident #8 was admitted to the facility and following his first fall.	F 323		

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A document summarizing communication with a member of Resident #8's family, dated 07/11/16, identified the family member had contacted the facility with their concerns. The facility informed the family member they "round hourly and try to keep [Resident #8] occupied so he doesn't try to get up on his own. Staff [would] also be educated on falls precautions with Resident #8 . . ."

The facility provided 29 days of "Fall Prevention [Hourly Rounds]" forms, dated May 21-July 12, 2016, specific to Resident #8. The forms failed to identify the date staff collected data on 8 of 29 days. Staff failed to complete the forms on 7 of 29 days. The documentation showed staff failed to thoroughly/accurately complete the hourly rounds form as evidenced by ranges from 1 to 14 hours per day.

- Random observations during initial tour on 10/12/16 at 10:05 a.m. showed the following:
* Room 253, Staff last documented on the hourly rounds form at 6:00 a.m.
* Room 260, Staff last documented on one of the resident's hourly rounds form at 11:00 a.m. and on the other resident's hourly rounds form at 6:00 a.m.

- Random observations on 10/13/16 at 10:15 a.m. showed the following:
* Room 363-2, Room 364-1, and Room 365-2, Staff last documented on the hourly rounds form at 6:00 a.m.
* Room 364-2, Staff last documented on the hourly rounds form at 6:00 a.m. Staff made an additional entry at 9:00 a.m. They failed to document hourly rounds between 6:00 a.m. and

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F 323	Continued From page 22 9:00 a.m. * Room 358-1, Staff last documented on the hourly rounds form at 8:00 a.m. During an interview on 10/13/16 at 10:30 a.m., a managerial nurse (#17) reported staff perform "hourly checks to prevent falls, to anticipate [the residents'] needs." He stated the "top two [needs] are hydration and toileting." He confirmed staff are expected to sign the form on an hourly basis after checking on the residents' whereabouts/needs. During an interview on the afternoon of 10/13/16, an administrative nurse (#7) reported the "Fall Prevention [Hourly Rounds] forms are not part of the permanent record." During an interview on the afternoon of 10/13/16 fall safety issues were discussed with administrative staff members (#6 and #7). The staff members provided no additional information. The facility failed to ensure staff implemented Resident #8's fall prevention interventions correctly and consistently, failed to evaluate the effectiveness of those interventions, failed to modify/replace those interventions as needed, and failed to evaluate the effectiveness of any new interventions as evidenced by the following: * The care plan identified "call light within reach," despite the fact Resident #8 had severe cognitive deficits and staff identified he was unable to utilize his call light appropriately two weeks post admission to the facility. * Although the care plan identified "hourly rounds," the facility failed to ensure staff checked on Resident #8's whereabouts/needs on an	F 323		

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hourly basis as evidenced by record review. Staff failed to document the date observations were made, failed to complete the hourly rounds form as evidenced by ranges from 1 to 14 hours per day, and/or documented Resident #8's whereabouts/needs were monitored the exact time of a fall with no concerns noted. Observations made during the complaint survey showed these practices continue to occur.
* One additional intervention identified on Resident #8's care plan was "PT/OT as ordered," despite the fact Resident #8 fell fifteen times within a five month period, resulting in significant injuries.

- Review of Resident #4's medical record occurred on 10/13/16 and diagnoses included a right femur fracture, on 09/13/16 and metastatic prostate cancer. The record identified the resident received hospice services, experienced intermittent confusion, had an indwelling urinary catheter, and received morphine (used for severe pain) and lorazepam (used for restlessness or anxiety).

The current care plan stated, ". . . Safety - at risk for falls, at risk for injury, oxygen precautions, aspiration precautions, hourly rounding, immobilizer and ace wrap to displaced right femur fracture . . . Approach . . . Resident assessed at risk for falls, Requires ½ siderails . . . call light within reach . . . falls precautions (approaches started 06/21/16) . . ."

Review of Resident #4's progress notes and corresponding falls documentation/reports identified the following falls and interventions:
*06/22/16 - "At [7:15 p.m.] resident was found on

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the floor by CNA. He was at the end of the bed on his back with his feet on the floor. He stated he needed help getting up because he was weak. Myself and two CNA [sic] finally got resident up with gait belt. He had abrasion on right knee and the catheter was on the bed. Complaints of right knee pain he stated, 'I was going to the garbage can.' No other complaints of pain . . . Contacted the son and call bell near."

Response to fall - "remind resident to use call bell for assistance when wanting toget [sic] up."

