| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355076 | A. BUILDING _____ B. WING _____ | 07/29/2015 |

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

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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on 07/27/15 and completed on 07/29/15, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey. | F 000 | | |
| F 170 | 483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL<br><br>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident group interview and staff interview, the facility failed to provide mail delivery on Saturdays for 10 of 10 sampled residents in the facility. Failure to provide mail delivery on Saturdays infringes on the residents' rights.<br><br>Findings include:<br><br>The resident group interview occurred on 07/28/15 at 10:30 a.m. and included eight residents (Resident A, B, C, D, E, F, G, and H), identified by the facility as interviewable. When asked about mail delivery on Saturdays, Resident (A) stated they do not receive mail on Saturdays and the other residents confirmed the statement. Resident (A) stated she visited with an activity staff member (#4) "a long time ago" | F 170 | Mail for the residents will be distributed to residents on Saturdays for any Saturdays in which the post office delivers mail.<br><br>All residents were affected by this deficient practice and will now have mail available.<br><br>During the work week, maintenance staff pick up the mail where it is brought to the business office, sorted by office staff, and brought to the nurses station for distribution. On Saturdays, Activity staff will pick up mail, sort, and bring to the nurses station for distribution.<br><br>The CEO provided education to the business office, maintenance, and activity | 8/29/15 |

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

Electronically Signed | 08/20/2015

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| F 170 | Continued From page 1<br>and the staff member stated the facility does not have anyone available to pick up the mail on Saturdays.<br><br>During an interview on 07/29/15 at 2:50 p.m., an activity staff member (#4) confirmed the residents have not received mail on Saturdays for about a year. | F 170 | room staff on this at various times during the work weeks of August 17-21 and August 24-28. The CEO will monitor delivery of Saturday mail through routine checking with activity and nursing staff to ensure mail was delivered and distributed.<br><br>Mail will be available on Saturdays beginning August 29, 2015. | |
| F 226 | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to implement policies regarding abuse/neglect for 1 of 1 sampled resident (Resident #6) identified with bruises of unknown origin. Failure to implement the facility's written abuse prevention policies and procedures and ensure a through investigation of injuries of unknown origin placed this resident and all other residents at risk for abuse and mistreatment.<br><br>Findings include:<br><br>Review of the facility policy titled "PROCEDURE FOR INJURIES" occurred on 07/29/15. This policy, revised on 2011, stated, POLICY: RNs | F 226 | For resident #6 and all other residents at NDHC, unexplained bruises will be investigated per updated facility policy, "Procedure for Injuries" (see attached policy). On 8/5/2015, DON assessed resident #6, left upper arm for bruising. No bruising noted at this time. Geri sleeves noted to be in place on lower arms. Resident denied any rough handling by staff. Resident unable to recall any incident that led to bruising to the left upper arm on June 22, 2015.<br><br>All new bruises will be monitored weekly for explanation of injury by the LTC unit manager. Any unexplained bruises, skin | 9/2/15 |

