STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355102	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 10/12/15 and completed on 10/15/15, the sample included two (2) residents for complete review, seven (8) residents for focused review, and one (1) closed record for review.	F 000		
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		11/19/15

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

Electronically Signed | 11/06/2015

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident status for 1 of 10 sampled residents (Resident #2). Failure to code the MDS correctly for delusions and hallucinations does not provide an accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets those needs. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2015, stated the following: * Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . Check E0100A, hallucinations: if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a	F 278	NCC will complete the MDS assessments with accuracy. 1. Accurate MDS coding of hallucinations/delusions will be completed on resident number 2. 2. Accurate MDS coding of hallucinations/delusions will be completed for all residents. 3. Resident number 2 will have a MDS correction sent in for proper coding of the hallucination/delusion section. All residents will have their last quarterly MDS reviewed for proper coding of hallucinations/delusions. If any errors are noted a correction will be sent in. MDS nurse will double check on all resident's MDS's that hallucinations/delusions are properly coded prior to submission. Education will be provided to nursing staff and those who complete the MDS on proper assessment of hallucinations/delusions, attempt of reality reorientation, proper documentation and coding of the MDS. 4. Completion date November 19. 2015. 5. NCC will monitor a random sample of residents that have hallucinations/delusions for proper documentation and coding on the MDS weekly with monthly summaries x 3, then quarterly by QA Coordinator. (Resident number 2 has passed away)	

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F 278	Continued From page 2	F 278		

delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion."

Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic pain, insulin dependent diabetes mellitus, anxiety disorder and major depressive disorder. The annual MDS, dated 10/01/15, identified moderate cognitive impairment as well as hallucinations and delusions during the seven day assessment reference period.

A social services MDS progress note, dated 10/02/15, stated, ". . . At one point during the interview, she did ask me what all those baby flies were doing on her privacy curtain. Resident has had some delusions and hallucinations over the past couple of weeks. Nursing reported on 9-27-2015 of resident believing her daughter and some friends were drinking and smoking in her room during her last hospital stay. . . ."

"Daily Skilled Nurse Assessments," dated between 09/27/15 and 10/01/15 lacked evidence Resident #2 experienced hallucinations and/or delusions.

During interview on 10/14/15 at 4:25 p.m., a staff member (#2) provided additional information and stated this information lacked the supporting documentation for coding the delusions and hallucinations.

The facility failed to identify if Resident #2 would

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F 278	Continued From page 3 accept a reasonable alternative explanation for the hallucinations and delusions; and lacked documentation to clarify if the same occurred during the resident's hospitalization. The medical record lacked evidence of "potential indicators of psychosis" including hallucinations and delusions.	F 278		
F 281	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 observation, review of facility policy, and staff interview, the facility failed to meet professional standards of quality for 1 of 2 residents (Resident #10) observed receiving insulin by a certified medication assistant (CMA). Failure to confirm the right medication may result in residents receiving the incorrect insulin. Findings include: Review of the facility policy "INSULIN ADMINISTRATION PER CMA" occurred on 10/14/15. The policy, dated 10/15/14, stated "CMA reads the insulin order in the EMAR [electronic medication administration record] . . . draw up insulin as ordered . . . Show the charge nurse the dose of insulin drawn and the vial of insulin. The nurse also needs to confirm correct units with the order. . . ." During observation on 10/13/15 at 9:15 a.m., a	F 281	NCC will provide services that meet professional standards of quality. 1. Accurate insulin preparation by CMA with nurse confirmation will be completed for resident number 10. 2. Accurate insulin preparation by CMA with nurse confirmation will be completed for all residents who receive insulin. 3. CMA's will draw up insulin as ordered, charge nurse needs to verify dose with order and insulin vial (per stated in policy) prior to administration to resident. CMA and nurse sign off on the insulin administered in the EMAR once completed. Education on insulin administration by CMA's policy will be reviewed at Novembers monthly staff meeting. 4. Completion date November 19, 2015. 5. NCC will monitor insulin preparation by CMA's with resident number 10 and a	11/19/15

