STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

(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 The Standard Medicare/Medicaid recertification and complaint survey started on 05/13/19 and concluded 05/16/19.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		6/12/19

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

Electronically Signed | 05/30/2019

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 1 supplemental resident (Resident #37) reviewed for advance directives. Failure to discuss the resident's advance care planning wishes, including resuscitation status, procure physician's orders reflective of the resident's wishes, and ensure the resident's medical record reflected his/her wishes regarding life-sustaining procedures limited the facility's ability to communicate to direct care staff and emergency personnel the residents' wishes in the event of a medical emergency. Findings include: Review of Resident #37's medical record occurred on May 13-14, 2019. The care card identified Resident #37 as a Code Level 2 (Do Not Resituate). The physician orders stated, ". . . CODE LEVEL 1 [Full Code] . . ." Resident #37's face sheet (pertinent resident information, including emergency contacts and POA [Power of Attorney]) identified the resident as a Full Code - Do Not Intubate. The facility failed to updated the care card to reflect resident's wishes for a Full Code.	F 578	Resident #37 medical records were reviewed to assure the correct code level is consistent between the face sheet, physician□s order, and the facility code level paper form. Consistency was determined. It was decided that nursing would no longer display code level on the CNA care cards. The CNA care card template has been revised and each resident has received a new care card. Education and instruction of this new change of practice has been provided to the nursing staff and will be completed by 6-10-2019. To assure that all residents have the accurate code level displayed on their charts, all charts were reviewed to ensure consistency throughout the face sheet, physician□s order, and the facility code level paper form, no further discrepancies were noted. Code status on the resident□s face sheet will also be reviewed at each resident□s care conference, any discrepancy noted between the face sheet, physician□s order, and facility code level sheet will immediately be corrected by Social Services or a Nursing Professional. A Nursing Professional will monitor code	

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F 578	Continued From page 2 During an interview on the morning of 05/16/19, an administrative staff member (#1) agreed the care card and the physician orders/facesheet code status failed to match.	F 578	level consistency on 3 resident charts per month for 3 months, then quarterly thereafter until compliance is determined, for a minimum of 6 months. This data will be submitted and reviewed by the QAPI committee on a monthly basis.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		6/12/19

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F 609	Continued From page 3 by: Based on review of facility policy and staff interview, the facility failed to ensure a possible violation involving neglect was reported immediately to the State Survey Agency and the results of the investigation were reported within five working days for 1 of 1 sampled resident (Resident #36) who experienced a fall in the facility van. Failure to identify Resident #36's fall may have resulted from neglect, report the incident, and report the results of the facility's investigation to the State Survey Agency per the facility's policy, placed Resident #36 and other residents at risk for possible neglect and/or injury. Findings include: Review of the facility policy titled "Abuse Prohibition/Elder Justice Act" occurred on 05/16/19. This policy, revised July 2017, stated, ". . . Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. . . . When suspicion . . . or reports of . . . neglect . . . occur, an investigation is immediately warranted. Once the resident is cared for the initial reporting has occurred an investigation is to be completed. . . . Final Written Investigation Report (within five working days) must be submitted . . ." During an interview on 05/16/19 at 10:45 a.m., when asked questions pertaining to Resident #36's fall in the facility van, an administrative nurse (#1) confirmed the facility failed to identify Resident #36's fall may have resulted from neglect and therefore failed to report the incident to the State Survey Agency, complete a thorough	F 609	For resident #36, a report of possible abuse/ neglect will be filed. The elder justice act policy was reviewed. It was updated to include guidance for all staff in the event that an accident occurs while the resident is under the care of NDHC. This includes motor vehicle accidents. Education was provided to the department managers at the May 29 monthly managers meeting. Further, in any situation that a resident is transferred to an emergency room, an incident report will be completed and the incident will be investigated to determine whether or not abuse and or neglect occurred. The definition of an accident was added to the policy. The director of nursing or their designee currently review all incident reports. If any of the incidents meet the criteria established in the policy, the DON or designee will initiate an investigation in coordination with social services per the elder justice act facility policy. The director of nursing or their designee will review 100% of incident reports. A summary of their review will be part of the nursing department quality assurance and reported monthly to the quality assurance committee for a period no less than 6 months.	

