STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	09/13/2010

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GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/07/10 and completed on 09/13/10 the sample included two residents for complete review, nine residents for focused review, and one closed record for review. The sample included five additional residents to verify specific concerns during the survey.	F 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to ensure residents were free from physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, for 1 of 1 sampled resident (Resident #7) physically restrained by facility staff. The use of physical restraint during resident care was not required to treat the resident's medical symptoms, was imposed for staff convenience, resulted in increased resident agitation, and potential injury to staff and the resident. Findings include: Review of Resident #7's medical record occurred on September 07-09, 2010. The facility admitted the resident in 07/10. Current diagnoses included depression and dementia. The resident's	F 221	1) The corrective action accomplished for Resident #7 to ensure that the resident has the right to be free from physical restraints is that nursing staff has been educated on 10/14/10 that holding a resident's wrists while doing cares in an unacceptable practice and is considered a "restraint for convenience". Nursing staff has been instructed that other interventions should be attempted such as leaving the resident alone and trying later. Resident #7 has not been restrained in any manner as had been documented in the IDP notes on 8/29/10.	10-22-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce O'Kelly | TITLE: Administrator | (X6) DATE: 10/14/2010

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 221	Continued From page 1 admission Minimum Data Set (MDS), dated 07/31/10, identified short and long term memory problems, moderately impaired daily decision making, deteriorated cognitive status, verbally abusive, physically abusive, and socially inappropriate/disruptive behaviors occurred daily and were not easily altered in the assessment period, walked independently in room, corridor, on and off unit, and required limited assistance of two or more persons for dressing. The Resident Assessment Protocol Summary (RAPS), dated 07/31/10, identified Resident #7 was difficult to care for due to behaviors, at times, required three staff members for care, and, at admission, had not had a bath for an extended period of time. The resident's Interdisciplinary Progress Notes, dated 08/31/10 at 11:30 a.m., by the facility's Resident Services Coordinator (RSC), stated "Many behaviors are being reported on Mood & [and] Behavior Report. Care plan was updated with interventions. Res. [Resident] was not used to changing clothes every day - he slept in his clothes and never had a bath - so this lifestyle is a big change. Nurses continue to monitor behaviors." During interview, on 09/08/10 at 11:15 a.m., Resident #7's family member (A) reported the resident's sleep habit at home was to go to bed at 11:00 p.m. or later and sometimes "slept in." This family member also reported Resident #7 "not used to being cleaned up." Resident #7's current care plan, dated 08/11/10, stated "Problems . . . I ws [was] unkempt before coming to facility. I have dementia & I grab at caregivers during cares. . . . Plans . . . I do need extensive help from 2-3 people with toileting,	F 221	2) Other residents having the potential to be affected by the same practice have been identified by the DNS or designee querying MDS 2.0, section E4EA, relating to residents resisting cares. Residents identified have been reviewed in behavior meeting on 10/13/10, with care plans updated and appropriate interventions in place. 3) Measures put into place to ensure the practice will not recur is nursing staff will be educated on 10/14/10 by DNS or designee, using the facility policy and procedures on behavioral causes and interventions. The care plans of residents identified as resisting cares will be updated as indicated with appropriate interventions in place. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the care plan on each resident identified as resisting cares will be updated with proper interventions in place. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 221	Continued From page 2	F 221		

personal hygiene & dressing/undressing. . . .;" dated 08/16/10, "Problems . . . I have sexual behaviors to staff related to dementia. . . . Plans . . . Medicate me as ordered. Document my behaviors episodes daily. Keep family updated as requested on my behaviors. Keep physician updated as to my behaviors. Monitor episodes.;" and, dated 08/29/10, "Problems . . . I'm hitting staff, cursing & swearing when they do cares on me. I don't like my clothes removed." The care plan lacked plans and approaches for the problems, dated 08/29/10.

Resident #7's Interdisciplinary Progress Notes, dated 08/29/10 at 8:00 p.m., stated "Resident became physically agressive [sic] [with] CNA's [certified nursing assistants] who were trying to assist him to bed. Resident physically [with] force hitting one CNA on top of her head and attempting to violently hit them. Resident yelling, cursing/swearing at CNA's who tried to get him to calm down. Resident['s] wrist had to be restrained by one CNA while the 2nd did cares. Resident get [sic] extremely aggitated [sic] when staff need to remove clothing."

During and following interview, on 09/09/10 at 9:30 a.m., an administrative nursing staff member (#7) offered no additional information regarding the physical restraint of Resident #7 by facility staff.

The facility staff identified Resident #7's behaviors on the admission MDS and RAPS. Family member (A) reported the resident's sleep habit at home as going to bed at 11:00 p.m. or later. The medical record identified the incident of physical restraint occurred at 8:00 p.m. and did not identify the facility staff attempted to leave the

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F 221	Continued From page 3 resident alone and try later. The medical record lacked any assessment or physician's order for use of a physical restraint. The resident's care plan, updated on 08/29/10, lacked plans or approaches for facility staff to attempt, including any type of restraint, when the resident became agitated.	F 221		10-22-10
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 record review, review of policy and procedure, resident interview, and staff interview, the facility staff failed to ensure reporting and thorough investigation of an injury of unknown origin, for 1 of 1 sampled resident (Resident #2) with such an injury. Failure to report and investigate this injury, as identified in the facility's policy, limited the facility's ability to determine the cause of Resident #2's injury and implement the appropriate interventions to prevent a reoccurrence. Findings include: Review of the policy, Abuse and Neglect, occurred on 09/09/10. This policy, revised 10/09, stated "The resident has the right to be free from verbal . . . physical and mental abuse . . . Residents must not be subjected to abuse by anyone, including but not limited to, center staff, other residents . . .	F 226	1) The corrective action accomplished for Resident #2 to ensure that there is no further potential of this injury is that nursing staff has been educated in daily report on 9/14-16/10 to report all incidents of injury. 2) Other residents having the potential to be affected by the same practice have been identified by licensed nursing staff using the 24 hour report sheet to review residents with injury. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 10/14/10 by DNS or designee, using the facility policy and procedures on abuse/neglect and incident reporting. The review will focus on a) Procedure for abuse and neglect and b) Policy for resident incident reports. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the 24 hour report sheets are reviewed for incidents of injury and a corresponding investigation report is completed. These audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 226	Continued From page 4 Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator . . . The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative . . . If the alleged or suspected violation is verified, appropriate corrective action will be taken. . . ." - Review of Resident #2's medical record occurred on September 07-09, 2010. The facility admitted the resident in 04/07. Current diagnoses included confusion, diabetes mellitus, dementia, and a history of left heel ulcer (healed 05/10). The resident's current Minimum Data Set (MDS), dated 07/16/10, identified short and long term memory problems, severely impaired daily decision making, rarely/never makes himself understood, extensive assistance of two or more persons for bed mobility and transfers, walking did not occur, and the resident did not have any falls in the past 180 days. Resident #2's Resident Assessment Protocol Summary (RAPS), dated 01/16/10, identified the resident often reached forward to the floor and required a lap buddy to prevent falling out of the chair. Resident #2's Consultants Progress Notes, dated 06/29/10, stated "Problem: Traumatic nail avulsion 3rd toe left foot. Subjective: No comment. Objective: No one is certain how this happened. .	F 226		