*07/11/16 - No progress note, but a falls documentation note, dated 07/11/16 at 7:45 a.m., stated, "CNA found resident sitting on floor with back against bed and feet out in fron tof [sic] him . . . Resident was attempting to self-transfer to the w/c [wheelchair] . . . Instructed resident to use call light when he needs assistance."

Response to fall - "Instructed resident to use call light when he needs assistance."

*"Falls Committee Progress Note 07/12/16," charted 07/20/16, "Previous Interventions: [left blank], Current Interventions: Call light within reach, assist of two gait belt, cue resident, allow additional time, fall precautions, Committee Notes: continue with current interventions . . ."

*08/15/16 at 4:43 a.m. - "CNA heard resident call for help found him on the floor beside the bed. He says he lost his balance was trying to sit on the edge of the bed and toppled off the bed. Resident has a scrape above his left eye, an abrasion to the left cheek, a skin tear to the left hand and had a nose bleed. Resident is alert and orientated with neuros [neurological checks] intact. Resident is cleaned up and back in the bed we reminded him to use his call light for assistance and will do frequent rounding. I have notified his wife . . . and the hospice nurse on

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call."

Response to fall - "will do more frequent rounding, resident was reminded to use his call light for assistance."

*09/06/16 - "At 155 PM [1:55] I heard a thud and resident yelled help me I went int [sic] the room and he was laying on the floor saying my leg hurts. He did have his right leg turned in to the medial side. I did call the hospice nurse and the provider her [sic] at the nursing home. [Name of provider] came and gave order to send him to the ER [Emergency Room]. The hospice nurse was here as well and suggested the same. The son was here very shortly after he fell . . . The ambulance came and placed him on a back board took him to the ER . . ."

Response to fall - "He was sent to the ER for eval."

Review of a physician's progress note from the ER, dated 09/06/16, stated, ". . . History of Present Illness, The patient presents with Extremity injury major . . . PT [patient] is currently on hospice care at a nursing home. PT states he got out of bed and took a step and his leg just gave out. PT complains of pain to his right leg . . . Physical Examination . . . Right, hip, deformity anterior dislocation, ankle/foot: right, internally rotated . . . Alert and oriented to person, place, time, and situation . . . Impression and Plan, Fracture [fx] of distal femur . . . Prostate cancer metastatic to bone . . . Pathologic fx . . ."

A nursing progress note, dated 09/09/16, stated, "Unit received call from Hospice Nurse this shift stating that resident will return back from the hospital on 09/10/16. Hi/low bed ordered for resident and received this shift . . ."

During an interview on 10/13/16, an

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administrative nurse (#10) provided no additional information regarding interventions attempted to address Resident #4's falls.

The facility failed to provide proactive interventions to address Resident #4's risk for falls and failed to reassess and implement individualized interventions specific to his health status and needs at the time of his falls. Resident #4 did not receive a low bed until returning from the hospital after his fourth fall.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia, weakness, and a history of falls.

Resident #7's care plan stated, "Problem: AMBULATION - walks independently, has a cane in room but does not use it . . . Approach: Ambulatory - Walks independently. Has a cane in room to use if needed. . . . Problem: SAFETY . . . Approach: Resident assessed at risk for falls, Call light within reach . . . Problem: TRANSFERRING - independent - no supervision required . . . Approach: Stand-by Assistance with Transfers, Cue resident before & [and] during transfers, Uses cane and/or walker, Give verbal cues as needed before/during transfer for sequencing and direction - Independent uses cane . . ."

Review of Resident #7's progress notes and corresponding falls documentation/reports identified the following falls and interventions: *11/16/15 at 9:17 p.m.: "Resident was observed sitting on the floor in the TV room by the nurses station. He was sitting on the left side of his

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walker. Visual body check and AROM [active range of motion] showed no injuries. Family notified."

Response to fall - "already in place"

*12/28/15 at 2:43 a.m.: "Resident seen by staff in the bathroom with BM [bowel movement] all over his body, he was cleaning him when suddenly resident rolled his eyes and passed out in his arms, resident was lowered down to the floor. No injuries sustained. . . ."

Response to fall - "Reoriented to call light, visited more frequently."

*01/07/16 at 9:30 a.m.: "CNA and med [medication] aide found resident kneeling on floor in dining room . . . unable to explain what happened. Assessed for any injuries and none noted no redness observed to knees. . . ."

