STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355074	A. BUILDING _____ B. WING _____	C 11/13/2014

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 complaint survey started on November 12, 2014 and completed on November 13, 2014, the sample included 7 residents for review.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 1 of 1 sampled resident (Resident #3) identified with multiple injuries of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a thorough investigation of injuries of unknown origin placed this resident at risk for abuse and mistreatment, and all other residents with injuries of unknown origin. Findings include: Review of the facility's "Investigation and Reporting of Abuse, Abuse, including Injuries of Unknown Source, Neglect, and Misappropriation of Resident Property" policy occurred on 11/13/14. The policy, revised 03/26/13, stated: "All actual and alleged incidents of Abuse, Abuse including Injuries of Unknown Source, Neglect, Misappropriation of Resident Property will be	F 226	All nursing and social workers have received written education on the policy Investigation and Reporting of Abuse, Abuse including Injuries of Unknown Source, Neglect, and Misappropriation of Resident Property. All residents have the potential to be affected. Any bruise/injury of unknown origin will be reported by staff members to their supervisor and the Investigation and Reporting of Abuse, Abuse including Injuries of Unknown Source, Neglect and Misappropriation of Resident Property will be followed. An Initial Allegation of Abuse Reporting form will be completed and faxed to the State Health Dept. within 24 hours of notification of the bruise/injury of unknown origin. Social Workers, Nurse Managers and the Director of Clinical Excellence and Resident Safety will review daily progress notes and the Bruises/Injuries of Unknown Origin V4 for completion. An investigation will be completed for each bruise/injury of unknown origin under the direction of the Director of Social Services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Walker	Administrator	12/16/14

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

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F 226	Continued From page 1 reported and investigated . . . Definition: . . . 2. Injuries of Unknown Source: The source of the injury was not observed by any person OR the source of the injury could not be explained by the resident. The injury is suspicious because of the extent of the injury OR the location of the injury OR the number of injuries observed at one particular point in time OR the incidence of the injuries over time. PROCEDURE: 1. All actual or alleged incidents . . . or Catastrophic events will be reported immediately to your supervisor, charge nurse, department manager, or manager on call. All bruises and injuries of unknown origin will have documentation in the medical record and a bruise/injury of unknown origin checklist completed. . . 6. All alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown origin . . . are reported immediately to the Administrator and an Initial Allegation of Abuse Reporting form is faxed to the State Health Department within 24 hours. . . . 8. A plan of correction will be developed to show how further incidents will be prevented. Staff will be monitored through observations, QA's [questions and answers], and performance evaluations. . . ." - Review of Resident #3's medical record occurred on November 12-13, 2014. The record identified diagnoses of Alzheimer's dementia. The care plan identified a problem on 07/02/14 of "deficit r/t [related to] impaired skill for decision making, long and short term memory impairment." A significant change Minimum Data Set (MDS), dated 09/17/14, identified delirium	F 226	Results of the investigation will be sent to the State Health Department within 5 days of notification and the administrator or representative will be notified. Any action required will be followed as outlined in the policy. QA will be done weekly for 4 weeks, or until compliance is achieved. Once compliance is achieved, audits will be completed monthly for 4 months then quarterly. All nursing and social workers are responsible to make sure the reporting is done within 24 hours and the investigation process is completed. All audits will be reported to the monthly QA Committee. Completion date is 12/16/2014. The Director of Clinical Excellence and Resident Safety is responsible for the process. per T.C. on 12/22/14 at 2:45 p.m. c both Vicky, DON, + Rhonda, administrator ask unknown/suspected reports are being sent to our office - Resist shows monitor.

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F 226	Continued From page 2	F 226		

inciuding inattention and disorganized thinking, no behavioral symptoms, and moderate impairment for decision making ("decisions poor; cues/supervision required").

Observation of cares on the afternoon of 11/12/14 identified a bruise over Resident #3's left ear encompassing the entire auricle, a light reddened bruise on the resident's right ring finger, and approximately a baseball size bruise to the left lower outer thigh just above the knee. The medical record lacked evidence of staff reporting the injury on the outer thigh and ring finger.