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F 609	Continued From page 4 investigation into the fall, and report the results of their investigation to the State Survey Agency. Facility staff failed to immediately report Resident #36's fall with injuries to the State Survey Agency and failed to report the results of their investigation within five working days of the incident. Refer to F689.	F 609		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		6/12/19

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F 657	Continued From page 5 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the current status for 6 of 14 sampled residents (Resident #3, #11, #14, #23, #24, and #36) and 2 supplemental residents (Resident #27 and #138). Failure to revise the care plans limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Patient/Resident Care Policies" occurred on 05/16/19. This policy, revised February 2018, stated, ". . . Care Plan will be developed, implemented, evaluated and revised [as needed] for every resident admitted to Long Term Care, and Swing Bed . . . identifies resident strengths, weaknesses, and problems . . . identifies measurable and objective goals . . . outlines instructions for resident care . . enabling continuity of care . . . approaches or interventions: directions for care. . . ." - Review of Resident #3's medical record occurred on all days of survey. The current physician orders stated, ". . . oxygen @ 2-4 L [liters]/MIN [minute] per nasal cannula O2 [oxygen] to be on continuous . . ." The current care plan stated, ". . I use PRN. [as needed] O2 per nasal cannula. I have anxiety, and COPD [chronic obstructive pulmonary	F 657	For resident number #3, 11, 14, 23, 24, 36, 27, and 138, medical records were reviewed and care plans were revised as to display and communicate care needs and ensure continuity of care for each resident. Resident #3 care plan was adjusted to reflect the continuous use of oxygen. #11 care plan was adjusted to include signs and symptoms related to diabetes and his use of anticoagulants. #14 care plan was adjusted to identify the need for bilateral splints as resident allows. #23 care plan was adjusted to remove the use of PRN Ativan, to include the use of oxygen, and address current skin issues. #24 care plan was adjusted to remove the section addressing the need for a medication. #36 care plan was adjusted to reflect resident as a non-smoker. #27 care plan was adjusted to identify the care and interventions for diabetes. #138 care plan was adjusted as so the care plan and CNA care card displayed matching physician orders. In order to display and communicate care needs and ensure continuity of care for each resident, all resident□s care plans have been reviewed and updated as needed. To assure that all residents maintain accurate care plans, in addition to departmental staff reviewing and updating care plans on an as needed basis, an email will be sent out each week to the email group Provider Rounds	

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F 657	Continued From page 6 disease] . . . O2 on per nasal cannula at 2 liters as needed . . ." The facility staff failed to revise Resident #3's care plan to reflect the continuous use of oxygen. - Review of Resident #11's medical record occurred on all days of survey. The current physician orders stated, ". . . Victoza . . . Give 1.2 mg [milligrams] subcutaneous daily . . . NovoLog . . . Give 24 units NovoLog insulin after meals . . . Accuchecks . . . check blood glucose 3x [times]/day one day weekly . . . Warfarin [anticoagulant] . . . 5 mg by mouth Monday and 2.5 mg by mouth all the other days" The current care plan stated, ". . . I receive insulin injections for Diagnosis of Diabetes . . . Give insulin as ordered . . . Blood sugars as ordered . . . Offer privacy . . ." The facility staff failed to include signs/symptoms related to diabetes and failed to address on Resident #11's use of anticoagulant on the care plan. - Review of Resident #14's medical record occurred on all days of survey. The current physician orders stated, ". . . Splint to left hand as resident allows, remove for hand washing and bathing. Ensure that hand is dry when splint is placed. . . ." Observation on all days of survey showed Resident #14 with bilateral hand splints. The current care plan stated, ". . . wears left hand splint as she will allow. Remove for hand hygiene. . . ." The facility staff failed to identify Resident #14's need for bilateral hand splints. During an interview on 05/16/19 at 10:45 a.m., an administrative nurse (#1) confirmed "[Resident	F 657	Group. This group consists of the MDS/Care Plan nurse, Social Worker, Director of Nursing, Assistant Director of Nursing, Dietary manager, Activities manager, QA nurse, and SCU nurse coordinator. This email will indicate and remind those in the group, which residents were seen by their provider that week and the need to check for updated orders and/or new communication that could potentially require an adjustment to the resident□s care plan. In addition, upon approaching the resident□s quarterly review meetings, the care plans will be reviewed with a CNA. The Care Plan Team will also offer to review it with the resident representative during their quarterly care plan meeting. Education was provided to department managers on May 29 at our monthly meeting as well as to the MDS/Care Plan nurse, SCU nurse coordinator, and the QA Nurse. A nursing professional(s) will monitor care plan continuity of care on 100% of care plans for the month of June 2019. If progress meets standard, for the 3rd quarter of 2019, 75% of the care plans will be monitored. If progress meets standard, 50% of the care plans will be monitored for the 4th quarter of 2019. If progress meets standard, 25% of the care plans will be monitored in the first quarter of 2020. If progress meets standard, the DON or designee will select 1 care plan per quarter through the rest of 2020 for compliance. If at any point, the standard is not met in a monitoring period, the prior quarter□s percentage of care plans	