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F 226	Continued From page 5 . . we were able to do a temporary nail removal atraumatically. . . . We will follow again on regular diabetic foot date. . . .;" and, dated 07/13/10, stated "Problem: Follow-up diabetic foot care. . . . Objective: . . . nonpalpable pulses. Feet are totally blue, cold to touch, thickening of nails . . . Plan: debrided the nails x [times] 10 . . ." Resident #2's Interdisciplinary Progress Notes, dated 06/29/10 at 11:15 a. m. stated, "[Podiatrist] here. Examined (L) [left] middle toe. It was very loose (nail) so he lifted it right off. Small amt. [amount] bleeding. Bandaid applied." Resident #2's current care plan, dated 07/26/10, stated "Problems, I could fall . . . Plans, Use foot rest on my wheelchair . . . Transfer me with assistance from 2 using the sit to stand lift . . . Lap buddy when in wheelchair . . . Problems, I have diabetes . . . Plans . . . Diabetic foot care every 9 weeks by [podiatrist] . . ." Resident #2's limited circulation to his feet, as identified in the podiatrist's notes, placed him at risk of complications related to the avulsed toe nail. Failure to investigate this injury of unknown origin increased the potential this injury may occur again to Resident #2 and other residents with similar risks of complications. During interview with an administrative nursing staff member (#7), on 09/09/10 at 9:30 a.m., information regarding an investigation of Resident #2's toe injury was requested. In the afternoon on 09/09/10, this staff member reported the facility lacked investigations of Resident #2's toe nail avulsion.	F 226		

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F 226	Continued From page 6 Facility staff documented Resident #2's toe nail avulsion. Failure to report and investigate this incident did not allow the facility the opportunity to identify how Resident #2's toe nail avulsion occurred and implement corrective action to prevent this from occurring to other residents and did not allow the facility to determine any patterns or track and trend this type of incident, placing all facility residents at risk.	F 226		10-22-10
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, professional reference, and staff interview, the facility staff failed to provide resident care in a manner respecting each resident's dignity or individuality regarding scraping food from residents' faces or clothing protectors, for 1 of 1 sampled resident (Resident #2) and 2 of 2 supplemental residents (Resident #13 and #14) during 3 of 3 meal observations. Scraping food from residents' faces and scraping food dropped on clothing protectors and feeding it to the resident is not a dignified practice. Findings include: Dugan, "Successful Nursing Assistant Care," 2nd edition, Hartman Publishing Company, Albuquerque, pages 255-256, states "Feeding a resident who cannot feed self . . . 17. Use washcloths to wipe food from a resident's mouth	F 241	1) The corrective action accomplished for Residents #2, #13 and #14 found to have been affected by the practice is that the CNA's have been educated on 9/14-16/10 in daily report that it is not appropriate to scrape food from resident's faces when feeding residents. All nursing staff have been instructed to notice if this practice is occurring so proper corrective action may be accomplished. 2) Other residents having the potential to be affected by the same practice have been identified by the DNS by querying MDS 2.0, section K5C, mechanically altered diet, along with the review of the resident dining room seating chart. Residents identified have been reviewed on 10/12/10 using the enhanced dining with dignity and respect policy. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 10/14/10 by DNS or designee, using the facility procedures on the nutritionally dependent resident.	

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F 241	Continued From page 7 and hands as needed during the meal. . . ." Observations in the facility dining room identified the following: *09/08/10, 9:05 a.m. - Certified nursing assistant (CNA) (#1) fed Resident #13 her breakfast meal including eggs and hot cereal. The CNA dropped eggs from a spoon onto the resident's clothing protector, scooped the eggs off the protector with the spoon, returned the eggs to the resident's plate, mixed them with eggs on the plate, and fed the mixture to Resident #13. On two occasions during this observation CNA (#1) scraped hot cereal from Resident #13's face with a spoon, mixed it with cereal in the bowl, and fed the mixture to the resident. *09/08/10, 11:45 a.m. - CNA (#10) fed Resident #2 his noon meal of pureed meat, carrots, and mashed potatoes. The CNA dropped potatoes onto the resident's clothing protector, scooped the potatoes off the protector with the spoon, returned the potatoes to the resident's plate, mixed them with potatoes on the plate, and fed the mixture to Resident #2. On one occasion during this observation, CNA (#10) scraped food items from Resident #2's face with a spoon, mixed it with food on the resident's plate, and fed the mixture to the resident. *09/09/10, 8:00 a.m. - CNA (#17) fed Resident #14 her breakfast meal, including eggs. The CNA (#17) scraped eggs from the resident's face with a spoon. During interview, on 09/09/10 at 9:30 a.m., an administrative nursing staff member (#7) agreed scooping food items from residents' clothing protectors, scraping food items from residents' faces, and feeding the food items to residents did not provide care in a dignified manner and was	F 241	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that residents assisted with feeding in the dining room are treated with dignity by not scraping food from resident's faces. These audits will be done monthly x 3 and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 241	Continued From page 8 not an acceptable practice.	F 241		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/30/09. Based on record review, review of policy and procedure, resident interview, family interview, group interview, and staff interview, the facility failed to provide medically related social services to ensure 1 of 2 (Resident #7) sampled residents who exhibited behaviors towards other residents and visitors attained or maintained the highest mental and psychosocial well-being possible. Failure to provide these services resulted in Resident #7's behaviors towards other residents and a visitor, limiting their physical, mental, and psychosocial well-being. Findings include: Review of the facility policy and procedure, Behavioral Causes and Interventions, occurred on 09/09/10. This document, revised 10/09, stated "PURPOSE, To aid in determining causes of behavior and appropriate intervention and strategies. BEHAVIOR MANAGEMENT ISSUES . . . 2. Wandering is random or repetitive locomotion.	F 250	1) The corrective action accomplished for Resident #7 to ensure that medically related social services are provided and that the highest practicable psychosocial well-being is attained or maintained is that Resident #7's behaviors have been reviewed by the primary physician on 9/9/10 and by the psychiatric nurse practitioner on 9/20/10. The facility's behavior committee met on 9/23/10, using the behavior meeting guidelines and reviewed Resident #7. Resident #7's behaviors have improved. Resident #7 will continue to be seen by psychiatric services as needed. Resident #7's behaviors are being monitored by facility staff and reported to nursing and social services staff on a daily basis in 24 hour report. Resident Services Coordinator has visited with Residents #15 and #16, as well as, Resident # 16's daughter and confirmed that both residents and the daughter feel safe and consider their fears resolved. Appropriate documentation has been done.	10-22-10

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F 250	Continued From page 9 This movement may be goal-directed . . . or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that cognitively impaired residents are frustrated, anxious, bored, hungry or depressed. 3. The behavior management team within the center should meet as soon as possible to discuss the resident's behavior and develop individualized interventions . . . STRATEGIES FOR ADDRESSING AGGRESSIVE BEHAVIORS . . . 6. If the resident becomes aggressive while providing care, offer to return later. . . . 14. If a resident is displaying aggressive behaviors, consider leaving the resident in a safe place and returning after a short period of time." During the group interview with residents the facility identified as interviewable, on 09/07/10 at 4:00 p.m., Resident #15 stated, "I remember one day, I went into my room. He [Resident #7's name] followed me in and used the toilet in my bathroom. It scared me." Review of Resident #7's medical record occurred on September 07-09, 2010. The facility admitted the resident in 07/10. Current diagnoses included depression and dementia. The resident's admission Minimum Data Set (MDS), dated 07/31/10, identified short and long term memory problems, moderately impaired daily decision making, deteriorated cognitive status, verbally abusive, physically abusive, and socially inappropriate/disruptive behaviors occurred daily and were not easily altered in the assessment	F 250	2) Other residents having the potential to be affected by the same practice have been identified by the Resident Services Coordinator querying MDS 2.0 sections relating to resident mood and behaviors. Residents identified have been reviewed in behavior meeting on 10/13/10 with appropriate interventions in place. 3) Measures put into place to ensure the practice will not recur is that the Resident Services Coordinator will review and follow facility policy and procedure on behavioral causes and interventions. In addition, nursing staff will be educated on 10/14/10 by DNS to review hand held documentation in the mood and behavior record. Licensed nursing staff and Resident Services Coordinator will document in IDP notes as needed. Resident Services Coordinator will review the mood and behavior report weekly and report findings at the monthly behavior meeting with appropriate interventions put in place. In addition, the Licensed Social Work consultant will review the Resident Services Coordinator's documentation quarterly, that a note has been made in the IDP record by the Resident Services Coordinator addressing behavior interventions attempted for residents who may be limiting others' physical, mental, and psychosocial well being. Residents will be reminded periodically in Resident Council and private visits how they can report any fears they may have regarding other resident's behaviors.	