Response to fall - "already in place"

*01/12/16 2:46 p.m.: "Resident was walking in hallway with his cane, lost his balance and fell. . . . assessed for injury with none noted. . . ."

Response to fall - "Continue with current plan of care."

*01/23/16 at 7:00 p.m.: "Notified by CNA that resident had fallen. Resident apparently lowered himself slowly to the floor. Vitals signs WNL [within normal limits], resident resting in bed at this time. No injuries noted, no pain reported to resident. . . ."

Response to fall - "closer monitoring when resident is ambulating."

* 01/27/16 at 10:38 a.m.: "New order received [sic] for PT [physical therapy] for strengthening and gait training . . ."

*01/28/16: "resident observed in sitting position in hallway on floor alert to self no pain noted no injury noted . . ."

Response to fall - "encourage resident to use

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F 323	Continued From page 28 walker and to use seat on walker when he wants to rest" *02/11/16 at 9:36 p.m.: "1445. [2:45 p.m.] Resident was observed by roommate's family, falling to the floor near nurse double doors. No injuries noted. . . ." Response to fall - "Assisted to sit in w/c [wheelchair] et [and] given boost. Resident unable to explain why he fell" *02/14/16 at 8:52 p.m.: "CNA observed resident sitting on dining room floor. Resident denies any pain related to fall. No injuries . . ." Response to fall - "Closer monitoring, encourage resident to use walk [sic]." *02/17/16 at 5:30 a.m.: "Resident was found on the floor. . . . No injuries . . ." Response to fall - "monitor for pain and latent injuries for 3 days" *02/23/16 at 12:43 p.m.: "Cna reports that when she was transfering [sic] resident to shower chair he went down on his knees and now has three small red areas to left knee and one red area to right knee, will monitor." Response to fall - "encourage use of walker with transfers" *02/24/16 at 3:30 p.m.: "Resident observed by staff reaching for the railing et [and] fell, hitting is [sic] left shoulder. . . . No injuries . . ." Response to fall - "assisted to sitting on the couch, by staff members, continues to wonder [sic] around the unit. Do encourage resident to use can et walk near the wall railing." The progress notes failed to include any "Falls Committee Progress Notes." During an interview on 10/13/16 at 11:00 a.m., two administrative nurses (#7 and #11) stated	F 323		

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F 323	Continued From page 29 staff provided showers almost daily due to Resident #7's behaviors regarding bowels and in hopes of preventing falls. They also stated the special care unit is specialized and they let residents be as independent as they can. The facility failed to provide proactive interventions to address Resident #7's risk for falls and failed to reassess and implement individualized interventions specific to his needs at the time of his falls. TRANSFERS 2. Based on observation, record review and staff interview, the facility failed to provide adequate assistive devices necessary to prevent accidents for 1 of 3 sampled residents (Resident #1) observed during transfers. Failure to apply and utilize a gait belt and report a fall placed the resident at risk for sustaining an injury. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia and weakness. The care guide stated, "Transfer: Transfers with a gaitbelt and assist of 1. [Resident #1] will transfer self without notifying staff at times. . . ." The care plan stated, "Problem: AMBULATION . . . one person assistance, Refuses to use a walker and wear gait belt . . . Problem: SAFETY - potential for falls related to unsteady gait, poor safety awareness, refuses to use a walker, and antidepressant med [medication] use, mattress next to bed - will lay on mat per her wishes, hourly rounding, high low bed . . . Approach . . . Floor mat next to bed while resident in bed. [Resident #1] will crawl onto mat herself and want to lay there for a time . . .	F 323		

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Problem: TRANSFERRING - self care deficit-requires extensive assistance . . . Approach: Transfers with a gaitbelt and assist of 1. [Resident #1] will transfer self without notifying staff at times. . . ."

Observation during initial tour on 10/12/16 at 10:30 a.m. showed Resident #1 kneeling on the bedroom floor in front of her sofa. Two mattresses were in the room but not on the floor. A falls prevention worksheet posted on Resident #1's door showed staff last signed off the safety checks at 6:00 a.m. (3 1/2 hours prior to this observation). A certified nursing assistant (CNA) (#12) walked by Resident #1's room and saw her kneeling on the floor. The CNA signed off the safety checks through 10:00 a.m., gowned and gloved, and entered Resident #1's room. The CNA (#12) lifted under both of Resident #1's axilla and the resident said "ow." The CNA asked the resident to help and the CNA lowered the resident to the floor. Resident #1 started to get up and the CNA said "I can help you" and lifted Resident #1's buttocks up and onto the couch. The CNA (#12) failed to notify the nurse regarding Resident #1 kneeling on the floor and potential fall and failed to use a gait belt to transfer the resident.