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F 281	Continued From page 4 CMA (#9) prepared Resident #10's dose of insulin. After withdrawing the ordered dose from the insulin vial, the CMA walked throughout the facility to find the nurse (#8) to verify the insulin. The nurse verified the quantity of the insulin in the syringe but failed to verify the vial of insulin/correct insulin. The nurse failed to confirm correct units with the order. During interview on 10/14/15 at 4:40 p.m., an administrative staff member (#1) stated the procedure included the nurse verifying the vial of insulin prior to the CMA administering the insulin.	F 281	random sample of residents who take insulin weekly with monthly summaries x 3 then quarterly by the QA Coordinator.	
F 309	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/04/14. CONSTIPATION 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 3 of 8 sampled residents (Resident #3, #5, and #6) who lacked timely and consistent interventions for constipation. Failure	F 309	NCC will ensure that the residents receive the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. 1. Bowel assessments and timely interventions, offering least invasive first will be provided to resident numbers 5 and 6 to minimize their risk of	11/19/15

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F 309	Continued From page 5 to assess, identify a pattern, and provide timely as needed (PRN) interventions for constipation may cause increased constipation and discomfort. Findings include: Review of the facility's policy titled "Bowel Protocol" occurred on 10/14/15. This policy, updated February 2015, stated, " . . . 5. The nurse is to monitor resident's bowel records, if two days with no stool offer prune juice, and or dulcolax tabs as on standing orders. If no results continue medicating as indicated on standing orders. . . ." The policy included a form nurses completed that stated, "Check No BM [bowel movement] report every morning. If resident is listed for no bowel movement for two days, you may offer prune juice or give dulcolax tabs. If no result by lunch from prune juice, administer the dulcolax tabs. if resident had dulcolax tabs in the am [morning] and no results in 4-6 hours following administer a dulcolax suppository. *The key to this form is that treatment continues through the shift onto the night shift if needed until we have results." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. Medications included Senna S (a laxative) two tablets by mouth three times daily, hydrocodone-acetaminophen 5-325 milligrams (mg) 1/2 tablet at bedtime (a pain medication which may cause constipation), Dulcolax 5 mg two tablets PRN, and Dulcolax 10 mg suppository PRN. Dietary interventions for constipation included one scoop of fiber basic	F 309	constipation. (Resident number 3 has been discharged) 2. Bowel assessments and timely interventions, offering least invasive first will be provided for all residents to minimize their risk of constipation. 3. All residents will be evaluated for their risk of constipation on admission, quarterly reviews and as needed. Dietary interventions will be implemented to reduce their risk of constipation. Nursing will review bowel movement reports at a minimum at the beginning of their shift and offer interventions as needed, using least invasive first. Care planning will reflect interventions. Education will be provided to nursing staff at the November staff meeting. 4. Completion date November 19, 2015. 5. NCC will monitor residents number 5 and 6 in addition to a random sample of residents that they have bowel assessments and timely interventions, offering least invasive first weekly with a monthly summary x 3 then quarterly by the QA Coordinator. B. 1. Fluids will be provided to resident number 1 in an upright position of 45-90 degrees to minimize their risk of aspiration. (Resident no. 2 has passed away) 2. Fluids will be provided to all residents in an upright position of 45-90 degrees to minimize their risk of aspiration unless otherwise documented as contraindicated. 3. A resident care standards policy has been developed and will be educated on	

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F 309	Continued From page 6 twice daily. Resident #5's BM record and medication administration record (MAR) for August and September 2015 showed staff administered a Dulcolax suppository after three days without a BM on 08/06/15, 08/25/15, and 09/03/15 and after four days without a BM on 08/19/15. Staff administered Dulcolax 5 mg two tablets after three days without a BM on 08/14/15. The record lacked evidence staff offered prune juice on the second day without a BM as outlined in the facility policy and failed to attempt a less invasive measure (oral medication before a suppository) to manage Resident #5's constipation. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation. Medications included MiraLax Powder 17 grams daily, Senna S two tablets twice daily, Dulcolax 10 mg suppository PRN, and Norco 10-325 mg tablet three times a day (a pain medication which may cause constipation). Dietary interventions for constipation included prunes every morning. Resident #6's BM record and MAR for September and October 2015 showed staff administered a Dulcolax suppository after three days without a BM on 09/07/15 and 10/01/15. Staff administered a suppository on the morning of 09/10/15 when the record showed a BM on 09/09/15. The record failed to show staff attempted a less invasive measure (oral medication before a suppository) and followed facility policy to manage Resident #6's constipation.	F 309	at the November staff meeting with CNA's and nurses. 4. Completion date November 19, 2015. 5. NCC will monitor resident number 1 in addition to a random sample of residents that fluids are administered in an upright position of 45-90 degrees to minimize their risk of aspiration on a weekly basis with monthly summaries x 3 then quarterly by the QA Coordinator.	