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F 250	Continued From page 10 period, required limited assistance of two or more persons for dressing, the resident wandered one to three days during the assessment period, easily altered, and walked independently in room, corridor, on and off unit. Resident #7's Resident Assessment Protocol Summary (RAPS), dated 07/31/10, identified wandering into other residents' rooms and socially inappropriate comments to staff and female residents. The resident's Interdisciplinary Progress Notes, dated 08/31/10 at 11:30 a.m., by the facility's Resident Services Coordinator (RSC), stated "Many behaviors are being reported on Mood & [and] Behavior Report. Care plan was updated with interventions. Res. [Resident] was not used to changing clothes every day - he slept in his clothes and never had a bath - so this lifestyle is a big change. Nurses continue to monitor behaviors." During interview, on 09/08/10 at 11:15 a.m., Resident #7's family member (A) reported the resident's sleep habit at home was to go to bed at 11:00 p.m. or later and sometimes "slept in." This family member also reported Resident #7 is "not used to being cleaned up." Resident #7's current care plan included, dated: *08/09/10, "Problems, I have wandered into other residents rooms. . . . Plans Redirect me if I'm entering a res. room. . . .;" *08/11/10, "Problems . . . I ws [was] unkempt before coming to facility. I have dementia & I grab at caregivers during cares. . . . Plans . . . I do need extensive help from 2-3 people with toileting, personal hygiene & dressing/undressing. . . .;" *08/16/10, "Problems . . . I have sexual behaviors	F 250	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that there is: 1. Documentation and follow up by the Resident Services Coordinator on residents with behaviors as well as any residents that are identified as limiting others' physical, mental, and psychosocial well being; and 2. Audit behavior and care plan documentation to assure accuracy. These audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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	355099	A. BUILDING _____ B. WING _____	09/13/2010

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F 250	Continued From page 11 to staff related to dementia. . . . Plans . . . Medicate me as ordered. Document my behaviors episodes daily. Keep family updated as requested on my behaviors. Keep physician updated as to my behaviors. Monitor episodes.;" *08/29/10, "Problems . . . I'm hitting staff, cursing & swearing when they do cares on me. I don't like my clothes removed." The care plan lacked plans and approaches for the problems, dated 08/29/10. *09/09/10, "Problems . . . I've been in other res. rooms uninvited. . . . Plans . . . Redirect me. Show me where to go. . . ." Resident #7's Interdisciplinary Progress Notes identified the following: *08/01/10, 1:30 p.m. - "Inappropriate behavior witnessed by 2 CNA's [certified nursing assistants] that he was fondling one resident's hand/head et [and] another resident he was heard saying, 'Take it all off baby.' Was told his behavior was inappropriate." *08/01/10, 2:15 p.m. - "A visitor offered to get resident a cup of coffee. Res. grabbed visitor [with] both hands and began to kiss her. Nurse distracted resident and visitor backed away. Res. was redirected." *08/02/10, 9:00 p.m. - "Resident had gotten into room next to his and had crawled into bed [with] wife of another resident. [Wife is Resident #16.] Resident found laying in crevise [sic] between the couple's beds. Staff immediately removed resident from room. . . ." Observation identified Resident #16 shares a room with her husband next to Resident #7's room. Resident #16's and her husband's beds are pushed together, side-by-side. *08/03/10, 3:00 a.m. - "Resident wandering about. Found resident in another resident's room naked	F 250		

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F 250	Continued From page 12 except for a T-shirt. Redirected resident back to his room. Resident becoming more difficult to re-direct, often needing assist of 2." *08/03/10, 3:00 p.m. - "Spoke to [physician] re: [regarding] inappropriate sexual comments et [and] behaviors. Discussed plan of tx [treatment] et psych [psychiatric] eval [evaluation]. . . ." *08/03/10, 3:30 p.m. - "Son here et discussed inappropriate behaviors. Discussed Seroquel [psychoactive medication] et psych. eval. Son agreed to tx." *08/06/10, 10:00 p.m. - "Res. wandered into another resident room and used other resident bathroom. Assisted back to bed. . . ." It is unknown if this is the same incident reported by Resident #15 during the group interview. *08/29/10, 8:00 p.m. - "Resident became physically aggressive [sic] [with] CNA's who were trying to assist him to bed. Resident physically [with] force hitting one CNA on top of her head and attempting to violently hit them. Resident yelling, cursing/swearing at CNA's who tried to get him to calm down. Resident['s] wrist had to be restrained by one CNA while the 2nd did cares. Resident get [sic] extremely aggitated [sic] when staff need to remove clothing." Review of Resident #16's Interdisciplinary Progress Notes identified the following: *07/28/10, 10:00 p.m. - "Res. daughter called and was concerned because her mother had made a statement to her that 'there was a man in overhauls [sic] in her room last night.' The daughter is worried that the res. dementia is getting worse. I informed the daughter that CNAs check [Resident #16] at night and that might have been what frightened her." *08/10/10, 1:00 p.m. - ". . . This RSC [Resident Services Coordinator] was informed that a res.	F 250		

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F 250	Continued From page 13 was in her room. He was just admitted, confused & wandering. She called for help & he was removed. Res. states he's not been back since. Asked if she's fearful of him or any resident here - answer is 'No.' She said she knows he doesn't know what's going on and feels like its been taken care of." On request of the surveyor on 09/08/10, the facility staff provided Resident #7's Mood & Behavior Record for the period July 27 - September 07, 2010. This document included 36 entries for the 43 days in the period, some days including one entry per shift. During this period Resident #7 demonstrated inappropriate behaviors. Interventions included reassurance, snack, assist to area of choice, one to one visit, and "other." Resident #7 demonstrated "Improvement" 12 of 36 (33%), "No Change" 22 of 36 (61%), and "Worsened" 2 of 36 (6%). The facility identified Resident #7's admission to the facility as a lifestyle change. The facility's Resident Services Coordinator identified the resident frequently slept in his clothes prior to admission to the facility. The resident's family member reported he usually stayed up late and frequently "slept in." The facility failed to develop and implement services in this regard to assist him in attaining his highest functional level possible at the facility. This failure resulted in facility staff physically restraining Resident #7 during cares. The medical record shows approaches for Resident #7's behaviors limited to redirection and monitoring. The interventions identified on the Mood & Behavior Record were ineffective for 24 of 36 (67%) entries. Lack of a documented	F 250		