Review of the progress notes failed to reflect this incident and Resident #1's potential fall.

During an interview on 10/13/16 at 10:10 a.m., an administrative nurse (#10) stated she would expect staff to first notify the nurse the resident is on the floor and she would expect staff to attempt to apply a gaitbelt (Resident #1 refuses at times) and assist the resident off the floor with two staff

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F 323	Continued From page 31 members. She also stated she would expect staff to complete the hourly safety checks and document on the fall prevention sheet.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on information received from the complainants, observation, record review, and staff interview, the facility failed to ensure 1 of 2 closed records residents (Resident #8) identified as having significant weight loss received necessary care and services in a timely manner to maintain his weight. Failure to ensure Resident #8 received assistance as needed may have contributed to his continued weight loss. Findings include: Information submitted by the complainants identified the facility failed to provide Resident #8 assistance during meals despite his continued weight loss.	F 325	Resident #8 is deceased. Case discussed with nursing and Nutrition Staff. All residents have the potential to be affected if nutritional status in not monitored and interventions are not put in place to ensure adequate nutritional status. Intake is monitored at all meals. Residents with impaired cognitive status or poor intake are assessed daily at meals. Residents are weighed monthly by C.N.A.'s and will be reweighed if there is a discrepancy. Documentation of weights will be done and Nutrition Services is notified of significant change	11/7/16

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F 325	Continued From page 32 - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included chronic subdural hematoma, dementia, reflux, oropharyngeal dysphagia, and failure to thrive. The quarterly Minimal Data Set (MDS), dated 05/16/16, identified severely impaired cognitive skills, supervision and assistance from one person required for eating, and a mechanically altered/theraputic diet. The weight record, dated February 19-July 12, 2016, identified Resident #8 weighed 170.1 pounds (lbs.) on admission to the facility and 144.7 lbs upon discharge from the facility. A nutritional care plan, last updated 07/12/16, identified, ". . . setup tray . . . Pureed - Nectar thickened liquids . . . Supplement - Ensure, Glucerna or Mighty Shk [shake] . . . Provide cueing for eating, Feed self independently . . . Ensure resident sitting upright in appropriate chair. . . .Encourage scheduled high kcal [kilocalorie] snacks . . . Monitor for chewing/swallowing problems . . . coughing/choking. . . . Speech Therapy" The progress notes identified the following: * 05/09/16, ". . . Was able to tolerate pureed diet help feed. Still coughs occasionally with nectar thick liquid. . . . He did have some coughing episode upon swallowing. . . ." * 05/10/16, ". . . Resident requires help feeding. . . . Help feed or needs cues during meals at this time. . . ." * 05/15/16, ". . . help feed or needs cues when eating. . . ." * 05/16/16, ". . . help feed or needs cues for meals. . . ."	F 325	in weight. Education provided to staff on November 4, 2016: Residents with significant weight loss are identified when nursing notifies Nutrition Services of changes in weights. Nutrition staff member will create a list of these residents and the information will be shared with the Clinical Excellence Director, DON, ADON and Nurse Managers. Appropriate interventions will be added to care plan/guide and communicated with staff. Interventions will be documented as well as effectiveness of interventions. Education also provided to staff on November 9 and 16, 2016 includes appropriate dining room placement, supplements, food likes/dislikes, dehydration, or adaptive equipment needs. These will be added to the care plan/care guide. If table placement for resident is changed in Dining Room nursing will notify Nutrition Manager. Dietician will do quality assessment reviews on all residents with significant changes weekly for four months, and if compliance is achieved then audits will continue for four months to insure compliance is maintained, and then will continue to be done quarterly. The results of this will be reported to the Quality Assurance Committee monthly. The Director of Dietary is responsible for this process.	