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- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and constipation. Medications included Senna 8.6 mg daily, a Fentanyl (a pain medication which may cause constipation) patch 50 micrograms (mcg) changed every three days, and hydrocodone-acetaminophen 5-325 mg every four hours PRN.

Resident #3's BM record and MAR for August 2015 showed Resident #3 had a BM on 08/14/15 and 08/20/15 (six days later). The MAR identified staff administered a prn suppository on 08/17/15, prn Dulcolax tablets on 08/18/15, and another prn suppository on 08/19/15. The record also identified Resident #3 had a BM on 08/25/15 and 08/29/15 (four days later). Staff administered a prn suppository on 08/29/15. The record lacked evidence staff offered prune juice on the second day without a BM as outlined in the facility policy. Staff also failed to attempt a less invasive measure (oral medication before a suppository) to manage Resident #3's constipation.

During an interview on 10/15/15 at 9:30 a.m., a supervisory nurse (#1) stated she expected staff to offer Senna or Dulcolax tablets prior to administering a suppository.

SWALLOWING

2. Based on observation, record review, and review of professional literature, the facility failed to ensure 2 of 2 sampled residents (Resident #1 and #2) provided fluids in a recumbent position received the care and services necessary to attain the highest degree of safety possible.

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F 309	Continued From page 8 Failure to ensure a resident with a known risk of aspiration was positioned properly prior to providing liquids may result in aspiration. Findings include: Kozier & Erbs "Fundamentals of Nursing Concepts, Process, and Practice," Ninth Edition, Pearson Education, Inc., copyright 2012, page 1280-1281, identified, "Dysphagia. Some clients may . . . be at risk for nutritional problems due to dysphagia. These clients may . . . aspirate food or fluids into the lungs - causing pneumonia. Clients at risk for dysphagia include older adults . . . Early detection and intervention can prevent the adverse outcomes of dysphagia in most clients. . . ." Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 47, 125, 128 and the educational handouts identified, ". . . During the oral intake of medicines, foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included pneumonia, gastro-esophageal reflux disease, and dementia with behavioral disturbance. A discharge summary from a hospitalization which occurred between 07/08/15 and 07/11/15 identified diagnoses of pneumonia and transient ischemic attack (TIA). The "HOSPITAL COURSE," stated, ". . . He did have	F 309		

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F 309	Continued From page 9 some difficulty swallowing and we did have difficulty advancing his diet. He did have a large amount of coughing and gagging with a regular diet, so he was down-graded to a mechanically altered diet with which he actually did quite well. He did have difficulty swallowing full pills, so medications did need to be administered in applesauce or pudding. After review of his chest x-ray results . . . we did change his antibiotics to Levaquin [antibiotic] to cover pneumonia . . ." Resident #1's current care plan identified a problem of "ASPIRATION PNEUMONIA/TIA: Res. [resident] hospitalized 7/8/15 - 7/11/15. . . Diet changed to mechanical soft. . . ." Approaches included ". . . Provide extra fluids as ordered. Lung assessments as ordered & [and] PRN [as necessary]. . . ." During observation of cares on 10/13/15 at 3:20 p.m., a nurse (#8) provided a drink of water to Resident #1 with the head of the bed elevated to approximately 30 degrees. - Review of Resident #2's medical record occurred on all days of survey. Discharge diagnoses from a hospitalization between 09/23/15 and 09/27/15 included pneumonia. Discharge instructions included a mechanical soft diet. During observation on 10/13/15 at 9:55 a.m., a nurse (#8) provided Resident #2 a drink of water and a drink of a chocolate drink with the head of the bed elevated at approximately 20 degrees.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		11/19/15