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F 250	Continued From page 14 behavior plan for Resident #7 resulted in continued ineffective interventions and continued behaviors, placing residents, visitors, and staff at risk of verbal, physical, and mental abuse.	F 250	1) The corrective action accomplished for Residents #6, #7 and #8 found to have been affected by the practice is that care plans have been updated on 10/12/10 by licensed nursing staff to address: a) the fiber supplement and resolution of the ulcer for Resident # 6; b) approaches for behaviors on Resident #7; and c) wheel chair positioning for Resident #8. 2) Other residents having the potential to be affected by the same practice have been identified by licensed nursing staff reviewing and revising care plans to address current problems and specific interventions by using the current physician orders and the 24 hour report sheet. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated on 10/19/10 by the DNS reviewing the facility's policy and procedure on proper care planning. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the care plan is appropriately updated to reflect proper care and treatment for each resident. These audits will be done monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	10-22-10
F 280 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, and staff interview, the facility failed to review and revise the resident care plans to address current problems and specific interventions for 3 of 10 sampled residents (Residents #6, #7, and #8) and 1 of 1 closed record resident review (Resident #11).	F 280		

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F 280	Continued From page 15 Findings include: - Review of Resident #7's medical record occurred on September 07-09, 2010. The medical record identified the facility admitted the resident in 07/10 and diagnoses including dementia and depression. The resident's admission Minimum Data Set (MDS), dated 07/31/10, identified short and long term memory problems, moderately impaired daily decision making, deteriorated cognitive status, and verbally abusive, physically abusive, and socially inappropriate/disruptive behaviors which occurred daily and were not easily altered. Resident #7's Resident Assessment Protocol Summary (RAPS), dated 07/31/10, identified wandering into other residents' rooms, resisting cares, and inappropriate sexual behavior with staff. The resident's Interdisciplinary Progress Notes for the period August 01-06, 2010 identified the resident "fondled" another resident's head and hand, made sexually suggestive comments to a resident, kissed a visitor, staff found the resident in the bed of a female resident in a room near his, staff found the resident partially dressed in a room near his, and the resident used another resident's bathroom in the night. Resident #7's medical record included the facility's assessment for self administration of medications (SAM), completed on admission. This assessment stated "No" regarding the resident's desire or ability to SAM. Resident #7's current care plan, identified the following: *dated 08/09/10, "Problems . . . I have wandered into other residents rooms . . . Plans, Resolved	F 280		

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F 280	Continued From page 16 09/09/10. Redirect me if I'm entering a res. [resident] room." *dated 08/16/10, "Problems . . . I have sexual behaviors to staff. Related to dementia. . . . Plans, Medicate me as ordered. Document my behavior episodes daily. Keep family updated as requested on my behaviors. Keep physician updated as to my behaviors. Monitor episodes." *dated 08/19/10, "Problems . . . I may self administer meds. [medications] . . . Plans . . . May set meds @ [at] meals. Report to nurse any meds not taken. [Check] decision tree for self adm [administration] abilities. . . ." *dated 08/29/10, "Problems . . . I'm hitting staff, cursing & [and] swearing when they do cares on me. I don't like my clothes removed." The care plan lacked Plans or Approaches for these problems." The care plan section "Special Instructions" stated "Unable to self administer medication." was crossed out and dated 08/19/10. During interview, on 09/09/10 at 9:30 a.m., an administrative nursing staff member (#7) confirmed the facility staff failed to include appropriate approaches for Resident #7's behaviors on his care plan and he should not be care planned for SAM. The facility staff failed to review and revise Resident #7's care plan to provide preventive measures for dealing with Resident #7's behaviors towards residents, visitors, and staff. The facility staff identified the resident capable of SAM despite the assessment indicating he could not. - Review of Resident #8's medical record occurred on September 07-09, 2010. The	F 280		

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F 280	Continued From page 17 resident's diagnoses included agitation, hallucinations, and a history of falls. The resident's MDS, dated 08/18/10, identified falls in the past 180 days. Resident #8's Interdisciplinary Progress Notes, dated 04/06/10, stated "Called to room . . . resident found on floor beside recliner . . . Had been in wheelchair . . .w/c alarm applied." The resident's current care plan, dated 09/01/10, stated "Problems . . . I have a tendency to fall down . . . Plans . . . arm cushion . . . recommended w/c [wheelchair] in upright position . . ." The care plan lacked a wheelchair alarm as a fall prevention approach. Resident #8's current physician orders, dated 09/09/10 and initiated 02/18/10, stated "Place in reclinging [sic] back w/c - tilt of 30 degrees . . . add (R) [right] w/c wing to prevent lateral shift. . . ." Observation of Resident #8 in her wheelchair on September 08-09, 2010 identified the resident seated upright with a standard upright back with a wheelchair alarm and without a right lateral support. During interview, on 09/09/10 at 9;30 a.m., an administrative nursing staff member (#7) reported the facility staff assessed and determined Resident #8 no longer benefited from the reclining back wheelchair and trunk support and should have contacted the physician to discontinue them from the physician's orders and care plan; and, should have included the wheelchair alarm on the resident's current care plan after staff initiated it on 04/06/10.	F 280		

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F 280	Continued From page 18 - Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included constipation and a history of pressure ulcers. Resident #6's current care plan stated, ". . . PROBLEMS . . . I have constipation . . . PLANS AND APPROACHES . . . 1 scoop of Benefiber BID [twice a day] . . . PROBLEMS . . . I have an open area (pressure ulcer) on my (R) [right] hip. . . ." The care plan identified goals and approaches/interventions related to Resident #6's pressure ulcer. Review of the "wound flow sheet" showed the pressure ulcer on Resident #6's right hip had healed on or around 05/19/10. An interview with a dietary staff member (#4) occurred on 09/09/10 at 1:50 p.m. When asked about Resident #6's use of Benefiber, the staff member stated Resident #6 no longer receives Benefiber and has not received it "for awhile now." The staff member stated "High Fiber" is given instead and Resident #6's care plan is inaccurate. An interview with a nursing staff member (#7) occurred on 09/09/10 at 10:35 a.m. The staff member indicated staff should have updated Resident #6's care plan after the resolution of the pressure ulcer in May. - Review of Resident #11's medical record on 09/09/10 identified admission to the facility on 04/30/09 and transfer to another facility July 2010. Medical diagnoses included Multiple Sclerosis, diabetes mellitus, and constipation. The annual MDS, dated 04/30/10, identified the resident as moderately independent in making daily decisions, usually makes herself	F 280		

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F 280	Continued From page 19 understood, and required extensive assistance from staff for eating. The MDS also identified "dehydration, output exceeds input." The Resident Assessment Protocol (RAP) for dehydration/fluid maintenance, dated 04/30/10, stated, "Resident hasn't been accepting all fluids. She is able to drink water from her cup independently at times, but does have gross hand tremors . . . 3 [three] day intake 1000cc/24 [hours] . . . Resident accepts only what she wants for fluids. Proceed to care plan for measures to promote fluid intake." The nutritional assessment, dated 05/15/10, stated, ". . . Fluids . . . minimum of 1600 cc/day [cubic centimeters per day] . . . Pt [patient] does like pop - recommend to try supplements with meals, root beer floats (as she likes ice cream) . . ." Resident #11's care plan failed to identify a problem or concern of dehydration or any interventions to promote fluid intake.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview, the facility failed to obtain a physician's order to resume administration of a multivitamin with iron for 1 of 1 sampled resident (Resident #1) and failed to obtain a urine sample/culture as per physician order for 1 of 1 sampled resident (Resident #6) with a history of urinary tract	F 281	1) The corrective action accomplished for Residents #1 and #6 found to have been affected by the practice is that a) the physician was notified on 9/8/10, and an order was received for Resident #1, who is now receiving a multi-vitamin with iron. b) The health care provider was notified of a missed U/A and U/C for Resident # 6 and an order was received on 10/7/10 to D/C the original order. 2) The facility recognizes that all residents have the potential to be affected by the same practice. Licensed nursing staff have reviewed physician orders from 9/14/10 through 10/14/10 to ensure that all orders were carried out.	10-22-10