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F 657	Continued From page 7 #14] does have bilateral hand splints." - Review of Resident #23's medical record occurred on all days of survey. The current physician orders stated, ". . . oxygen at 2-4 L/min per nasal cannula . . ." and lacked evidence resident is currently on PRN Ativan. Review of the electronic treatment administration record (eTAR) showed Resident #23 received a dressing change to lesion on right side of face every 3 days started on 04/02/19 and changed the dressing change to every shift on 05/07/19. The current care plan stated, ". . . Currently my skin is in good condition. My skin is fragile and I bruise easily . . . Observe her skin daily for any skin impairments or problems, Inform the nurse as needed . . . I have anxiety I take PRN Ativan . . ." The current hospice care plan stated, ". . . Skin/Membrane Impaired due to Disease progression . . . Assess and monitor progress of wound/ulcer healing . . . Assess wound at each visit . . . Collaborate with facility staff re: [regarding] pt's [patient's] care needs at each visit . . . Establish skin care regimen Current wound care is cover with telfa and mefix tape, ongoing assessment . . ." The facility staff failed to update Resident #23 care plan related to use of PRN Ativan and oxygen use. The facility care plan and hospice care plan failed to match skin related issues. - Review of Resident #24's medical record occurred on all days of survey. Although Resident #24 was diagnosed with an adjustment	F 657	monitored will be maintained.	

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F 657	Continued From page 8	F 657		

disorder/depressed mood, the current physician orders identified she did not require the use of an antidepressant.

The current care plan stated, ". . . I have a diagnosis of dementia and depression . . . I am on an anti-depressant. . . ." The facility staff failed to update Resident #14's care plan, removing the section addressing the need for a medication.

During an interview on 05/16/19 at 10:45 a.m., an administrative nurse (#1) confirmed "[Resident #24] does not [receive] an antidepressant."

- Review of Resident #27's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The current physician orders showed Lantus (insulin) 100 un/ml give 18 units every night and blood glucose checks three times per week. The current care plan failed to identify care and interventions for diabetes.

- Review of Resident #138 occurred on May 13-14, 2018. The current physician orders stated, ". . . pureed diet as tolerated . . . Osmolite 1.5 CAL [calories] . . . tube feeding . . . 65 mL [milliliters]/ hour . . ." The current care card stated regular diet. The current care plan stated, ". . . April 2019: I will have a tube feeding placed due to medical concerns with an ulcer in my stomach . . . Eating - I need set up with assistance of 1 eating meals and snacks . . . I currently have a new placement of a Jejunostomy feeding tube . . ."

The facility staff failed to update Resident #138 care plan and care card to match the physician orders.

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F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. 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 individualized, meaningful activities for 1 of 14 sampled residents (Resident #31) dependent on staff for activity participation. Failure to implement an individualized program to meet the interests/needs of dependent residents may have a negative affect on their overall well-being. Findings include: Review of the facility policy titled "Resident Activities" occurred on 05/16/19. This undated policy stated, ". . . The Activities Director coordinates the programs designed to promote physical, social and mental well-being of the resident in this facility. . . . Programs are organized to stimulate self-care, resumption of normal activities, and psychosocial functioning. . . . The religious preferences of residents . . . is strongly recognized and involvement encouraged. . . ."	F 679	Upon admission or as needed, the facility will interview each resident and / or their family to determine their preferences and interests. These findings will be documented in the residents activity interest, MDS assessment, and will be included in their comprehensive care plan. This interview, may identify low activity tolerance residents. When low tolerance activity residents are identified, one to one visits will be initiated and added to the weekly interdisciplinary meeting agenda for review. The residents activity of interest or preferred activities as identified will be part of the activity care plan and scheduled as one to one visits or if applicable be part of group activities. For resident #31 and all other similarly identified residents, the manager of activities or designee will chart a note that the resident has been identified as a low	6/12/19