Review of progress notes identified:
* 09/11/14 at 6:43 a.m.: "When performing cares . . . CNA's [certified nursing assistants] noted a large bruise by her left elbow approx [approximately] 5cm [five centimeters] and multiple bruises from her right outer knee down her right calf to her foot. Resident can be combative with cares and also has no regard for her own safety due to her dementia and may have sustained these bruises due to this fact . . ." A "Bruises/Injuries of Unknown Origin" investigation report, dated 09/11/14 at 11:48 a.m., stated, "resident has dementia and can be very combative with cares often times hurting herself when attempting to hurt thwe [sic] staff - resident has no regard for her own safety . . . Staff documentation on Sept 5th, 6th, 8th and 9th states combative with cares. The bruising is likely due to her combative behavior. No indication of abuse or neglect. Staff will continue to monitor."

* 09/16/14 at 6:37 a.m.: "CNA's informed me that resident had an egg shaped hematoma above her left eye . . . and [resident] is not able to tell me how she sustained it. . . ." A "Bruises/Injuries

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F 226	Continued From page 3 of Unknown Origin" investigation report, dated 09/16/14 at 3:56 p.m., stated, ". . . Possibly the bed rail. . . . We can try and keep resident as safe as she will allow and also we could remove the side rail . . . remove side rail . . . Unsure where [resident] received the bruise above her eye as she walks around independently and has no regard for her personal safety. She also has a history of becoming resistive during cares and when the nurse went to look at her eye she was found with her head against the bed rail. The bed rail will possibly be removed from her bed. No indication of any abuse or neglect. It was determined that [resident] uses the bed rail for re-positioning, so it will be padded rather than removed." * 10/02/14 at 5:50 a.m.: "CNA's show me that resident has a scratch to the back of her left ear - dry blood present . . . " At 6:35 a.m., ". . . Resident did fall on 9/29 and may have sustained this at that time. Another possibility is that this resident is often combative with cares and could have sustained it this way. Will monitor." A "Bruises/Injuries of Unknown Origin" investigation report, dated 10/02/14 at 3:09 p.m., stated, ". . . Resident has dementia and does not know her limits/resident can also be combative with staff/resident fell out of her WC [wheelchair] on 9/29. . . . No indication of abuse or neglect. . . . Scratch could have also been self inflicted from scratching behind her ear." * 10/08/14 at 9:51 a.m.: "CNA observed bruising to the right side of head and bruising to right side of face near eye during shower. . . . " A "Bruises/Injuries of Unknown Origin" investigation report, dated 10/08/14 at 10:41 a.m. stated, ". . . It is unknown how [resident] got the bruise to her	F 226		

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F 226	Continued From page 4	F 226		

head and face. She may have bumped her head/face on furniture or some other object. No indication of abuse or neglect. . . ."

* 11/10/14 at 4:31 p.m.: "Resident has bruising to left ear . . ." A "Bruises/Injuries of Unknown Origin" investigation report, dated 11/11/14 at 3:03 p.m. stated, ". . . [resident] lays on that side most of the time and the staff think the bruising may be a result of this. No indication of abuse or neglect. . . ."

During interview on the morning of 11/13/14, a managerial staff member (#3) of the special care unit stated all allegations of abuse and neglect are routed through social services.

During interview on the afternoon of 11/13/14, a social services staff member (#5) stated she reviews all reports of allegations/injuries of unknown origin every day when she comes to work. The staff member stated usually direct care staff report via progress notes and that is what triggers investigations. This staff member further stated: a determination may be made the resident has no regard for safety; suspiciousness of abuse/neglect would be identified in an injury of unknown origin report; "believe most are happening because of falls."

The "Bruises/Injuries of Unknown Origin" investigation reports identified the administrator signed off on each report between 1 to 14 days after the reported injuries. The policy identified notification of the administrator immediately of alleged violations including injuries of unknown origin.

The investigation reports lacked evidence of a

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F 226	Continued From page 5 thorough investigation of each (significant and non-significant) injury; relied on the recall of a resident who has moderately impaired cognitive skills for decision making, including short and long term memory loss; failed to recognize a correlation of the five injuries as "suspicious because of the extent of the injury OR the location of the injury OR the number of injuries observed at one particular point in time OR the incidence of the injuries over time;" and failed to immediately report all alleged violations involving mistreatment, negiect, and abuse, including injuries of unknown origin to the Administrator and within 24 hours to the State Health Department as per the facility's PROCEDURE.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, information received from the complainant, and staff interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly, and comfortable interior on 1 of 1 special care unit (4 West). Failure to maintain a clean and sanitary environment does not provide a comfortable living environment for residents. Findings included: Information provided from a complainant identified environmental concerns on the special	F 253	All staff has been educated on reporting areas in the environment that need to be fixed by Plant Operations Department or cleaned by the Housekeeping Department. Items to report are torn wall paper, cracks, rough surfaces on walls, soiled/stained and any carpet with odor also any furniture that has nicks or scratches on it. As was stated during the exit interview and a copy of the invoice shown to surveyors, tile flooring for the Alzheimer's Unit was ordered, now has been delivered to our facility on Dec 15. Installation of the tile flooring will then be arranged. Plant Operations have fixed the wall on the 12x 12 area with paint as no wallpaper is available to replace the current pattern. Room 406 was repaired on November 14th. The cabinet in the dining area was repaired on December 12th.	