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| F 226 | Continued From page 2<br>[Registered Nurses], LPNs [Licensed Practical Nurses], and CNAs [certified Nursing Assistants] are to report all . . . bruises, . . . to their Unit Nurse AS SOON AS POSSIBLE. The unit nurse shall assess the injury. . . . If the RNs, LPNs, or CNAs can explain the reason for injury or are almost certain, this is to be charted in the Nurses Notes. There is no need to do protocol sheet if injury is explained. . . . PROCEDURE: . . . 4. A registered nurse shall assess all bruises/injuries of unknown origin. Based upon his/her assessment of injury and criteria for further investigation, the nurse will fill out "Referral for DON/RCC [Director of Nursing/Resident Care Coordinator]" and report this to DON/ADON [Assistant Director of Nursing] on that day. Criteria for further investigation: - Bruise is larger than 2 cm [centimeters] . . . The DON/ADON will decide whether there is need to report the injury as a suspected act of abuse according to facility's "Abuse and Neglect" policy."<br><br>Review of Resident #6's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/13/15, identified total assistance of two staff members for bed mobility, transfers, toileting, and personal hygiene. The resident's current care plan stated, "Problem: I need extensive assist in most areas of my daily cares. . . . Problem: I am unable to bear weight. All my transfers are with EZ lift (a full body mechanical lift) . . ."<br><br>Resident #6's skin charting assessment, dated 06/22/15, stated, "LEFT UPPER ARM - 10.5 x [by] 1.5 cm bruise, consisting of a line of circular shaped bruising, purple in color, each circular bruise getting bigger from right left [sic]. RIGHT | F 226 | tears and other injuries will be reported to the DON or ADON. If injury has not already been investigated per protocol, investigation will be done at that time as a mean of identifying potential abusive occurrences (see Abuse Prohibition Policy attached).<br><br>Nursing staff will be educated regarding reporting injuries of unknown origin, including bruising and the procedure for injuries and abuse prohibition at educational training meetings to be held on the following dates: 8/24/15, 8/25/15, 8/26/15.<br><br>Five resident charts will be reviewed weekly for 6 months minimally, then, 10 resident charts will be reviewed monthly for 3 months minimally, then 10 resident charts will be reviewed quarterly for 6 months minimally to collect data regarding bruise documentation and investigation of any bruise meeting the criteria for investigation of injury of unknown origin. The charts will be reviewed and data collected by the QA nurse and unit manager. The QA data will be reported to the QAPI committee monthly. QA data reporting will continue to the QAPI committee until compliance is met. | |

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| F 226 | Continued From page 3<br>ANTERIOR LOWER LEG: 1.5 x 1.1 cm dark purple circular bruise. CNA stated was not there the previous night, could possibly be from fully [sic] body lift. Reminded CNAs to transfer resident with caution."<br><br>During an interview on the afternoon of 07/29/15, an administrative nurse (#10) stated she had not been informed about Resident #6's bruises. | F 226 | | |
| F 257 | 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS<br><br>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and resident, group, and staff interview, the facility failed to maintain a comfortable temperature level for 2 of 3 dining rooms (North and South). Failure to maintain comfortable room temperature levels between 71-81 degrees Fahrenheit (F) may result in resident discomfort.<br><br>Findings include:<br><br>Eight residents, identified by the facility as interviewable, attended the resident group interview on 07/28/15 at 10:20 a.m. When asked if the temperature felt comfortable in the facility, Resident D stated the temperature in the North dining room and activity room were "cold all the time." Resident A and F agreed. Resident H stated his room and the bath house were cold all | F 257 | The air temperature has been adjusted to be within required standards in the areas identified specifically as the dining rooms and the activity room. Resident room temperatures are controllable in each room as well. A supplemental air conditioner in the south dining room has been removed. The manager of Environmental Services has monitored temperatures in these areas since the survey to adjust and maintain compliance.<br><br>All residents in the facility have the potential to be affected by this practice. The affected areas were monitored up to 4 times a week after the initial fixes by the manager of Facility Services or designee. Once the fixes proved to be achieving | 8/29/15 |

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| F 257 | Continued From page 4<br>the time.<br><br>During an interview on 07/28/15 at 3:03 p.m., Resident #4 stated, "It's cold everywhere [in the facility]." She identified her room, the dining room, and the activity room temperatures as cold.<br><br>Air temperatures measured on 07/28/15 identified the following:<br>* North dining room - 68 degrees F at 2:53 p.m.<br>* South dining room - 64 degrees F at 3:56 p.m.<br><br>A tour of the environment occurred on 07/28/15 at 1:00 p.m. with two administrative staff members (#5 and #6). Temperature measurements during the tour included:<br>* South dining room 71 degrees F at 1:40 p.m.<br>* North dining room 65 degrees F at 2:11 p.m.<br><br>During the tour, the staff member (#6) stated facility staff members brought in their own personnel air conditioner to use in the South dining area. He turned this air conditioner off. The administrative staff member (#5) confirmed the dining room temperature felt "chilly" and adjustments were needed. | F 257 | necessary compliance, the temperatures will be monitored no less than 1 x week. This will be done through quality assurance monitoring of the affected areas to ensure temperatures are within required standards. Testing of other random areas within the facility will be done on a monthly basis by the manager of Facility Services or their designee.<br><br>The manager of Facility Services or designee shall report the results of specific area and random testing to the QA and I committee. The committee will review and assist as necessary in trouble shooting and monitoring performance. | |
| F 278 | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the | F 278 | | 9/2/15 |