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F 679	Continued From page 10 - Review of Resident # 31's medical record occurred on all days of survey. Diagnoses include cerebral infarction with hemiplegia. The current care plan stated, " . . . Please visit me during 1-1 Personal Visits. . . . The topics are also good in conversation with me. . . . My wife and I have 4 children. I worked as a farmer. I am of Lutheran Faith and of Scottish Heritage. It is important to me to have music to listen to that I enjoy. I like country western music. Having pets around to see is important to me. I like dogs. It is important to me to do things with groups of people and do my favorite things. I am interested in airplanes and sports. Participating in religious services is also important to me. I like children, being with family, visiting, watching movies and TV, bingo and cards, pets, gardening, hunting and sports. I like major league baseball. I also like to go on van rides and going to restaurants. . . ." Observations the week of May 13-16, 2019 showed the following: * 05/13/19 at 4:32 p.m. and 05/14/19 at 7:45 a.m. and 9:05 a.m., Resident #31 sat in his wheelchair near the RN station/TV. * 05/14/19 at 11:00 a.m. and 12:45 p.m., Resident #31 lay in bed. * 05/14/19 at 4:08 p.m., Resident #31 sat in his wheelchair in his room. * 05/15/19 at 10:10 a.m., Resident #31 lay in bed. * 05/15/19 at 10:25 a.m., Resident #31 sat in his wheelchair near the RN station/TV. No observations were made of Resident #31 participating in an activity during the survey. The Activity Participation Logs identified the	F 679	tolerance activity resident and recommended interventions. At the weekly interdisciplinary meeting, low tolerance residents will be part of the standing agenda. Any currently identified residents as well as any other residents potentially in this area will be addressed to identify activities for the resident to participate in, whether they be one to one□s or group activities. The activity department is represented at this meeting as well as other members of the care team that regular observe resident activity. The goal will be 5 to 7 activities per week. At the weekly meeting, a review of prior week suggested activities will be evaluated for their effectiveness. The activity department was educated on low tolerance activity residents, their needs, and the recommended plan of correction. Education to all staff will be provided in the daily briefs on how they can support resident activities. The manager of activities or designee will monitor the activity level of participation of 100% of identified resident each month for the first quarter. For quarters 2, 3, and 4, residents will be monitored one month per quarter. In addition to discussing at the weekly interdisciplinary meetings, the manager or designee will report the results to the monthly Quality Assurance meeting.	

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F 679	Continued From page 11 following: * April 1-30, 2019 - 10 days with an activity, a "personal visit" from staff on seven occasions and a "visitor" on three occasions. Documentation also showed "bed, recliner/room, or recliner/nurses' station" listed 48 times, "nurses' station/people watching" listed nine times, and "bath" listed once. * May 1-14, 2019 - five days with an activity, a "personal visit" from staff on five occasions and "mail" on one occasion. Documentation also showed "bed or recliner/nurses' station" listed 20 times, "nurses' station/people watching" listed four times, "bath" listed three times, and "mail" listed once. During an interview on the morning of 05/16/19, two Activity staff members (#6 and #7) stated staff are expected to visit with the residents for approximately 10-15 minutes. Facility staff failed to provide an individualized, meaningful activity program for Resident #36. Staff visited Resident #36 up to one hour-45 minutes during the month of April and one hour-15 minutes during the first two weeks of May.	F 679		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		6/12/19