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F 325	Continued From page 33 * 05/18/16, ". . . help feed or needs cues for meals. . . . Res [residentt] . . . triggers for 3 mont [sic] weight loss from admit weight -7.9%. . . ." * 05/23/16, ". . . needs cues for meals. . . ." * 06/06/16, ". . . Resident is alert but confused. . . . significant weight loss of 16# [pounds] (9.4%) over past 4 months. . . . " * 07/06/16, ". . . Resident is alert but confused. . . . weight . . . 5 month . . . down significant 20# (-12.4%) . . ." * 07/08/16, "Resident looks so weak says that he feels terrible. . . . ordered to send the resident to the hospital for further evaluation . . ." The "Emergency Documentation" from the hospital, dated 07/08/16, identified, ". . . The patient presents with weakness. . . . is slow to answer and has a very weak voice making it difficult to understand what he is saying. . . . generalized, lack of stamina, lack of strength and 'tired.' The degree at present is severe. . . . Altered mental status. . . . Acute dehydration. . . ." A document summarizing communication with a member of Resident #8's family, dated 07/11/16, identified the family member had contacted the facility, following the emergency room visit, with their concerns. The facility informed the family member that Resident #8 fed himself and sat near a feeder table. The facility also informed them they would "continue to watch [Resident #8] during meals to monitor the intake and his swallowing." During an interview on 10/13/16 at 1:35 p.m., a licensed/registered dietitian (#18) identified Resident #8 sat at a small independent table in the dining room with one other resident. She	F 325		

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F 325	Continued From page 34 described the table as being located in a "high traffic area, where the action is, where the CNAs [certified nursing staff] are, so [the residents] can be watched." She explained the CNAs feeding residents at the two assisted tables on either end of the dining room (one to two tables away) would have been responsible to monitor Resident #8 as well. Observation on 10/13/16 at 1:35 p.m. showed CNAs seated at the assisted tables feeding their assigned residents. Two gentlemen were seated at the table previously occupied by Resident #8. When asked which staff members were monitoring the residents currently seated at Resident #8's table, the licensed/registered dietitian (#18) stated, "I don't know. I see what you mean." During an interview on the afternoon of 10/13/16 issues pertaining to meal assistance were discussed with administrative staff members (#6 and #7). The administrative staff members provided no additional information related to meal assistance. Failure to identify the need for assistance during meals may have contributed to Resident #8's continued weight loss/dehydration.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328		11/7/16

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	355074	A. BUILDING _____ B. WING _____	C 10/13/2016

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F 328	Continued From page 35 Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely secure an oxygen tank in 1 of 6 sampled resident rooms (Resident #6). Failure to secure the oxygen tank placed the facility's residents, visitors, and staff at risk of injury in the event the unsecured tank falls and becomes a projectile object. Findings include: Observation on 10/12/16 at 3:00 p.m., showed an oxygen tank free-standing in the corner of Resident #6's room (approximately 6 inches from either wall) behind her recliner. At 3:23 p.m., a nurse (#1) confirmed staff should secure the oxygen tank in a cylinder transport cart.	F 328	Resident #6 The oxygen tank was removed from the resident's wheelchair O2 holder and placed in the corner of the room by the residents daughter so she could take the resident out to smoke. The oxygen tank was removed from the room and stored securely in the O2 room. All residents have the potential to be affected if equipment is not stored/secured correctly. Oxygen tanks are stored in secure holders. This family was instructed not to move oxygen tanks. All staff were educated on safe handling, storage, and importance of making sure oxygen tanks are secured at all times. Staff were also educated to call maintenance to remove any unused oxygen from resident rooms. This education was done as a Read and Sign inservice, which was placed on all units on November 9, 2016. Staff were also educated on this process at the CNA/Nurse meetings held November 16, 2016. All staff monitor oxygen tanks for safe storage and handling. DON, ADON and	

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F 328	Continued From page 36	F 328	nurse managers will review oxygen ordered on each unit and check for appropriate placement of tanks. These rounds will be done weekly and reported monthly for four months to the Quality Assurance Team. If in compliance will no longer need to do audits on this process. Responsibility of DON.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		11/11/16

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F 441	Continued From page 37 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility handout, and staff interview, the facility failed to follow infection control practices for 2 of 5 sampled residents (Resident #1 and #5) and one random observation. Failure to follow infection control practices related to enteric (intestinal) precautions (Resident #1 and random observation), and hand hygiene (Resident #5) has the potential to spread infection to other residents, staff, and visitors. Findings included: Review of the facility handout titled "Attention All staff Entering Rooms With Transmission-Based Precautions" occurred on 10/13/16. This handout, dated 03/21/16, stated, ". . . Contact Precautions . . . C difficile . . . requires . . . soap and water only for hand hygiene (no alcohol hand sanitizer). . . . Hand Hygiene: Soap and Water . . . Opportunities/requirements . . . Before and after assisting resident with toileting . . . After contact with residents with infectious or suspect diarrhea	F 441	Infection Prevention and Enteric precautions are provided to residents #1 and 5.(Resident #1 discharged). Resident #5-siogn placed in room to wash hands with soap and water. All staff are to use proper precautions; which include hand washing, appropriate gowning and gloving, sanitizing of equipment. Housekeeping also has the same expectations. All residents have the potential to be affected if proper infection control procedures are not followed. Education was provided to nursing with a Read and Sign Inservice on November 9, 2016 and again at the CNA/Nurse Meetings held November 16, 2016. Housekeeping staff were educated on November 8th, and Nutrition staff educated on October 27th and November 17th by the Infection Control Nurse. Staff	