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| F 278 | Continued From page 5<br>assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 4 sampled residents (Resident #5 and #10) coded as on a turning/repositioning program. Failure to code the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may affect the development of a comprehensive care plan.<br><br>Findings include: | F 278 | For resident #5 and #10.<br><br>Section M 1200C<br><br>Will no longer be coded on the MDS assessment as being on a repositioning program. Modifications to the most recent MDS assessment have been completed and were submitted on 7/30/2015. See attached CMS submission report and Department of Human Services accepted assessment report.<br><br>All other residents that have been on a turning and repositioning program have | |

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| F 278 | Continued From page 6<br>The Long-Term Care Facility RAI User's Manual, October 2014, page M-38 stated, "M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention."<br><br>- Review of Resident #5's medical record occurred on all days of survey. The quarterly MDS, dated 06/12/15, identified total assistance of two staff members for bed mobility and a turning/repositioning program. The care plan stated, "Problem: I am at risk for skin problems . . . float heels when in bed . . ."<br><br>Resident #5's medical record failed to identify a specific and individualized repositioning program.<br><br>- Review of Resident #10's medical record occurred on 07/29/15. The quarterly MDS, dated 06/15/15, identified limited assistance of one staff member for bed mobility and a turning/repositioning program. The care plan stated, "Problem: I have a healed venous stasis ulcer on my lower left leg of which I am very guarded. Fragile area on coccyx . . . Float heels on a pillow whenever in bed . . ."<br><br>Resident #10's medical record failed to identify a specific and individualized repositioning program. | F 278 | had MDS assessments modified and submitted on 7/30/2015. See attached CMS submission report and Department of Human Services accepted assessment report. Billing adjustments will be made accordingly for any resident whose bill was affected by this modification. MDS staff had education per phone with Joan Coleman regarding accurate coding for turning and repositioning program coding on the MDS assessment, section M 1200C.<br><br>QA data will be collected by MDS coordinator monthly prior to submission evaluating resident's turning and repositioning schedules determining if criteria is met or not met to qualify as a repositioning program on the MDS as per the RAI manual. Data will be reported to the QAPI Committee monthly until compliance is determined (see attached QA monitoring form). | |

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| F 314 | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement interventions to prevent the development of pressure ulcers for 2 of 3 sampled residents (Resident #3 and #6) with a history of pressure ulcers. Failure to consistently implement pressure relieving interventions (repositioning, pressure relief cushions, and heel boots) may lead to the reoccurrence and/or development of pressure ulcers.<br><br>Findings include:<br><br>Review of the facility policy titled "SKIN CARE AND SKIN ASSESSMENTS" occurred on 07/29/15. This policy, revised March 2015, stated,<br>". . . Positioning: . . .<br>a. Positioning devices such as pillows or wedges should be used to keep bony prominences (knees, ankles) from direct contact with each other.<br>b. For residents that are completely immobile, | F 314 | For residents #3 and #6, a monitoring system has been put into place to ensure that preventative pressure ulcer interventions are consistently in place per the plan of care.<br><br>The unit nurse will verify that all interventions are in place to prevent pressure ulcer development for residents #3 and #6 and document such on each shift per the "Intervention Implementation Monitoring Tool" every shift for 7 days (see attached monitoring tool).<br>DON/ADON will collect these monitoring tools weekly and calculate compliance. Findings will be reported monthly to the QAPI committee monthly. Monitoring will continue until compliance is determined by the DON/ADON or by QAPI committee.<br><br>For all other residents at NDHC with high risk for development of pressure areas, | 9/2/15 |