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F 689	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility job description, and resident/staff interviews, the facility failed to provide the necessary assistance to prevent a fall with injury for 1 of 1 sampled resident (Resident #36) who experienced a fall in the facility van. Failure of the facility to ensure staff transporting Resident #36 had the necessary training resulted in Resident #36 experiencing an unwitnessed fall resulting in swelling, a 16 x 20 centimeter (cm) bruise to his right pectoral muscle, and increased discomfort/pain. Findings include: Review of the job description titled "Transportation Aid" occurred on 05/16/19. This policy, dated 2017, stated, ". . . Operates medical equipment in treatment and delivery of patient/resident care . . . operate [Facility] vehicle . . . large percentage of the work is done within the van in transporting residents to out of the facility appointments . . ." During an interview on 05/14/19 at 1:50 p.m., Resident #36 (identified by the facility as interviewable) stated his "left hip hasn't been the same since" he fell out of his wheelchair during an accident in December. Review of Resident #36's medical record occurred on all days of survey. Diagnoses including left above-knee amputation and pain. The quarterly Minimum Data Set (MDS), dated 09/30/18 (prior to the accident), identified intact cognition, extensive assist of one required for	F 689	An accident investigation was completed and submitted to the North Dakota Health Department. To ensure Resident #36 and all other residents whom are transported by the facility van receive the care and services necessary to attain the highest degree of safety possible, to ensure van equipment is working properly, and to ensure staff receive training specific to the van equipment, the facility policy Vehicle, Driver, and Client Safety has been established. The Driver Daily Safety Checklist has been developed and initiated. The Transportation Van Initial and Annual Competency Checklist has been initiated. All current transportation van staff will meet compliance by 6-10-2019. The policy Abuse Prohibition/Elder Justice Act investigation/reporting/response section has been updated to include the following statement: in the event that an accident occurs while a resident is under the care of NDHC, including but not limited to a resident being transferred to an ER, a report will be initiated and fully investigated as to rule out or substantiate abuse and/or neglect. Nursing and transportation staff will be educated on these policies and procedures by 6-10-19. The manager of nursing or designee will monitor 100% of the daily checklists and driver competency reviews for the first 90 days. If satisfactory, the quality assurance will be done one month per quarter for the	

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F 689	Continued From page 13 locomotion off the unit, zero falls since previous assessment, occasional pain, and received scheduled pain medications. The current care plan stated, ". . . I need assist with . . . my cares due to my mobility issues . . Right foot rest on wheel chair at all times . . . transport to dialysis . . . facility transports me to these appointments . . ." The progress note identified the following: * 12/19/18 at 4:29 p.m., "PC [Plan of Care] from [facility] ER [Emergency Room] department at 2:00 p.m. Nurse states resident was discharged and had went to dialysis. Resident has large hematoma to right pectoral muscle. Recommend compression and ice. Resident to f/u [follow up] with primary for MRI [magnetic resonance imaging]. . . ." * 12/19/18 at 8:04 p.m., "Resident returned to facility at 6:15 p.m. with facility van driver following dialysis appointment in Grand Forks. Resident complained of being 'sore all over' following motor vehicle accident in facility van while out of facility. Skin assessment completed upon return. Resident's right pectoral muscle is swollen and tender to touch and has scattered purple bruising over area measuring 16 cm x 20 cm, resident stated it was from the seatbelt during the vehicle accident. . . ." * 12/20/18 at 10:50 a.m., "Resident stated he is a bit sore today, really notices it while laying in bed and attempting to turn, stated he needed assistance turning in bed. Requested an ice pack to right chest, given at 10:30 a.m., area swollen, tender." * 12/20/18 at 1:57 p.m., "C/O [Complained of] left hip and left side chest discomfort when in bed	F 689	balance of the year.	

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this a.m. . . ."
* 12/20/18 at 9:00 p.m., "Resident complains of pain with repositioning. Pain meds [medications] given as ordered. . . ."
* 12/21/18 at 4:04 p.m., "3:30 p.m., Returned from dialysis. Facility van driver informed nursing he [Resident #36] had brought himself to the ER to have his left hip pain addressed post MVA [motor vehicle accident]. Upon waiting at the ER resident decided to just return to facility with van driver and get his pain medication here.
Follow-up note from ER that resident to follow-up with [Physician] in 2-3 days. May use ice paks [sic] prn [as needed]. If he develops increased pain, swelling, or trouble breathing please return to ER. . . ."
* 12/22/18 at 2:02 p.m., "Resident requested Aspercreme x [times] 2 to chest, left hip and left stump on this shift. . . ."
* 12/24/18 at 2:48 a.m., "Aspercreme . . . Resident request for aches. . . ."
* 12/25/18 at 8:41 p.m., "Staff stated that resident laid down in bed at 4:30 a.m. this morning, resident told writer that he didn't sleep well while laying down, unable to get comfortable in bed."