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F 281	Continued From page 20 infections. Failure to obtain and carry out physicians' orders has the potential for negative outcomes to the residents. Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, The Art & Science of Nursing Care, 4th ed., Lippincott, Philadelphia-New York-Baltimore, 2001, pg 109, stated: "Nurses are legally responsible for carrying out the orders of the physician in charge of a patient unless an order would lead a reasonable person to anticipate injury if it were carried out." - Review of Resident #1's medical record on 09/09/10 identified medical diagnoses included malaise, fatigue, and anemia. The resident's most recent blood tests included a hemoglobin of 9.8 g/dl (grams per deciliter) drawn on 06/30/10. The normal hemoglobin range is 14-18 g/dl. Review of Resident #1's care plan, dated 07/14/10, stated "I take a MVI [multivitamin] with iron daily" for problem areas of skin breakdown and poor food intake. Resident #1's medication administration record indicated the resident had not received a MVI with iron since his re-admission on 06/28/10. An interview with an administrative nursing staff member (#7) occurred on 09/09/10 at 10:00 a.m. The staff member stated staff should have obtained an order and resumed the MVI with iron upon Resident #1's return to the facility on 06/28/10.	F 281	3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated on 10/19/10 by the DNS using the facility's policy and procedure on physician's orders. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that physician orders will be obtained and carried out to ensure positive outcomes for each resident. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 281	Continued From page 21 The facility's failure to obtain a physician's order to resume the MVI with iron may have contributed to increased iron deficiency in a resident with anemia. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included a history of urinary tract infections (UTI), senile dementia, and schizophrenia. A nurse's note dated 08/30/10 stated, ". . . Call from [provider name] re: [regarding] behaviors . . . See orders rec'd [received] . . . Resident has been very agitated today - Setting off door alarm - . . . Very disruptive . . ." A health care provider's order dated 08/30/10 stated, ". . . Obtain UA [urinalysis] for UA et [and] culture . . ." Resident #6's medical record lacked a urine culture report from 08/30/10 or any evidence staff obtained a urine specimen. An interview with a nursing staff member (#7) occurred on 09/09/10 at 9:40 a.m. The staff member stated staff did not obtain a urine sample or urine culture because the health care provider's order "got missed."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	1) The corrective action accomplished for Residents #3 and #5 found to have been affected by the practice is that a) Resident #3's care plan has been updated as of 10/8/10 for hypoglycemic incident. b) The CNA assignment sheet has been updated to reflect the care plan approaches for elevating Resident #5's legs.	10-22-10

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F 309	Continued From page 22 Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #3) who experienced hypoglycemia and 1 of 3 sampled residents (Resident #5) with a diagnosis of edema. Failure to follow physician's orders placed the residents at risk for complications related to hypoglycemia and increased edema. Findings include: Review of the facility policy titled "PHYSICIAN'S PROTOCOL" occurred on 09/08/10. This policy, dated 2010, stated, ". . . INSULIN REACTION: Check blood sugar. If conscious and can swallow, give orange juice or glutose (glucose). If unconscious or unable to swallow, give Glucagon one amp [ampule] IM [intramuscular] or Subq. [subcutaneous] and notify physician. . . ." Review of the facility policy titled "HYPOGLYCEMIC INCIDENTS" occurred on 09/08/10. This policy, revised January 2009, stated, "PURPOSE: To protect from complications of hypoglycemia. . . . PROCEDURE: . . . 2. For blood glucose levels 70 and below, or physicians guidelines, as long as resident is able to swallow (observe for gag reflex with tongue blade). a. Give a rapidly absorbed carbohydrate* such as: 1) 4 oz. [ounces] of orange, apple or grape juice 2) 6 oz. of regular soda * These amounts are equal to 15 grams of carbohydrate. b. Repeat blood glucose test after 15 minutes.	F 309	2) Other residents having the potential to be affected by the same practice have been identified by the DNS querying the MDS 2.0; section I1A, diabetes mellitus and section J1G, edema. Residents identified will be assessed by licensed nursing staff who will update care plans and CNA assignment sheets as needed. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated on 10/19/10 by the DNS using the facility's policy and procedure on hypoglycemic incidents and on following physician's orders. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that the physician orders have been followed for all residents identified with hypoglycemia and edema. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 309	Continued From page 23 c. Repeat administration of carbohydrate if necessary. d. Follow with longer acting carbohydrate protein such as: 1) Cheese and crackers 2) Milk and fruit 3) Sandwich e. Notify physician. f. Monitor blood glucose levels every 15 minutes until blood glucose level is above 70. 3. For blood glucose levels 45 or below as long as resident is able to swallow: a. Give glucopaste/glucogel/tube per physician's order . . . b. Repeat blood glucose test after 15 minutes. c. If continues 45 or below, repeat glucopast or glucogel after 15 minutes from when first given or if resident remains alert to swallow. d. Notify physician immediately . . . 4. If resident is unable to swallow and has an order for glucagon IM or SG [subcutaneous], it should be administered, or the resident should be transported to local emergency room via 911. a. Glucagon should be given per physician's order and physician notified per policy. b. Monitor blood glucose levels every 15 to 30 minutes until blood glucose level is above 70 . . . 6. Transport to emergency room if glucagon is ineffective or blood sugar remains below 45 after 30 minutes from the beginning of the hypoglycemic event. 7. If resident is unable to swallow and does not have an order for glucagons, notify physician immediately . . ." Managing Diabetes in the Long-Term Care Setting, Clinical Practice Guideline, American Medical Directors Association (AMDA), 2008, stated, ". . . Hypoglycemia is defined as a blood	F 309		

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F 309	Continued From page 24 glucose level less than 70 mg/dl [milligrams per deciliter] . . . Hypoglycemia is one of the most serious short-term complications of diabetes treatment. If not properly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . . It is recommended the physician be called as soon as possible when: The patient has a blood glucose value less than 70 mg/dL AND is unresponsive OR has consecutive blood glucose reading less that 70 mg/dL. (Treatment of symptomatic hypoglycemia should not be delayed.) . . . - Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included diabetes mellitus and agitation. Medications included NPH (Neutral Protamine Hagedorn) insulin 25 units every morning and Regular insulin four times a day as needed per sliding scale. Review of Resident #3's Interdisciplinary Progress Notes identified the following: * 07/28/10 at 4:00 p.m. - "Res [resident] very lethargic, would not open eyes. BS [blood sugar] 45, attempted to give glutose 15 [grams] but Res spit et [and] blew jell out of mouth. Res given choc [chocolate] pudding et ice cream but kept turning head away. [nurse name] asked Res if she'd like a candy bar, naming several kinds, Res asked for Snickers Bar, Res ate 2 sm. [small] fun size bars. BS 41. Res talking et finished container of pudding et container of ice cream, stating she'd sure like another Snicker." * 07/28/10 at 5:20 p.m. - "Res BS 57, requested dietary to feed Res, she states she's hungry." * 07/28/10 at 9:15 p.m. - "Res BS 358 . . ." * 08/02/10 at 5:00 a.m. - "BS 56 - Resident lethargic - but able to swallow glutose 15 [grams].	F 309		