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| F 314 | Continued From page 8<br>devices that completely relieve pressure from the heels are to be used. . . ."<br><br>- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dementia, hypertension, and a history of a heel pressure ulcer. Current physician's orders included, "Heel lift boot to be worn on right foot whenever in bed." The certified nursing assistant (CNA) care card (used by CNAs to direct resident care) identified the use of a right heel guard and "Honeycomb cushion in recliner and W/C [wheelchair]." The current care plan stated, ". . . Heel lift boots when in bed, if she refuses float her heels on pillows. . . ."<br><br>Observation on 07/27/15 at 5:16 p.m. showed Resident #3 in the TV area seated in a recliner without a honeycomb cushion. A CNA (#12) assisted Resident #3 to ambulate to the bathroom and back to the TV area. The CNA then assisted Resident #3 to sit in a wheelchair without a honeycomb cushion in place. The resident remained in the wheelchair during the evening meal.<br><br>Observations throughout the day on 07/28/15 showed Resident #3 seated in a recliner in the TV area between meals. The recliner lacked a honeycomb cushion. At 4:37 p.m., a CNA (#7) assisted Resident #3 to ambulate to the bathroom in the resident's room. After toileting, the resident became tired with ambulation. An unidentified CNA brought a wheelchair for Resident #3 to sit in, which lacked a honeycomb cushion. The resident remained in the wheelchair until the evening meal. | F 314 | the Intervention Monitoring Tool will be completed by September 2, 2015. To ensure continued compliance with implementation of interventions to prevent development of pressure areas, all residents at high risk of development of pressure areas will have the Intervention Implementation Monitoring Tool completed by the unit nurse each shift for 24 hours, quarterly. DON/ADON will report compliance with Intervention Implementation monthly to the QAPI committee until compliance has been determined by the QAPI committee.<br><br>Nursing staff will be educated on pressure area prevention and the importance of consistent use of interventions per the plan of care at inservices to be held on the following dates: 8/24, 8/25, 8/26, 2015. | |

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| F 314 | Continued From page 9<br>Observations on 07/29/15 from 7:40 a.m. until approximately 10:00 a.m. showed Resident #3 asleep in her bed without a heel boot in place and her heels/feet resting directly on the mattress. Observation at 11:20 a.m. showed Resident #3 in a wheelchair without a honeycomb cushion in place. Observations from 12:55 p.m. until approximately 3:15 p.m. showed Resident #3 seated in a recliner without a honeycomb cushion in place.<br><br>- Review of Resident #6's medical record occurred on all days of survey and identified a history of a coccyx pressure ulcer. A physician's order stated, "Nurse to make sure resident is positioned completely on sides when in bed by use of taps wedges."<br><br>Resident #6's quarterly Minimum Data Set (MDS), dated 05/13/15, identified total assistance required for bed mobility and transfers, one pressure ulcer (now healed), and a turning/repositioning program. The current care plan stated, ". . . reposition me every two hours when in bed using the taps system . . . heel lift boots when in bed and with all transfers to protect the feet during the transfer . . . foot cradle on bed . . ."<br><br>Observation on 07/27/15 at approximately 2:30 p.m. showed Resident #6 positioned on her back in bed with her feet elevated on a pillow. Facility staff failed to apply the heel lift boots, utilize the foot cradle, and position the resident on her side.<br><br>Observation on 07/28/15 at 9:55 a.m. showed two CNAs (#13 and #14) assisted Resident #6 to the toilet and then to bed. Before leaving the | F 314 | | |

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| F 314 | Continued From page 10<br>room, the CNAs positioned the resident on her right side and elevated her feet on a pillow. The CNAs failed to apply the heel lift boots and utilize the foot cradle.<br><br>Observation on 07/29/15 at 1:55 p.m. showed Resident #6 in bed and positioned on her left side with her feet elevated on a pillow. Facility staff failed to apply the heel lift boots and utilize the foot cradle.<br><br>During an interview on 07/29/15 at 3:25 p.m., a supervisory nurse (#15) stated Resident #3 should have a cushion in her recliner and wheelchair, and staff are expected to float the resident's heels and/or use heel boots in bed. | F 314 | | |
| F 323 | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 5 of 7 sampled residents (Residents #1, #2, #3, #7, #8) and 1 supplemental resident (Resident #13) observed during transfers. Failure to apply foot pedals to wheelchairs during staff-assisted transport and/or utilize a gait belt | F 323 | Leg and Foot Rests:<br><br>For residents #1, #2, #7, #8 and #13 along with other residents at NDHC, wheelchair leg rest/foot rest usage will be followed as per policy (see attached policy). | 9/2/15 |

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| | 355076 | A. BUILDING _____ B. WING _____ | 07/29/2015 |