The December 2018 medication administrative record (MAR) identified Resident #36 received the following scheduled pain medications:
* Fentanyl 12 micrograms/hour (mcg/hr) patch
* Norco 5-325 milligrams (mg) tab 4 times a day

The December 2018 and January 2019 MARs identified the prn pain medication Aspercreme was only requested/applied to Resident #36's left hip/stump following the accident.

During an interview on 05/16/19 at 10:30 a.m.,

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when asked questions pertaining to the training staff received on the van equipment, a certified nursing assistant (CNA)/van driver (#4) stated she "received training on the equipment prior to transporting residents," but was "not re-educated after the accident." When asked to describe Resident #36's fall, the CNA (#4) stated, "I heard [Resident #36] slid out of the wheelchair. I wasn't there, but I'm not sure how that happened. Once [the wheelchairs] are hooked, they aren't able to move." Observations of the van equipment showed wheelchairs are secured with four floor harnesses, two in the front and two in the back. Residents are further secured with a seatbelt that runs from the ceiling and floor on the left side of the wheelchair, from the floor on the right side of the wheelchair, and is secured at the waist. Each portion of the seatbelt/harness is adjustable/can be tightened, and the seatbelt locks when jerked.

During a phone interview on 05/16/19 at 10:30 a.m., when asked to describe the accident involving Resident #36, a CNA/van driver (#5) reported, "The weather conditions were horrible," and explained she "drove into the other lane, facing oncoming traffic." When asked to describe Resident #36's fall, the CNA (#5) stated, "The chair tipped over. He was face down on the floor [of the van]. (Based on this eye-witness testimony, the wheelchair was not poperly secured.) The seat belt was still attached. The seatbelt was in place, with the shoulder strap. It was really tight on him. I loosened the belt to release pressure. I tried picking him up, but couldn't do it. He was too heavy. I called 911. I tried to make him comfortable until the fire and ambulance came." When asked if he sustained any injuries from his fall, the CNA (#5) stated,

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"He complained of pain on the left, between the heart and shoulder. He got swollen. He had a big bruise on his left shoulder." When asked how staff ensure residents are secured in the van, the CNA (#5) stated, "You can manually tighten the seat belt, can adjust it."

During an interview on 05/16/19 at 10:45 a.m., when asked questions pertaining to the fall, an administrative nurse (#1) reported she was unable to locate documentation showing van equipment was in proper working order and staff received training specific to the van equipment prior to/following the incident, or documentation showing staff completed an incident report immediately following Resident #36's fall. The administrative nurse (#1) also confirmed the facility failed to identify Resident #36's fall may have resulted from neglect and monitor future van transport to ensure this type of incident did not occur again.

The facility failed to do the following:
* ensure Resident #36 received the care and services necessary to attain the highest degree of safety possible while being transported via the facility van,
* ensure van equipment was in proper working order following Resident #36's fall,
* ensure staff received training specific to the van equipment following Resident #36's fall,
* ensure staff completed an incident report immediately following Resident #36's fall,
* identify Resident #36's fall may have resulted from neglect,
* complete a thorough investigation into how Resident #36 fell/sustained his injuries while being transported via the facility van, and

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F 689	Continued From page 17 * monitor future van transport to ensure this type of incident did not occur again.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, facility staff failed to offer fluids to 5 of 14 sampled residents (Resident #8, #14, #24, #30, and #31) who required staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include:	F 692	To assure that residents #8, #14, #24, #30, and #31 are being offered fluids, the policy Minimum Fluid Requirement was reviewed and no corrections or additions added, the policy Routine Care was reviewed and updated. Nursing staff have been provided a copies of both policies to read and review for education, this will be completed by 6-10-19. Annual CNA competencies will continue to	6/12/19