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F 253	Continued From page 6 care unit (4 West). During observation on November 12 and 13, 2014, observation showed the following: * In the dining area, a large area of wallpaper, approximately 12 inches by 12 inches, torn from the wall. * The dining area (two adjoining rooms separated by a half wall) had numerous soiled areas on the carpet, the heaviest soiled areas around the diameter of the tables. * A cabinet in the dining area used to store supplies had numerous nicks on the doors, limiting the ability to make it a cleanable surface. * The carpet in the hallway outside of the nurses station was heavily soiled or stained. * A strong odor of urine in Room 406 including the bathroom. The carpet had two red stains at the end of the bed located closest to the window. * The sheetrock/plaster wall above the heater in Room 406 had a rough surface and visible cracks limiting it from being a cleanable surface. * Information provided by a family member (A) and another concerned person (B) identified concerns with the lack of cleanliness of the flooring specifically carpeting.	F 253	An initial Environmental Rounding has been completed on all nursing units to identify areas in the environment that require repair or replacement. Plant Operations and Housekeeping have been notified of any areas that require maintenance. QA will be done weekly for 4 weeks or until compliance is achieved that areas identified in the Environmental Rounding have been addressed. Once compliance is achieved, Environmental Rounding will be completed weekly (a different nursing unit will be rounded on each week) to identify any further environmental concerns. All audits will be reported to the monthly QA Committee. Completion date is 12/16/2014. The Director of Plant Operations and the Director of Environmental Services are responsible for the process.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, and staff interview, the facility failed to ensure adequate monitoring of blood glucose for 1 of 1 insulin dependent diabetic resident (Resident #1). Failure to monitor and provide necessary interventions for blood glucose levels has the potential to impair function, contribute to accidents, injuries, seizures and coma. Findings include: The American Diabetes Association (ADA) (2014 guidelines) states blood glucose monitoring is "the main tool you have to check your diabetes control. . . . It is noted in milligrams in a deciliter, or mg/dL . . . Keeping a log of your results is vital . . . a good picture of your body's response to your diabetes care plan. . . ." The ADA defines hyperglycemia as "high blood glucose . . . happens when the body has too little insulin or when the body can't use insulin hormone that helps the body use glucose for energy. . . . Hyperglycemia can be a serious problem if you don't treat it, so it's important to treat as soon as you detect it. If you fail to treat hyperglycemia, a condition called ketoacidosis (diabetic coma sleep-like state in which a person is not conscious. May be caused by hyperglycemia (high blood glucose) or hypoglycemia (low blood glucose) in people with diabetes. . . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 8th edition, Pearson Education, Inc., New Jersey, page 73, states, "Carrying Out a Physician's Orders: Nurses are expected to analyze procedures and	F 309	All nursing staff has received written education on the Blood Glucose Protocol and specifically what to do to address out-of-range Accuchecks when a provider does not give the nurse orders. Staff also educated on s/s of hyper/hypoglycemia & the importance of staff to feed diabetics. All residents with diabetes have the potential to be affected. Nurses will monitor blood glucose levels, either per protocol or as directed by providers orders, on those residents that have a diagnosis of diabetes. If a blood glucose is out-of-range as per protocol, and there are no orders to address this or the provider does not give orders when notified, the Nurse Manager is to be notified (DON or ADON in their absence). The Nurse Manager is to contact the provider for clarification. If no clarification is given, the DON or ADON will contact the Medical Director for direction. A progress note will be entered into the chart of the follow up.	

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medications ordered by the physician. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescribing physician. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice. . . ."

- Review of Resident #1's record occurred on November 12-13, 2014. Diagnoses included insulin dependent (Type II) diabetes. Current insulin orders included Lantus (long-acting insulin) 10 units daily, started on 11/05/14.

The medication administration record (MAR) showed nursing staff administered Resident #1 the first dose of Lantus on the evening of 11/05/14.