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F 312	Continued From page 10 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, record review, and staff interview, the facility failed to provide activities of daily living (ADL) assistance to maintain good hygiene and hydration for 3 of 7 sampled residents (Resident #2, #4, and #7) observed receiving assistance from staff. Failure to ensure fluids are within reach may result in dehydration and urinary tract infections (UTIs), and failure to perform adequate perineal care may result in skin irritation/breakdown. Findings include: - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, constipation, and a history of UTIs. The current Minimum Data Set (MDS), dated 08/18/15, identified limited assistance from one person for transfers and ambulation, and supervision of one person for eating. Observation during the evening of 10/12/15 showed Resident #4 in bed. A water glass sat on the bedside table located across the room from the resident (not within reach). - Review of Resident #7's medical record occurred on all days of survey. Diagnoses	F 312	NCC will provide to residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition , grooming, personal and oral hygiene. A. 1. Fluids will be within reach of resident numbers 4, and 7. (Resident number 2 has passed away) 2. Fluids will be within reach of all residents with limited mobility. 3. Education will be provided to staff at their November staff meeting on the residents with limited mobility for their fluids to be within reach. Careplanning will reflect residents interventions. 4. Completion date November 19, 2015. 5. NCC will monitor residents number 4 and 7 in addition to a random sample of residents that their fluids will be within reach weekly with a monthly summary x 3, then quarterly by the QA Coordinator. B. 1. (Resident number 2 has passed away) 2. Pericares will be completed per policy for all residents who need assist. 3. Education will be completed at November staff meeting for CNA's and nurses on our pericare policy. The contract provider will be educated that	

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F 312	Continued From page 11 included Parkinson's disease and constipation. The current MDS, dated 07/18/15, identified extensive assistance from two or more people for transfers, extensive assistance from one person for locomotion, and supervision/set up help for eating. Observations during the afternoon of 10/13/15 showed Resident #7 in bed. A water glass sat on a table by the window, across the room from the resident and not within reach. During an interview on 10/15/15 at 9:30 a.m., a supervisory nurse (#1) agreed staff should keep fluids within reach for the residents. - Review of Resident #2's medical record occurred on all days of survey. Resident #2's care plan identified a problem with personal hygiene and an approach of "Provide 2 assist with personal hygiene." During observation on 10/13/15 at 9:55 a.m., a nursing staff member (#8) and a health care practitioner (#11) removed Resident #2's incontinence product saturated with urine prior to the application of a dressing to an open area on the resident's coccyx. After the dressing change, the nurse placed a new incontinence product and failed to provide incontinence care.	F 312	she is not to be completing pericares. Care planning will reflect residents interventions. 4. Completion date November 19, 2015. 5. NCC will monitor a random sample of residents that they have proper pericares completed per policy weekly with monthly summaries x 3, then quarterly by QA Coordinator.	
F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		11/19/15

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	355102	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAPOLEON CARE CENTER	311 E 4TH ST NAPOLEON, ND 58561

(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 314	Continued From page 12 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services for 1 of 3 sampled residents (Resident #1) identified with pressure ulcers. Failure to assess, identify and monitor all wounds, venous and/or pressure, may result in unrecognized changes, delayed implementation of treatment, and delayed healing. Findings include: Review of the facility policy "PRESSURE ULCER STAGES AND INTERVENTIONS" occurred on 10/15/15. This policy, dated 04/14, stated, "POLICY: The facility will take steps to prevent the occurrence of pressure sores and to treat the sores that do develop in a systematic approach. . . . All stage 2 and greater pressure ulcers will result in documenting in the wound assessment wizard (WAM) for that resident on a weekly basis. . . . Documentation is discontinued when ulcer is healed." Review of the facility policy "DECUBITUS (PRESSURE ULCER) PREVENTION AND MONITORING" occurred on 10/15/15. This policy, dated 03/09, stated, ". . . PROCEDURE: 1. All residents admitted at risk for pressure ulcers will be placed on . . . skin monitoring . . . At	F 314	NCC will ensure that residents who enter the facility without pressure sores do not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote wound healing, prevent infection and prevent new sores from developing. 1. Routine assessment, identifying and monitoring all wounds will be provided for resident number 1. 2. Routine assessment, identifying and monitoring all wounds will be completed for all residents. 3. All residents will be assessed on admission, quarterly and as needed for pressure ulcers. Proper documentation with weekly measurements in the WAM (wound assessment manager) will be completed for resident number 1 and all residents who have stage 2 or greater pressure ulcers. Education will be provided to the nurses at their November staff meeting re: identifying, assessing and documenting in the WAM. Education will be provided to the CNA's at their November staff meeting on prevention and reporting of pressure ulcers. 4. Completion date November 19, 2015.	