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F 309	Continued From page 25 Resident non-complaint [with] swallowing glucose. Resident was alert enough to hit on nurses arms attempting to get glucose in. Finally got resident to take down approx [approximately] 2 oz orange juice and approx 2 oz of ice cream when she clearly stated "I don't want anymore." * 08/03/10 at 2:00 a.m. - "Resident acting strangely. Blood sugar done [with] results 28. Resident had received 6 unit [sic] Reg [insulin] per S/S [sliding scale] @ [at] HS [hour of sleep]. Resident awake but seem [sic] to have some problem swallowing. Unable to get Glucose gel down - Orange juice in 5 ml [milliliters] doses given until a total of 4 oz given [with] 3 tsp [teaspoons] sugar in. Resident alert but not coheiant [sic]. * 08/03/10 at 2:20 a.m. - "Blood Sugar 27 - Resident awake but not comprehending what is happening. [name of hospital] called to get order for Glucagon." * 08/03/10 at 2:35 a.m. - "[name] called order received to give Glucagon injection now for low Blood sugar. Injection administered." * 08/03/10 at 2:45 a.m. - "Resident resting quietly - Facial coloration pale pink. Blood sugar 55." * 08/03/10 at 2:50 a.m. - "Blood sugar 95. Resident resting quietly - Resp [respiration] somewhat gurgly at present . . . Will continue to Monitor." According to the facility's policy and procedure, the facility nursing staff failed to call Resident #3's physician when she would not swallow the glucogel, failed to monitor her blood sugar every 15 to 30 minutes until obtaining a blood sugar reading above 70, and failed to notify the resident's physician immediately to obtain an order for Glucagon or transfer her to the emergency room when she became lethargic and	F 309		

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F 309	Continued From page 26 could not swallow. During an interview on the afternoon of 09/08/10, an administrative nurse (#7) agreed the nursing staff failed to follow the facility's policy and procedure related to Resident #3's hypoglycemia episodes. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included hypertension and edema. A physician's order dated 06/28/10 stated, ". . . Put in bed [with] legs elevated 2x [times]/day. . . ." Resident #6's most recent care plan stated, ". . . PROBLEM . . . I have swelling in my ankles & feet & my blood pressure is elevated . . . PLANS AND APPROACHES . . . Lay me down in a.m.'s & p.m.'s & elevate feet . . ." Observation on 09/07/10 at 1:24 p.m. showed two CNAs (certified nursing assistants) (#11 and #12) assisted Resident #5 to lie down in bed. The CNAs failed to elevate Resident #5's legs. Observation on 09/08/10 at 9:43 a.m. showed two CNAs (#10 and #11) assisted Resident #5 to lie down in bed. The CNAs failed to elevate Resident #5's legs. An observation on the afternoon of 09/08/10 showed Resident #5 lying in bed asleep without her legs elevated.	F 309		
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	F 323	1) The corrective action accomplished for Residents #3 and #6 found to have been affected by the practice is that a transfer lift assessment has been completed on each resident on 10/13/10. An appropriate lift is being used for each resident and care plans have been reviewed and updated.	10-22-10

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F 323	Continued From page 27 prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/30/09. Based on observation, record review, review of the mechanical lift operating instructions, and staff interview, the facility failed to ensure residents received adequate supervision and assistance to prevent accidents for 2 of 5 sampled residents (Resident #3 and #6) observed during transfers with a sit to stand mechanical lift. This practice placed the resident at risk for injury or pain during the transfers. Findings include: Review of the safety instructions for the Sara 3000 sit to stand mechanical lift occurred on 09/13/10. The instructions stated ". . .intended to be used for raising to a standing position and short transfer of residents (e.g. [such as] raising from bed and transit to wheelchair, or from wheelchair to toilet) . . . Encourage the resident to lean forward slightly to enable the sling to be placed around his/her lower back. Position the sling around the residents's back so that the bottom of the sling lies horizontally about two inches or five centimeters above the resident's waistline . . ." Review of the manufacturer instructions for the Arjo Sara sit to stand mechanical lift occurred on 09/13/10. The instructions stated, "Warning: All	F 323	2) Other residents having the potential to be affected by the same practice have been identified by the DNS querying the MDS 2.0, section G6D, lifted mechanically, to determine appropriate transfer for residents identified. Licensed nursing staff will use the transfer lift assessment to assess residents that were identified for proper lift transfers. Care plans and CNA assignment sheets will be updated as needed. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 10/14/10 by the DNS and the Staff Development Coordinator using the manufacturer's safety instructions on how to utilize lifts appropriately. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that a) appropriate transfer lift assessments have been completed and b) that lifts are being used appropriately for safe resident transfers. These audits will be done weekly x 1 month and monthly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 323	Continued From page 28	F 323		

instruction must be followed to avoid possible injury to patient or operator . . . place the sling round the patient's back so that it lies approximately 50 mm [millimeters] (2") [2 inches] or so horizontally above the waist line . . . Be careful not to raise the patient too high as this could cause unnecessary pressure under the arms. . . . Patients wearing nylon nightdresses/dressing gowns are prone to be 'slippery' - the sling may ride up the back causing pressure under the arms. It may be necessary to hold the sling in position when lifting/lowering. . . ."

- Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included pain and agitation. The admission Minimum Data Set (MDS), dated 06/12/10 identified the resident experienced moderate pain less than daily in her back and "other" (either localized or diffuse pain of any other part of the body), and required extensive assistance of two staff members for transfers.

Observation in the bathing room on 09/06/10 at 7:00 a.m., showed two certified nursing assistants (#1 and #2) assisted Resident #3 after her bath. The resident stood on the lift while the two CNAs dressed her. Observation showed the sling around the resident's waist slipped upward above her breast line and upward into her axillae, causing Resident #3's shoulders to shrug upward and her elbows to bow outward. The resident stated "ow, ow, ow."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included arthritis and anxiety. The most current

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F 323	Continued From page 29 MDS, dated 06/18/10, indicated Resident #6 required extensive assistance from 2 or more staff for transfers and experienced moderate pain less than daily in her head and "other" (either localized or diffuse pain of any other part of the body). Observation of Resident #6's cares occurred on 09/08/10 at 10:11 a.m. Two CNAs (#10 and #11) transferred Resident #6 from the toilet to her wheelchair using a Sara lift. Observation showed the strap around the resident's waist slipped upward across her breasts during the transfer. The strap around the resident's back slipped upward into her axillae, causing Resident #6's shoulders to shrug upward and her elbows to bow outward. Resident #6's knees were bent at an almost 90 degree angle. A CNA (#10) encouraged the resident to stand up straight, but Resident #6 was unable to do so. During an interview on 09/09/10 at 11:00 a.m., an administrative nurse (#3) agreed the CNAs utilized the lifts inappropriately.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide sufficient fluids for 1 of 1 resident (Resident #6) requiring supervision with eating/drinking. Failure to ensure adequate fluid intake may contribute to	F 327	1) The corrective action accomplished for Residents #6 found to have been affected by the practice is that nursing staff have been educated at daily report on 10/13/10 to offer Resident #6 fluids with cares and to encourage Resident #6 to consume more fluids at meals and throughout the day.	10-22-10