A progress note, dated 11/06/14 at 1:44 p.m. identified an update with the nurse practitioner of glucose results of "519 [mg/dL] left hand; / 523 mg/dL rt [right] hand. Orders were no blood sugars till 11/17/14 even the QID [four times a day] per standing orders. Update the nurse manager of her condition and orders." The record lacked evidence of the nurse manager's follow-up.

Progress notes stated the following:
* 11/08/14 at 7:23 a.m.: "Resident is lethargic and appears tired tonight and has slept in her chair which is her norm. . . ."
* 11/09/14 at 6:36 a.m.: ". . . Resident continues to be lethargic . . . Resident did sleep the later half of the shift in her bed. . . ." At 1:50 p.m., "Blood sugars are on old [sic]."
* 11/13/14 at 2:39 a.m.: "0130 [1:30 a.m.] resident is lying in her bed and sleeping tonight. Resident is lethargic when cares are performed . . .

QA will be done weekly for 4 weeks or until compliance is achieved, on any Accuchecks that are out-of-range, to determine that orders are in place to address this. Once compliance is achieved, QA will be completed monthly for 4 months, then quarterly. The Nurse Manager is responsible for the QA. All audits will be reported to the monthly QA meeting.

Completion date is 12/16/2014. The DON is responsible for the process.

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Resident gives staff a weak smile and her verbal attempts are incomprehensible. . . ."
* 11/13/14 at 6:48 a.m.: "Resident continued to sleep in her bed the entire night. Fax sent to [nurse practitioner] informing her of this residents lethargy, weakness, inability to form understandable words or sentences and a request for her to come and assess this resident."

During observation of the supper meal on the evening of 11/12/14, Resident #1 attempted to feed herself and struggled to bring the spoon to her mouth. She ate five bites of food. On the morning of 11/13/14, two CNAs (#13 and #14) provided toileting assistance for Resident #1. Resident #1 required significant support by the CNAs to stand. On 11/13/14 at 11:00 a.m., Resident #1 sat at the dining room table in a wheelchair asleep and with her head down.

On 11/13/14 at 11:00 a.m., prior to staff serving Resident #1's lunch meal, the surveyor requested a nurse (#12) perform an accucheck on Resident #1. The accucheck recorded a blood glucose level of 436 mg/dL.

Progress notes on 11/13/14 at 1:59 p.m., written by a nurse (#12) stated: "New orders received from [physician], Orders to DC [discontinue] lantus 10 units, increased lantus to 15 units, Start sliding scale per hospital policy, NOvolog [sic] 5 units TID [three times a day]. And glucose monitoring 4 times daily. . . ."

Facility staff failed to utilize professional judgment and monitor Resident #1's blood glucose levels after 11/06/14 when she exhibited significant adverse reactions and failed to inform the supervising physician of Resident #1's declining

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F 309	Continued From page 10 status until 11/13/2014.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 7 sampled residents (Resident #1 and #7) and two unidentified residents received the necessary assistance for adequate nutrition and personal hygiene. Failure to provide feeding assistance has the potential to result in poor nutrition and/or weight loss. Findings include: Observation of the supper meal, between 5:00 p.m. and 6:00 p.m., on 11/12/14, showed the following: * A random resident, noted with a garbled speech, reached with out-stretched arms while three different certified nursing assistants (CNAs) (#7, #8, and #9) walked by her. This surveyor informed a CNA (#7) that the resident needed some assistance, the CNA directed/walked with the resident to her bathroom for toileting. * At 5:20 p.m., after Resident #1 received her tray she started picking at her food with her hand. A CNA (#9) failed to provide the resident cueing/assistance while observation showed the resident having difficulty raising the food on her	F 312	All nursing staff/feeding assistances have received written education on feeding residents in a timely manner and being aware of toileting needs on residents who are having difficulties carrying out activities of daily living. As this F tag refers to a "special care unit", which is the Alzheimer's Unit, the education provided is from the Alzheimer's Association. For resident #7, staff has been educated on her non-verbal behavior and instructed to assist and cue her with meals as per care guide/plan. Residents in all dining rooms have been placed so a staff member would be available to sit between 2 residents, if necessary, to allow residents to be fed in a timely manner. The nurse that is responsible for the dining room on each floor, will verify that residents that require assistance/cueing receive their trays last and staff will immediately sit down to start the meal. Staff should remain seated with the resident until they are done eating. Any resident that is having difficulties carrying out their activities of daily living, will be offered toileting every 2 hours. Staff instructed to be aware of non-verbal signs that the resident may need to use the bathroom.	