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F 441	Continued From page 38 including, but not limited to . . . C difficile [c. diff.] . . . Glove Use . . . Remove gloves and wash hands with soap and water as required or disinfect hands before touching anything clean in a room, before touching anything belonging to another resident or when leaving a room. . . ." - Observation during initial tour on 10/12/16 at 10:05 a.m. showed a housekeeping staff member (#14) standing in a hallway outside of a resident's room with an isolation gown on. The housekeeping staff member (#14) stated she applied the isolation gown to clean an isolation room. She said she entered the resident's room, left the room to obtain a rag, moved the housekeeping cart up the hallway for the other housekeeper, and returned to the resident's room. The housekeeping staff member (#14) failed to remove the isolation gown and perform hand hygiene prior to exiting the room. - Review of Resident #1's medical record occurred on all days of survey and identified the infection, C. diff. A sign affixed to the resident's door stated "Enteric Precautions." Observation during initial tour on 10/12/16 at 10:30 a.m. showed a certified nursing assistant (CNA) (#12) donned gloves and a gown, entered Resident #1's room and transferred the resident to the sofa. The CNA (#12) removed the gown and gloves, exited the room and hand sanitized in the hallway. The CNA (#12) failed to perform hand washing prior to exiting the room. Observation on 10/12/16 at 5:30 p.m. showed two CNAs (#12 and #15) donned gloves and a gown and entered Resident #1's room. The CNA	F 441	were re-educated on proper hand washing and following appropriate precautions. Education also provided on when to use soap and water to wash hands after removing gloves in rooms that staff use enteric precautions in. Housekeeper also instructed to remove gown and gloves prior to leaving room. Infection Control Nurse will place signs in all resident rooms with Enteric Precautions. (Currently we only have one) Director of Housekeeping, DON and Nursing Managers will do observations of Infection Control practices (5 per unit per week) and educate staff as needed. These audits will be done weekly until compliance is achieved, and then monthly for four months to insure compliance is maintained. These audits will be reported to the Quality Assurance Committee monthly. DON and Housekeeping Directory are responsible for this process.	

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F 441	Continued From page 39	F 441		

(#15) performed perineal cares for Resident #1 who was incontinent of urine. The CNA (#15) handed a soiled wipe to the other CNA (#12) who disposed of it in the trash can. The CNA (#12) changed her gloves. Both CNAs (#12 and #15) repositioned the resident, placed a pillow under her legs, applied a blanket, lowered the bed, and gave water and the call light to Resident #1. The CNA's removed their gown and gloves, exited the room, and hand sanitized in the hallway. The CNAs (#12 and #15) failed to remove their gloves and perform hand hygiene after performing perineal cares and prior to performing other tasks and the CNAs failed to perform hand washing prior to exiting the room.

- Observation on 10/12/16 at 4:30 p.m. showed a CNA (#16) assisted Resident #5 with toileting. Resident #5 performed perineal cares, stood, and the CNA (#16) performed perineal cares. The CNA changed gloves and ambulated the resident to her bed. The CNA (#16) gave the resident water, fluffed the pillows, applied a blanket, and removed her gloves. The CNA donned gloves, bagged the soiled items, and exited the room. The CNA (#16) disposed of the soiled items in the soiled utility room and removed her gloves. The CNA (#16) failed to offer hand hygiene to the resident, perform hand hygiene after performing perineal cares, prior to completing other tasks, and after disposing soiled items.

During an interview on 10/13/16 at 9:50 a.m. and at 10:45 a.m., an administrative nurse (#9) confirmed the housekeeping staff member should have removed her gown prior to exiting the resident's room and stated staff should offer

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F 441	Continued From page 40 residents hand hygiene.	F 441		
F9999	FINAL OBSERVATIONS The complaint issues regarding failure to offer liquids, failure to perform perineal cares in a timely manner, failure to assess the resident after a change in condition, and concerns regarding neglect could not be substantiated.	F9999		