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F 327	Continued From page 30 dehydration, delayed wound healing, urinary tract infections, and electrolyte imbalances. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included senile dementia, constipation, a history of urinary tract infections, and a history of pressure ulcers. Medications included Lasix (a diuretic which may cause volume depletion and dehydration), Fentanyl transdermal patch (a pain medication which may cause constipation and dry mouth), and Claritin (an allergy medication which may cause dry mouth). Resident #6's current care plan stated, ". . . PROBLEMS . . . I don't drink enough fluids . . . GOALS . . . I will try to drink 1200 cc [cubic centimeters, i.e. milliliters]/24 hours . . . PLANS AND APPROACHES . . . Offer me fluids with my cares . . . Offer me fluids of choice at meals . . . PROBLEMS . . . I have constipation . . . PLANS AND APPROACHES . . . Encourage me to drink plenty of fluids . . ." Review of Resident #6's "Dining Records" (which staff use to record food, fluid, and supplement intakes for each day) for the months of March 2010 through September 8, 2010 revealed the following: * March - average daily fluid intake was 485 mL (milliliters) * April - average daily fluid intake was 529 mL * May - average daily fluid intake was 592 mL * June - average daily fluid intake was 496 mL * July - average daily fluid intake was 669 mL * August - average daily fluid intake was 648 mL * September - average daily fluid intake was 634	F 327	2) Other residents having the potential to be affected by the same practice have been identified by the DNS querying the MDS 2.0, section J1D, insufficient fluids in the last 3 days. Residents identified will be reviewed by licensed nursing staff for fluid intake by checking the residents' dining intake record. Care plans will be updated with appropriate interventions as needed. 3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 10/14/10 by the DNS using the facility's policy and procedures on hydration and include information on cueing and encouraging fluids with cares and dining. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are offering fluids with cares and at dining. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 327	Continued From page 31 mL Observations of Resident #6 occurred throughout the survey and revealed the following: * 09/07/10 at 1:38 p.m.: A certified nursing assistant (CNA) (#11) offered to assist Resident #6 to the bathroom. Resident #6 refused. A few minutes later, a CNA (#12) re-approached the resident and again offered Resident #6 the bathroom. Resident #6 refused again. Neither CNA offered the resident water or other fluids. Observations of Resident #6 until approximately 3:00 p.m. showed the resident self-propelling in her wheelchair around the nurses' station or sleeping in her wheelchair. Staff did not offer fluids during this time. * 09/07/10 at 4:20 p.m.: Two CNAs (#14 and #13) assisted Resident #6 to the bathroom. At the completion of cares, the CNA (#13) brought Resident #6 to the lounge area. Neither CNA offered the resident water or other fluids. * 09/08/10 at 7:35 a.m.: Resident #6 received her breakfast tray in the dining room. The tray contained 240 mL of water, 240 mL of milk, 120 mL of fiber juice, and 120 mL prune juice, among other foods. At 7:50 a.m., Resident #6 pushed herself away from the table and left the dining room. She drank approximately 180 mL of milk and 60 mL of fiber juice. The other fluids remained untouched. Staff in the dining room failed to cue or encourage Resident #6 to consume more fluids. * 09/08/10 at 11:50 a.m.: Resident #6 finished eating lunch and left the dining room. She drank 120 mL of milk and left the rest of her fluids untouched. Staff in the dining room failed to cue or encourage Resident #6 to consume more fluids. * 09/09/10 at 8:00 a.m.: Resident #6 finished	F 327		

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F 327	Continued From page 32 eating breakfast and left the dining room. She drank approximately 30 mL of fiber juice and 60 mL of milk. Her other fluids (120 mL of prune juice and 240 mL of water) remained untouched. Staff in the dining room failed to cue or encourage Resident #6 to consume more fluids. In an interview on 09/09/10 at 10:35 a.m., a nursing staff member (#7) stated staff "know they are supposed to" offer fluids frequently to Resident #6.	F 327		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334	1) The corrective action accomplished for Residents #6 found to have been affected by the practice is that Resident #6's medical record was reviewed to see if Resident #6 had adverse effects. None found. The infection control nurse and DNS reviewed the facility's policy on 10/8/10 using the procedures on immunizations for residents. 2) The facility recognizes that all residents have the potential to be affected by the same practice. Note: On 9/24/10, all residents and/or responsible parties have been sent information regarding immunizations. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff will be educated on 10/19/10 by the DNS on the use of follow-up cards for all residents identified as requiring an immunization.	10-22-10

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F 334	Continued From page 33 contraindications or refusal. The facility must develop policies and procedures that ensure that – (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced	F 334	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that follow-up cards were used for all residents and required immunizations were completed as needed. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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	355099	A. BUILDING _____ B. WING _____	09/13/2010

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F 334	Continued From page 34 by: Based on record review, review of facility policy, and staff interview, the facility failed to offer an influenza vaccine annually (unless contraindicated) for 1 of 1 sampled resident (Resident #6) who was ill at the time staff offered the vaccine. Failure to offer the vaccine after the resident's illness subsided placed Resident #6 at risk of acquiring influenza and has the potential to transmit influenza to others should Resident #6 become infected. Findings include: Review of the facility policy entitled "Immunizations for Residents" occurred on 09/09/10. This policy, revised October 2007, stated, ". . . 3. Influenza Vaccine . . . b. Annual Influenza vaccinations will be given for all residents for the current year beginning in October. . . . e. . . . Note: If resident is exhibiting signs of respiratory infection such as sore throat, rhinitis cough, or fever and/or is receiving antibiotics, administration of vaccine should be postponed until the infection is resolved. Provide vaccination when the infection is resolved. . . ." Review of Resident #6's medical record occurred on all days of survey. Current physician's orders identified a standing order for the administration of an influenza vaccine and indicated the resident last received the vaccine in October 2008. Resident #6's medical record did not include a record of an influenza vaccine administered for the 2009-2010 influenza season. Nurses' notes indicated Resident #6 experienced a harsh cough productive of green/yellow sputum on or around 10/12/09 which lasted for several weeks. The nurses' notes did not indicate any attempt to	F 334		

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F 334	Continued From page 35 re-administer the influenza vaccine once the resident's illness subsided. During an interview on 09/09/10 at 10:35 a.m., an administrative staff member (#7) stated because Resident #6 was sick at the time staff gave the vaccines, she did not receive hers. The staff member also stated staff did not offer the vaccine to Resident #6 at a later time and that she "got missed."	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions during 3 of 3 days of survey (September 07-09, 2010). Failure to follow proper sanitation and food handling practices has the potential to result in a foodborne illness and may affect all residents who consume food prepared in and served from the facility's kitchen. Findings include: Review of the facility policy entitled "Food	F 371	1) The corrective action accomplished is that a) open spaces on the steam table and all pans containing food are covered to retain proper heat in the steam table; b) the onions found on the floor in the dry storage room have been properly stored on the bottom rack in the refrigerator; c) dietary staff has been reminded and retrained on 10/14/10 by the Dietary Manager to place utensils in a dish rack for air drying; d) cutting boards have been replaced on 9/13/10; and e) dietary staff has been reminded and retrained on 10/14/10 by the Dietary Manager to put on clean aprons before putting away clean dishes. 2) The facility recognizes that all residents have the potential to be affected by the same practice and have been identified as such.	10-22-10