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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 312	Continued From page 11 spoon to her mouth. At 6:00 p.m., 40 minutes after Resident #1 received her tray, a CNA (#8) sat down next to Resident #1 to provide feeding assistance. * At 5:20 p.m., after Resident #7 received her tray she fed herself half of her roast beef, a few bites of coleslaw, 90% of the canned fruit and half a glass of water. During this time, Resident #7 kept repeating "Help me." The resident did not touch the remainder of the meal which included mashed potatoes, a supplement, a red drink, and ice cream. At 5:45 p.m. a CNA (#8) sat down, interacted with the resident, and then removed the resident's tray, not offering to assist her to consume the rest of the meal. * An unidentified resident sitting at a table chewed on her clothing protector until she received her tray. Observation showed the resident confused as to what to do when the tray arrived. The staff failed to provide feeding assistance. On the afternoon of 11/13/14, while sharing the above observations which occurred in a special care unit, one managerial staff member (#3) and one administrative staff member (#1) provided no additional information.	F 312	QA will be done weekly for 4 weeks or until compliance is achieved that resident #7 is having her ADL needs met and that residents that require assistance with meals (resident fed last and staff available to sit down and assist) and toileting, are having their needs met (toileting offered every 2 hours.). The nurse will be responsible to make sure this is done on their shift. Nurse Managers will also do observations at mealtimes and during the shifts, that needs are being met. Once compliance is achieved, audits will be completed monthly times 4 then quarterly. All audits will be reported to the monthly QA Committee. Completion date is 12/16/2014. The DON is responsible for the process.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 12	F 315		

function as possible.

This REQUIREMENT is not met as evidenced by:
Based on record review, information submitted by the complainant, and review of facility information, the facility failed to provide prompt treatment for a urinary tract infection (UTI) for 1 of 2 sampled residents (Resident #2) with a history of UTIs. Failure to ensure prompt diagnosis and treatment of a UTI may result in unnecessary discomfort, increased behaviors, and/or sepsis.

Findings include:

Information submitted by the complainant identified concerns facility staff failed to promptly recognize symptoms of a UTI and provide necessary treatment.

Review of the facility document titled "Urinary Tract Infection Suspected Protocol" occurred on 12/13/14. The document stated, ". . . MINOR SYMPTOMS . . . 2. Change in behavior or mental status . . . Check vital signs every 8 hours over a 24 hour period . . . Assess for major symptoms every 8 hours for 24 hours. . . . If minor symptoms persist at 24 hours call designated provider for orders . . ."

Nurses' notes and behavior charting identified the following:
*08/23/14 at 10:00 a.m.: ". . . generalized aches all over . . . pt [patient] refused to get out of bed. Stated she was achy all over. . . ."
*08/23/14 (untimed): ". . . When I went in to do residents am [morning] cares she told me to 'just kick her out the door,' and when I said I would

All nursing staff has been re-educated on the Urinary Tract Infection Suspected Protocol (UTI protocol) and documentation of the protocol in the chart, and also calling the provider upon receipt of any results from urinalysis' or urine cultures. The Medical Director has instructed Nurse Practitioners on not writing ambiguous orders.

Resident #2's care guide and care plan has been updated to state that if her behaviors increase or change, the UTI Protocol is to be initiated.

The nurse will initiate the UTI Protocol on any resident exhibiting the symptoms listed as "Major" or "Minor" or as ordered by a provider. A note will be made in the progress note of initiation of the UTI Protocol and the follow-up. The provider will be notified of any abnormal results of a urinalysis or urine culture. The family and resident will also up dated of abnormal results and any new provider orders.