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F 314	Continued From page 13 least weekly written assessments including location, stage, odor, color, size, drainage, response to treatment. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a chronic stage 4 pressure ulcer to the left heel, type II insulin dependent diabetes mellitus, anemia, peripheral vascular disease, and chronic kidney disease. Health care practitioner orders included to measure and document all wounds to the left lower extremity. Review of Resident #1's quarterly Minimum Data Set (MDS), dated 10/07/15, identified the resident had one stage 3 pressure ulcer, no stage 4 pressure ulcers, infection of the foot, diabetic foot ulcer(s), and "Skin/ulcer treat: apply dressings to feet." A yearly MDS, dated 06/11/15, identified the resident had one stage 2 pressure ulcer which developed on 02/16/15, infection of the foot, and diabetic foot ulcer(s). Resident #1's care plan identified a problem of "ACTUAL SKIN BREAKDOWN" and identified on 08/25/15, "All ulcers healed except L [left] heel ulcer. . . ." Approaches included "Monitor for L foot healing. 9/2/15 Cellulitis to top of L foot (pre ulcer). Healed 10/12/15." Departmental notes (progress notes) and "Wound Assessment Reports [WAR]" identified the following: * A progress note, dated 09/07/15, stated, "With dressing change nurse did notice top of foot to be red to pink in color with this area measuring 12.5 cm [centimeters] wide by 12 cm long. Resident did have a few scabbed areas to top of foot	F 314	5. NCC will monitor resident number 1 in addition to a random sample of residents that have stage 2 or greater pressure ulcers that they have appropriate treatment, and weekly measurements completed to promote healing, and that the MDS is coded correctly from WAM and wound documentation weekly with monthly summaries x 3, then quarterly by QA Coordinator.	

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F 314	Continued From page 14	F 314		

measuring 1.5 cm by 0.5 cm and 0.7 x 0.9 cm and one that measured 2.2 cm in diameter and 4 smal [sic] areas each with a diameter no greater than 0.2 cm. . . . Ulcer to the inner left heel . . . and to the more lateral aspect of the heel. . . ." The note included measurements of the ulcer to the inner left heel. Progress notes and/or the WAR following this note failed to identify a weekly assessment of the area on the top of the foot, the ulcer to the inner left heel and the lateral aspect of the heel. A WAR, dated two days later, identified the top of the foot healed. A progress note, dated 09/13/15, stated: ". . . tip of left great toe more irritated today more red, this is one of the toes that had a bandaid on . . . and had toenails trimmed, covered with 4 x 4 for added protection." A WAR failed to identify and include an assessment of the toe.

* 09/23/15 and 09/16/15: A WAR included treatment of a dry 4 x 4's to the "top of the [left] foot." Neither assessment included a description of the area on the top of the foot, the left great toe, the ulcer to the inner left heel and the lateral aspect of the heel.

* 09/25/15: A progress note lacked an assessment of the "tip of the left great toe" identified in the 09/13/15 progress note, and the ulcer to the inner left heel and the lateral aspect of the heel.

* 09/28/15: A progress note noted the ulcer to the left heel and lacked an assessment of the area on the top of the foot, and the ulcer to the inner left heel and the lateral aspect of the heel.