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F 692	Continued From page 18 Review of the facility policy titled "Minimum Fluid Requirement" occurred on 02/16/19. This policy, revised October 2015, stated, ". . . All residents at [Facility] will be encouraged to consume fluids to maintain their optimal level of functioning . . ." - Review of Resident #8's medical record occurred on all days of the survey. The current care plan stated, " . . . I am not drinking like I should during the day. Please continue to offer me fluids throughout the day . . . Water pitcher in room. Offer fluids with cares. Observe signs and symptoms of clinical dehydration . . ." Observation on 05/14/19 at 8:54 a.m., showed two certified nursing assistants (CNA) (#3 and #16) provided cares to Resident #8 and failed to offer fluids during or after cares. - Review of Resident #14's medical record occurred on all days of the survey. The current care plan stated, " . . . I am not drinking like I should during the day. Please continue to offer me fluids throughout the day . . . Offer me fluids with cares. Observe signs of clinical dehydration . . ." Observation on 05/14/19 at 8:42 a.m., showed two CNA (#14 and #15) provided cares to Resident #14 and failed to offer fluids during or after cares. - Review of Resident #24's medical record occurred on all days of the survey. The current care plan stated, " . . . I feel I am drinking well during the day. Please continue to offer me fluids throughout the day. . . . Offer me fluids with	F 692	monitor for CNAs offering fluids during cares. Starting on 5-29-19 we will monitor resident #8, #14, #24, #30, and #31 on the day shift and on the evening shift, for 3 consecutive days, to ensure that these residents are being offered fluids during AM and HS cares. We will then continue to monitor resident #8, #14, #24, #30, and #31 weekly for one month to ensure that fluids continue to be offered during AM and HS cares. QA will be monitored by a Nursing Professional and reported to the QAPI committee. A Nursing Professional will then continue to monitor, on a weekly basis, for fluids being offered on 3 random residents during AM and HS cares for one month and then quarterly thereafter until compliance is determined for a minimum of 6 months. The QA data will be reported to QAPI committee on a monthly basis.	

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F 692	Continued From page 19 cares. Observe for signs and symptoms of clinical dehydration . . ." Observation on 05/14/19 at 3:31 p.m., showed a CNA (#13) provided cares to Resident #24 and failed to offer fluids during or after cares. - Review of Resident #30's medical record occurred on all days of the survey. The current care plan stated, " . . . I am not drinking like I should during the day. Please offer me fluids throughout the day . . . Offer me fluids with cares . . . Water pitcher in room . . . Observe signs and symptoms of clinical dehydration . . ." Observation on 05/14/19 at 11:08 a.m., showed two CNA (#2 and #3) provided cares to Resident #30 and failed to offer fluids during or after cares. - Review of Resident #31's medical record occurred on all days of the survey. The current care plan stated, " . . . I am not drinking like I should during the day. Please offer me fluids throughout the day . . . Offer me fluids with cares. Water pitcher in room. Observe signs and symptoms of clinical dehydration. . . ." Observation on 05/15/19 at 10:25 a.m., showed two CNA (#11 and #12) provided cares to Resident #31 and failed to offer fluids during or after cares. During an interview on the morning of 05/16/19, an administrative nurse (#1) stated she expected staff to offer fluids with all cares.	F 692		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/12/19

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F 880	Continued From page 20 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 21 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, facility staff failed to follow standard infection control practices for 3 of 14 sampled residents (Residents #14, #23 and #31) and 1 supplemental resident (Resident #15) observed receiving assistance with activities of daily living. Failure to follow infection control practices while assisting a resident during personal cares has the potential to transmit	F 880	Cares will be monitored x1 for residents #14, #23, #31 and #15 to assure that proper hand hygiene is being done, that the policy on reusable resident care equipment is being followed, and that the tip on the drainage tub on urine drainage bags is being sanitized after draining urine. This will be completed by 6/12/2019.	