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F 315	Continued From page 13 never do that she told me to 'get the hell out of her room.' Resident refused to get up out of bed until I went in for the fourth time around 11 am and then she finaliy was ready to get out of bed. . . ." *08/24/14 (untimed): ". . . Resident refuses to get up in the morning states she feels too tired and wants to 'sleep until noon.' I tried several times to get resident up but was refused and told 'DO NOT COME UNTIL NOON' at about ten minutes to eleven I went in to offer to get her up again because she had a visitor and resident finally complied. . . ." A message to the provider, dated 08/26/14, stated, ". . . For the past couple of days resident has stated she doesn't feel good. Has had increased behaviors including being more verbally aggressive [sic] towards staff. Going to begin to monitor urine. . . ." A provider order, dated 08/28/14 at 1050 a.m., stated, "Please obtain a UA/UC [urinalysis/urine culture]." An order, dated 08/29/14 at 2:45 p.m., stated, "Do not call on call physician with UA results. I will address Tuesday [09/02/14]." A urine culture report, with final results dated 08/30/14 at 10:58 a.m., identified a positive result for Escherichia coli (E. coli, a bacteria commonly found in the gastrointestinal tract). Nurses' notes further identified: *08/30/14 at 1:00 p.m.: ". . . At 1200 [noon] resident's daughter called regarding results of UA/UC. Informed resident's daughter [name] that final results stated 29 WBC [white blood cells] with clumps and E. Coli were present. Daughter became very concerned about resident. On call	F 315	QA will be done weekly for 4 weeks or until compliance is achieved of the UTI Protocol being followed on residents meeting the "Major" or "Minor" symptom criteria and that the Protocol is completed and documented. Once compliance is achieved, audits will be completed monthly times 4 then quarterly. The nurse in charge and the Nurse Managers are responsible for this QA. All audits will be reported to the monthly QA Committee. Completion date is 12/16/2014. The DON is responsible for the process.	

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F 315	Continued From page 14 hospitalist paged, where he ordered Macrobid [an antibiotic] . . ." "08/30/14 at 12:33 p.m.: ". . . TO [telephone order] from [on call physician] rec'd [received] and obs'd [observed] . . ." Information submitted by the complainant, as well as staff documentation, identified Resident #2 was not feeling well as early as 08/23/14; however, the record showed staff failed to diagnose/treat the E. coli UTI until 08/30/14 (7 days later). This may have resulted in unnecessary discomfort and increased behaviors for Resident #2.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and information submitted by the complainant, the facility failed to provide supervision necessary to prevent accidents for 1 of 7 sampled residents (Resident #2) with falls. Failure to provide adequate supervision for Resident #2 resulted in an unwitnessed fall from her wheelchair. Findings include:	F 323	Nursing Staff, activity staff, volunteers, and transportation staff has been educated on those residents that cannot be left alone in their rooms in a wheelchair. Volunteers and transportation staff have been instructed to leave all residents at the nurses' station when returning them to their nursing units. Activity staff may return residents to their rooms if their name is not on the board (identifying those residents who cannot be left alone in their wheelchair in their room) at the nurses' station. Resident #2 will have QA completed that she is not left alone in the wheelchair in her room. Her name will be included on the board at the nurse's station, identifying her as a resident who should not be left alone in their room when in a wheelchair.	

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F 323	Continued From page 15 Information submitted by the complainant identified Resident #2 experienced a fall from her wheelchair while left unattended in her room. Review of Resident #2's medical record occurred on November 12-13, 2014. Diagnoses included dementia and osteoporosis. The resident's care plan, dated 08/06/14, stated, ". . . SAFETY - at risk for falls, potential for injury from falls, poor regard for own safety due to dementia . . . Not to be left in room when in wc [wheelchair] (August 6, 2014) . . ." Nurses' notes identified the following: "10/17/14 at 11:30 p.m.: ". . . At 1700H [5:00 p.m.], CNA [certified nursing assistant] informed this writer that resident slid on the floor from her wheelchair in her room. Resident was seen sitting on the floor with the wheelchair cushion supporting her buttocks and her back resting on the wheelchair. . . ." "10/18/14 at 9:48 p.m.: ". . . Resident changed back to broda chair [reclining wheelchair] per family's request. Resident sliding out of reguiar wheel chair. . . ." Resident #2's "Falls Documentation," dated 10/18/14, identified staff did not witness the fall which occurred in Resident #2's room. Failure to follow Resident #2's plan of care resulted in a fall with the potential for avoidable injuries.	F 323	All residents that have it stated on their care plan/care guide that they should not be left alone in their room in a wheelchair will also be identified on a board at the nurses' station. Activity staff and nursing staff, when bringing residents back to their rooms, should check this before taking a resident to their room. Transportation staff and volunteers should leave all residents at the nurses' station upon return to the floor. QA will be done weekly for 4 weeks or until compliance is achieved that resident #2 and all other identified residents are not left alone in their wheelchair when in their room. The nurse will be responsible for this QA. Nurse Managers oversee this QA. Once compliance is achieved, audits will be completed monthly times 4 then quarterly. All audits will be reported to the monthly QA Committee. Completion date is 12/16/2014. The DON is responsible for the process.	
F9999	FINAL OBSERVATIONS Based on observation, record review, review of facility policy, review of professional references, family interview and staff interview, the complaint	F9999		

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F9999	Continued From page 16 issues investigated were substantiated.	F9999		