* 09/30/15: The WAR identified treatment of a dry

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F 314	Continued From page 15 4 x 4 dressing to the top of the foot and failed to identify if a change had occurred to the area on the top of the left foot, and lacked a description or treatment of the ulcer to the inner left heel and the lateral aspect of the heel. * 10/07/15: The WAR identified treatment of a wet to dry dressing to the heel, and failed to identify/describe if a change had occurred to the area on the top of the left foot, and the ulcer to the inner left heel and the lateral aspect of the heel. * 10/14/15 progress note: "Resident has a discolored area to the top of his left foot. The area measures 7 cm x [by] 4.5 cm and is different shades of purple. There was a dry scab to the top of the left foot that fell off when foot cares were completed. No open areas noted underneath the scab. . . ." (Neither the progress notes and/or the wound assessments following the identification of "red and pink" tissue and scabbing on 09/07/15 included an assessment of these areas including healing or lack of healing). A WAR, dated 10/14/15, did not include a description of the scab, or the ulcer to the inner left heel and the lateral aspect of the heel. During interview on 10/14/15 at 3:10 p.m., the staff nurse (#10) who entered the above assessment confirmed the presence of a scab on the top of the left foot and stated with dressing changes measurements were not taken of the scabbed areas on the top of the foot. During observation of cares on 10/13/15 at 3:20 p.m., a staff nurse (#8) removed a gauze wrap dressing from Resident #1's left foot. The dressing contained a small amount of serous	F 314		

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F 314	Continued From page 16 (clear drainage) and a slight amount of reddish drainage. The nurse wet a gauze pad with a wound cleaner and cleaned the heel and also the scabbed area/wound on the top of the foot. The nurse then placed a gauze dampened with saline onto the heel and the top of the foot and secured the dressings with a kling wrap. Observation also showed a dry scab on the tip of the great toe on the left foot. During interview on 10/15/15 at 10:55 a.m., a staff member (#2) stated a separate WAR is required for each identified pressure/wound area. The progress notes and/or WAR lacked consistent assessments, on a weekly basis, of all wounds identified on the left lower extremity. Failure to identify, assess, and monitor these wounds may result in unrecognized changes, and delayed treatment and healing.	F 314		
F 323	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/04/14. Based on observation, record review, and staff	F 323	NCC will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and	11/19/15

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F 323	Continued From page 17 interview, the facility failed to provide necessary supervision and assistive devices to prevent accidents for 2 of 5 sampled residents with falls (Resident #5 and #7). Failure to consistently implement fall prevention measures (Resident #7) and ensure appropriate transfer methods (Resident #5) placed these residents at risk for falls and/or injury. Findings include: - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included Parkinson's disease and a history of falls. The current Minimum Data Set (MDS), dated 07/18/15, identified moderately impaired cognition, extensive assistance from two or more people for transfers and bed mobility, and extensive assistance from one person for locomotion. Nurses' notes identified the following: *04/19/15 at 5:14 p.m.: ". . . 1545 [3:45 p.m.] res [resident] playing with bed remote and had bed in the highest position and laying of [sic] bed on his stomach with his feet hanging over the edge of the bed . . ." *06/29/15 at 7:21 p.m.: ". . . 1715 [5:15 p.m.] Resident with a fall while attempting to transfer self from his bed to his w/c [wheelchair]. CNA [certified nursing assistant] was in prior to incident asking if resident wanted to get up. Resident denied. Left to rest in bed as they went to care for another resident. A few minutes later residents bed alarm/call light went off. Found that resident had raised his bed quite high (he states its easier for him to transfer when it's higher) and resident was sitting on floor with legs extended in	F 323	assistance devices to prevent accidents. 1. Fall prevention measures will be in place for resident number 7, and appropriate transfer methods will be in place for resident number 5. 2. Fall prevention measures will be in place for all residents who are fall risk. Appropriate transfer methods will be in place for all residents. 3. All residents on admission and as needed are assessed for fall risk. Fall precautions are put into place and careplanned. Bed controls will be kept out of reach if residents have impaired cognition and have shown improper use of the bed control. Residents are assessed on admission, quarterly and as needed for proper transfers. Transfers are careplanned and placed in the CNA FYI section in the LTC found on the computer kiosk, in addition to being communicated in verbal shift report when changed and or updated. 4. Completion date November 19, 2015. 5. NCC will monitor resident number 7 and a random sample of residents that fall precautions are in place as care planned weekly with a monthly summary x 3, then quarterly by QA Coordinator. NCC will monitor resident number 5 and a random sample of residents that transfers are completed as ordered and care planned weekly with a monthly summary x 3, then quarterly by QA Coordinator.	