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

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| F 323 | Continued From page 11<br>correctly may result in falls and/or injuries to residents.<br><br>Findings include:<br><br>GAIT BELTS<br><br>Review of the facility policy titled "Gait Belt" occurred on 07/29/15. This policy, dated 2007, stated, "Purpose 1.) To prevent injury to the resident or staff while ambulating the resident. . . . Procedure . . . 2.) Securely apply the gait belt around the resident's waist. 3.) . . . while holding the belt securely in the back with an underhand grasp."<br><br>- Observation on 07/27/15 at 3:00 p.m. showed two unidentified staff members transferred Resident #3 from a recliner to a wheelchair. The staff members assisted the resident to stand by lifting under her axillae. The staff members failed to apply and utilize a gait belt.<br><br>- Observation on 07/28/15 at 10:17 a.m. showed a Certified Nursing Assistant (CNA) (#3) applied a gait belt around Resident #2's waist and assisted her to stand. Another CNA (#1) entered the room and held under Resident #2's right armpit rather than utilizing the gait belt.<br><br>FOOT PEDALS<br><br>- Observation on 07/28/15 at 7:50 a.m. showed a CNA (#1) transported Resident #1 in a wheelchair into the bathroom. The resident's feet brushed along the floor during the transport. After morning cares, the CNA (#1) transported the resident to the dining room. During the transport, | F 323 | Residents will be screened for leg rest/foot rest need upon admission by therapy staff and will be reviewed by care plan team at IDT weekly meetings, during transfer review. All current residents will be screened by therapy staff by September 2, 2015.<br><br>Any resident who is being pushed in a wheelchair needs foot rests, unless resident is typically a self-mobilizer and is cognitively and physically able to lift their feet off the floor. Leg rests/foot rests will be available and easily accessible for every residents' wheelchair.<br><br>All residents will be safely transferred with the proper use of leg rests/foot rests. Leg rests/foot rests usage will be monitored on residents #1, #2, #7, #8, and #13 three times per week for two weeks and then 3 different random residents will be assessed each week for 3 months by therapy staff or restorative aide. Data will be reported monthly to QAPI committee. Data collection and monitoring will continues until compliance is determined by QAPI committee.<br><br>Therapy, activities and nursing staff will be educated regarding leg rest/foot rest usage by certified therapy staff at inservices to be held on the following dates: 8/24, 8/25, 8/26, 2015.<br><br>Gait Belts:<br><br>For residents #2 and #3 and all other | |

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| F 323 | Continued From page 12<br>Resident #1's right foot brushed along the floor.<br><br>- Observation on 07/28/15 at 10:40 a.m. showed a CNA (#3) transported Resident #2 to the dining area in her wheelchair without foot pedals. Resident #2's feet brushed along the floor during the transport.<br><br>- Observation on 07/28/15 at 12:15 p.m. showed a CNA (#1) transported Resident #1 in a wheelchair. The resident's feet brushed along the floor during the transport.<br><br>- Observation on 07/28/15 at 4:40 p.m. showed a CNA (#11) transported Resident #7 from the Sunshine Parlor to the lounge adjacent to the nurse's station. The resident's feet brushed along the carpeted floor during the transport.<br><br>- Observation on 07/29/15 at 8:20 a.m. showed a CNA (#8) transported Resident #1 to the table. The resident's feet brushed along the floor during the transport.<br><br>- Observation on 07/29/15 at 11:26 a.m. showed an unidentified CNA transferred Resident #8 into a wheelchair and applied foot pedals to the wheelchair. The CNA failed to place Resident #8's left foot onto the foot pedal and his left foot brushed along the floor as the CNA transported the resident.<br><br>- A random observation on the afternoon of 07/29/15 showed an unidentified staff member pushed Resident #13 down the hallway in her wheelchair. The resident's feet were bouncing along the floor, and the staff member paused several times to remind the resident to lift her | F 323 | residents of NDHC, the gait belt policy has been updated to emphasize the use of gait belts for residents that require assist with transfers and upright mobility (see attached policy).<br><br>Any resident who isn't independent with mobility, requires the use of a gait belt by staff. This will be determined by therapy (see attached policy).<br><br>Gait belt will be placed in each resident's room.<br><br>All non-independent transfers of residents will be safely transferred with the proper use of gait belts. Gait belt usage will be monitored on resident #2 and #3 three times per week for two weeks, then 3 different, random residents will be assessed by therapy staff, each week for 3 months. Data will be reported monthly to the QAPI committee. Gait belt monitoring will continue until compliance is determined by QAPI committee.<br><br>Therapy, activities and nursing staff will be educated regarding proper gait belt use, by certified therapy staff at inservices to be held on the following dats: 8/24, 8/25, 8/26, 2015. | |