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F 371	Continued From page 36 Temperatures" occurred on 09/09/10. This policy, revised March 2009, stated, ". . . PROCEDURE . . . 5. Hot foods which are potentially hazardous should be served above 135 [degrees] F [Fahrenheit]. . . ." Review of the facility policy entitled "Aprons" occurred on 09/09/10. This policy, revised March 2009, stated, ". . . PROCEDURE . . . 4. Dietary staff are to change aprons between 'dirty and clean sides,' while washing dishes. . . ." Review of the facility policy entitled "Food Storage" occurred on 09/09/10. This policy, revised March 2009, stated, ". . . PROCEDURE . . . 3. In dry storage, all foods will be stored six inches off the floor and away from the wall. . . ." The initial dietary tour occurred on 09/07/10 at 9:15 a.m. Observation showed a large mesh bag of onions stored on the floor in the dry storage room. Observation of tray line occurred on 09/08/10 at 11:40 a.m. Immediately after the final resident received his/her tray (approximately 12:15 p.m.), the surveyor requested a dietary staff member (#5) obtain temperature readings of the foods. The pureed beef measured 122 degrees F. The staff member stated, "It's probably because I have a gap in that pan and the steam is escaping." This allowed steam to escape through the open areas of the pan and caused the water to cool faster. The dietary tour occurred on 09/09/10 at 8:27 a.m. with a dietary staff member (#4). Observation showed the large mesh bag of onions stored on the floor in the dry storage room	F 371	3) Measures put into place to ensure the practice will not recur is that dietary staff will be educated on 10/14/10 by the Dietary Manager on each item addressed and corrected under #1. In addition, the Dietary Manager will use the facility's policy and procedures on how to properly store, prepare, distribute and serve food under sanitary conditions. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary Manager or designee to monitor by using audits that food is properly stored, prepared, distributed and served under sanitary conditions. These audits will be done monthly x 3 months and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 371	Continued From page 37 (as it was during the initial dietary tour). Observation showed four scoops used to serve food contained water leftover from the dish washing process. A dietary staff member (#4) immediately removed the scoops and indicated staff would be wash them again. Observation also showed eight acrylic cutting boards with deep score marks and rough edges (i.e., an uncleanable surface). During observation of the dish washing process, a dietary staff member (#6) placed dirty dishes in a dish washing rack, removed her gloves and washed her hands, and immediately began putting away clean dishes without changing her apron. During an interview on 09/09/10 at 1:00 p.m., a dietary staff member (#4) stated she would store the onions in the walk-in cooler; they just had not been put away yet. She also stated the pans in the steam table were not arranged as they should have been so the pureed meat cooled off.	F 371		
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.	F 441	1) The corrective action accomplished for Residents #3, #5, #6 and #10 found to have been affected by the practice is that all CNA's have been reminded verbally in daily report since 10/8/10 by the DNS regarding proper hand hygiene. In addition, all CNA's that were on duty at the time of the survey (9/7-9/10) will have attended the facility's online training for hand washing by 10/21/10. All nursing staff have been instructed to notice if this practice is occurring so proper corrective action may be accomplished. 2) The facility recognizes that all residents have the potential to be affected by the same practice.	10-22-10

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F 441	Continued From page 38 (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 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 policy, and staff interview, the facility failed to follow infection control practices for 4 of 8 sampled residents (Resident #3, #5, #6, and #10) observed during perineal cares. Failure to follow infection control practices has the potential to spread infection within the facility. Findings include: Review of a facility policy titled "Hand Hygiene and Handwashing" occurred on 09/09/10. This policy revised on July 2009, stated, ". . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for	F 441	3) Measures put into place to ensure the practice will not recur is that nursing staff will be educated on 10/14/10 by DNS or designee, using the facility procedures on hand hygiene and hand washing. Nursing staff will be given a pocket reminder on hand washing. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits that nursing staff are following the facility's hand washing procedures. These audits will be done monthly x 3 and quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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

PRINTED: 10/05/2010
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OMB NO. 0938-0391

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Fax received from Administrator on 10-21-10/1000 hr

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F 441	Continued From page 39 routinely cleaning your hands: . . . * After having direct contact with a resident's skin * After having contact with body fluids, wounds or broken skin * After touching equipment or furniture near the resident * After removing gloves . . ." Review of Resident #3's medical record occurred on all days of survey. The resident's admission Minimum Data Set (MDS), dated 06/12/10, identified the resident required total assistance by staff for personal hygiene. Observation on 09/06/10 at 8:35 a.m., showed two certified nursing assistants (CNAs) (#8 and #9) utilized a full body mechanical lift and assisted Resident #3 to her bed. The CNAs applied gloves and CNA (#8) checked the resident's brief and stated the resident did not require a brief change. The CNAs removed their gloves. The CNA (#9) washed her hands in the resident's bathroom and the CNA (#8) exited the room with the lift and immediately entered another resident room across the hall. The CNA (#8) failed to wash or sanitize her hands after providing cares for Resident #3 and before entering another resident's room. Observation on 09/06/10 at 11:05 a.m., showed Resident #3 laying on her bed and the CNAs (#1 and #8) applied gloves and checked her brief. The CNA (#8) identified the brief as wet and proceeded to remove the brief, change gloves, apply a clean brief, and remove her gloves again. The CNAs utilized a full body mechanical lift and transferred the resident from her bed to the wheelchair. CNA (#1) washed her hands in the resident's bathroom and transferred Resident #3	F 441		

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F 441	Continued From page 40 to the dining room. The CNA (#8) exited Resident #3's room with the lift and immediately entered another resident's room across the hall. The CNA (#8) failed to wash or sanitize her hands after providing cares for the resident and before entering another resident's room. During an interview on the morning of 09/09/10, an administrative nurse (#7) stated she expected facility staff members to wash or sanitize their hands after removing their gloves. - Observation on 09/07/10 at 3:04 p.m. showed two CNAs (#13 and #14) assisted Resident #5 to the bathroom using a Sara lift (a type of sit-to-stand mechanical lift). The CNA (#13) donned gloves and removed Resident #5's incontinent brief (soiled with stool and urine). After providing perineal care for Resident #5, the CNA (#13) wiped the toilet seat (soiled with stool) with an incontinence wipe and removed her gloves. She assisted the other CNA (#14) to transfer Resident #5 into her wheelchair and removed the lift strap around the resident's waist and back. The CNA (#13) then took Resident #5 to the dining room in a wheelchair. Once in the dining room, the CNA (#13) removed hand sanitizer from her pocket and used it to cleanse her hands. - Observation on 09/07/10 at 4:20 p.m. showed two CNAs (#13 and #14) assisted Resident #6 to the bathroom using a Sara lift. After the resident voided in the toilet, the CN (#13) donned gloves and provided perineal care. The CNA (#13) then removed her gloves, assisted the other CNA (#14) with positioning Resident #6 in her wheelchair, and removed the lift straps around the resident's waist and back. The CNA (#13)	F 441		

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F 441	Continued From page 41 brought Resident #6 to the lounge area in a wheelchair. Once in the lounge area, the CNA (#13) removed hand sanitizer from her pocket and used it to cleanse her hands. The CNA (#13) failed to perform hand hygiene after performing perineal cares for residents. - Observation on 09/09/10 showed two CNAs (#15 and #16) gave Resident #10 a bed bath. The resident was incontinent of urine and stool. After cleaning the perineal area, the CNA (#16) placed the wash cloth in the wash basin. At the completion of cares, the CNA (#16) emptied the wash basin into the toilet. The CNA then rinsed the wash basin in the sink and poured the rinse water into the toilet. Rinsing the wash basin in this manner may cause water (contaminated with stool) to splash onto clean surfaces such as the sink, faucet, and/or mirror.	F 441		