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F 323	Continued From page 18 front of him with back against fridge. . . . Reminders given to resident to utilize call light, wait for help, and not to raise his bed so high. . . ." *07/26/15 at 7:57 p.m.: ". . . 0645 [6:45 a.m.] Resident was found on floor in his room. . . . When nurse entered room noted bed to be raised in a high position and resident lying on floor on right side resting on right hip and elbow with right arm extended and hand grasping tightly on spoke of rear w/c tire. Resident states was trying to get to the bathroom. . . ." *07/27/15 at 3:49 p.m.: ". . . Visited with resident today regarding the use of an alarmed pelvic belt for his safety as has had many near misses and falls. In addition, lately resident has been raising his bed quite high and then attempting to transfer which equals falling from more than average heights. . . . I also visited with resident about keeping bed controls out of reach when resident is in bed. Agreed to this. . . ." *08/12/15 at 12:42 p.m. (Occupational Therapy note): ". . . Resident was seen today on follow up. . . . Staff have removed the controls of the bed as he is not consistent with positioning himself with these controls and has been none [sic] to place himself at risk for injuries and falls. . . . Agree with staffs decision to keep the bed controls out of reach as he is not able to consistently use this device safely. . . ." *09/30/15 at 4:57 p.m.: ". . . 1620 [4:20 p.m.] Residents bed alarm was going off. When CNA entered room noted bed was raised about 3 ft [feet] - 4 ft into the air with HOB [head of bed] at 90 degrees. Resident was standing up with back towards his bed and facing roommates bed. . . . Med [medication] aide reports that at 2 p.m. the bed control was out of his reach when she was in	F 323		

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F 323	Continued From page 19 the room. . . ." Resident #7's current care plan lacked the fall prevention measure of keeping the bed control out of reach. Observations during the afternoon of 10/13/15 and the morning of 10/14/15 showed Resident #7 in bed. The bed control was located along side rail next to the resident (within reach). During an interview on 10/15/15 at 9:30 a.m., a supervisory nurse (#1) verified staff should keep the bed control out of Resident #7's reach. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and history of a cerebral vascular accident (stroke) and falls. The quarterly MDS, dated 07/07/15, identified severely impaired decision making and extensive assist of two or more staff for transfers, bed mobility, and toileting. The current care plan stated, "Transfer w/ [with] 1 assist and standing mechanical lift. . . ." Observation on 10/13/15 at 1:05 p.m., showed two CNAs (#3 and #4) transferred Resident #5 from his wheelchair to his bed using a gaitbelt. During an interview on 10/15/15 at 10:40 a.m., a supervisory nurse (#1) verified staff failed to follow the careplan and use the standing mechanical lift for Resident #5's transfer.	F 323		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		11/19/15

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F 456	Continued From page 20 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure timely availability of all supplies necessary for utilization of 1 of 1 suction machine. Failure to ensure all necessary supplies were immediately available placed residents requiring suction at risk of harm. Findings include: On 10/14/15 at 5:00 p.m. observation, including location and demonstration of proper use, of a facility suction machine available for emergency use occurred. The nurse (#10) identified the location of the machine in a storage room near the nurse's station. Observation showed the machine located on top of a storage cart and no suction catheters/yankauer tips available for suctioning with the machine. The nurse (#10) could not locate the necessary supplies and demonstrated difficulty opening a supply cabinet adjacent to the cart which the nurse indicated contained the supplies. Unable to open the supply cabinet, the nurse exited the storage room and found another staff member (#9) to assist. This process of searching and obtaining the necessary supplies took approximately five minutes before the suction machine was functional and available for use in an emergency. During interview on 10/15/15 at 10:00 a.m., an administrative staff member (#1) agreed necessary items needed for suctioning should be	F 456	NCC will maintain all essential mechanical, electrical and patient care equipment in a safe operating condition. 1. The suction machine cart will be stocked and readily accessible for emergency use. 3. Night nurses will be checking the cart one night a week to assure it is properly stocked. All nurses will be responsible to restock the cart after use. Education will be provided to the nurses at their November staff meeting. 4. Completion date November 19, 2015. 5. NCC will monitor the suction machine cart, supplies and night nurse sign off sheet weekly with a monthly summary x 3, then quarterly by QA Coordinator.	

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F 456	Continued From page 21 available for immediate access with the suction machine.	F 456		