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(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 880	Continued From page 22 infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Handling Contaminated Objects" occurred on 05/16/19. This policy, last reviewed 04/01/19, stated, ". . . The lift equipment will be wiped down with a disinfecting solution (Sani/Cavi Wipes) after each use . . ." Review of the facility policy titled "Hand Hygiene" occurred on 05/16/19. This policy, last reviewed 04/01/19, stated, ". . . When to perform hand hygiene . . . leaving the patient/resident care area . . . after removing gloves . . ." - Observation on the morning of 05/14/19 showed a certified nursing assistant (CNA) (#10) and licensed nurse (#9) performed perineal cares for Resident #15 in her room. After finishing cares, staff failed to clean the lift before storing it. - Observation on 05/14/19 at 12:44 p.m., showed two CNAs (#15 and #18) performed perineal cares for Resident #14 in her room. After finishing cares, one CNA (#15) failed to sanitize/wash her hand after removing her gloves and/or prior to exiting Resident #14's room. - Observation on 05/14/19 at 4:08 p.m. showed two CNAs (#8 and #17) performed perineal cares for Resident #31 in his room. One CNA (#8) drained Resident #31's urinary drainage bag. The CNA (#8) failed to sanitize the tip of the drainage tubing prior to reconnecting it to the bag. After finishing cares, one CNA (#8) failed to clean the lift before storing it.	F 880	Nursing staff will be educated on the hand hygiene policy, the reusable resident care equipment and the proper draining of urinary drainage bags. They will do a return demo to ensure that they are performing tasks correctly. We will continue to do annual CNA Skill evals. The Infection Preventionist will do Quality Assurance checks monthly for the next 6 months on 10 CNAs per month for hand hygiene, wiping down of reusable resident care equipment, and sanitizing of drainage tube after draining a urinary drainage bag. This information will be brought to the monthly QAPI meeting to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING _____ B. WING _____	05/16/2019

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F 880	Continued From page 23 During an interview on 05/16/19 at 10:45 a.m., an administrative nurse (#1) stated she expected staff to sanitize Resident #31's catheter drainage tube. - Observation on 05/15/19 at 3:30 p.m. showed CNA (#8) and an unidentified staff member performed perineal cares for Resident #23 in her room. After finishing cares, staff failed to clean the lift before storing it.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 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 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	F 883		6/12/19

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F 883	Continued From page 24 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's 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 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 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. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination	F 883	For Residents #23 and #24, who had received PCV13 but not PPSV23, they will each receive the PPSV23 after education to the Resident/Family and consent from the Resident/Family. For all other residents the Infection Preventionist will perform an immunization status assessment to catch any other residents	

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F 883	Continued From page 25 for 2 of 5 sampled residents (Resident #23 and #24) reviewed for immunization status. Failure to implement a process to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contact pneumonia and also spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "Resident Immunizations" occurred on 05/16/19. This policy, dated 02/18/15, stated, ". . . A series of pneumococcal vaccinations will be offered to adults greater than 65, depending on current vaccinations status and practitioner recommendation . . . Individuals receiving the pneumococcal vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record . . ." Review of the CDC: Vaccination Information Statements (VIS) webpage (https://www.cdc.gov/vaccines/hcp/vis/index.html), last updated October 12, 2018, stated, ". . . Pneumococcal conjugate vaccine (called PCV13) protects against 13 types of pneumococcal bacteria . . . is also recommended for . . . all adults 65 years of age and older. Your doctor can give you details. . . . Pneumococcal polysaccharide vaccine (PPSV23) protects against 23 types of pneumococcal bacteria. . . . PPSV23 is recommended for: . . . All adults 65 years of age and older . . . Your healthcare	F 883	missing either PCV13 or PPSV23. If a resident is found to have one of the vaccines due it will be administered after consent and education. For education the CDC VIS will be used. This will be completed by 6-12-19. Nursing staff will be educated on the resident□s immunization policy and what to look for as far as immunizations when a resident is admitted and to assure that their immunization needs are met throughout their stay. The Infection Preventionist will keep the immunization status sheet up to date on all present residents and new admits. It will be reviewed at our Monday AM meeting to assure that no immunizations are needed. The Immunization status sheet will be included in the Infection Preventionist QA monthly data, reviewed at the monthly QAPI meeting.	

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F 883	Continued From page 26 provider can give you more information about these recommendations. . . ." - Review of Resident #23's medical record occurred on all days of survey. The record showed Resident #23, admitted in 2015, received the PCV13 vaccine on 04/23/15 (prior to admission). The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PPSV23 immunization and/or provided education to the resident and/or their legal representative. - Review of Resident #24's medical record occurred on all days of survey. The record showed Resident #24, admitted in 2015, received the PCV13 vaccine in 2015. The record lacked evidence the facility assessed the resident's pneumococcal immunization status for the PPSV23 immunization and/or provided education to the resident and/or their legal representative. During an interview on the morning 05/16/19, an administrative nurse (#1) verified the facility failed to assess residents for pneumococcal immunization and/or follow the CDC recommendations for the pneumococcal vaccinations. The facility failed to follow their policy and the CDC recommendations for pneumococcal vaccine administration.	F 883		