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| F 323 | Continued From page 13<br>feet.<br><br>During an interview on 07/29/15 at 4:00 p.m., a supervisory nurse (#9) stated she expected staff to use foot pedals on resident's wheelchairs. | F 323 | | |
| F 327 | 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION<br><br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure fluid intake to maintain adequate hydration for 1 of 5 sampled residents (Resident #3) who required staff assistance with food/fluids. Failure to ensure residents consume adequate amounts of fluid may result in dehydration, electrolyte imbalances, and/or urinary tract infections (UTIs).<br><br>Findings include:<br><br>Review of Resident #3 ' s medical record occurred on all days of survey. Diagnoses included dementia. The resident ' s current care plan stated, " . . . I do not drink enough during the day. Please continue to offer me more fluids throughout the day. . . . Approach . . . Offer me a minimum of 12 oz [ounces] of fluids with meals. Offer fluids with cares . . . "<br><br>Observation on 07/27/15 at approximately 2:30 p.m. showed Resident #3 asleep in a recliner in the TV area. At 5:16 p.m., a CNA (#12) assisted | F 327 | For resident #3 and all other residents at NDHC, the dietary staff will provide 8 oz. of water with all meals in addition to other liquids given with meals.<br><br>NDHC nursing staff will observe cares of resident #3 on day shift and evening shift for 3 consecutive days to ensure that resident #3 is offered fluids during AM and HS cares. This observation will be repeated quarterly for resident #3 for one day each quarter.<br><br>All other residents at NDHC will have AM and HS cares observed one time per quarter to ensure that they are offered fluids during cares. For all residents at NDHC, the CNAs will be observed annually providing cares and offering fluids will be part of the competency check list. Individual fluid intakes will be assessed upon admission, post hospitalization, with diagnosis of UTI and | 9/2/15 |

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| F 327 | Continued From page 14<br>Resident #3 to use the bathroom and into a wheelchair. The CNA failed to offer Resident #3 fluids.<br><br>Observation on 07/28/15 at 7:50 a.m. showed Resident #3 in the dining room eating breakfast. Observation showed approximately 8 ounces of orange juice, and no other fluids offered to Resident #3. At 8:30 a.m., an unidentified CNA assisted Resident #3 into a recliner in the TV area, where she remained until 11:36 a.m. At that time, a CNA (#16) assisted Resident #3 to use the bathroom and failed to offer the resident fluids. Observations from approximately 1:30 p.m. until 4:37 p.m. showed Resident #3 asleep in the recliner in the TV area. At 4:37 p.m., a CNA (#7) assisted Resident #3 to the bathroom but failed to offer the resident fluids.<br><br>During an interview on 07/29/15 at 3:25 p.m., a supervisory nurse (#15) stated she expected staff to offer Resident #3 fluids with all cares. | F 327 | with quarterly or annual MDS assessment (see attached policy).<br><br>QA data will be collected from the care observations and CNA competency checks by the DON/ADON and reported monthly to the QAPI committee for 3 months, if compliance is met then data will be collected for 1 month each quarter and reported to the QAPI committee for 1 year.<br><br>The dietary manager will collect data weekly to ensure that 8 oz. of water is provided to each resident with meals in addition to other fluids that they receive with their meal. Each dining room and tray service will be checked weekly for 3 months, then monthly for 3 months, if compliance is met then data will be collected quarterly and reported to the QAPI committee for one year.<br><br>All dietary, activities and nursing staff will be educated regarding providing 8 oz. of water with all meals, offering fluid with cares and collecting intakes at inservices being held by Lisa Becker, LRD, on the following dates: 8/24, 8/25, 8/26, 2015. | |