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

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING _____ B. WING _____	07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 06/30/14 and completed on 07/02/14, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 8 additional residents to verify specific concerns during the survey.	F 000		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure personal funds deposited with the facility staff conveyed within 30 days of death for 2 of 2 residents (Resident #14 and #23) reviewed. This has the potential to affect all residents with funds in a resident account. Findings include: Review of the facility policy/procedure titled "Resident Trust Account: General Information" occurred on 07/02/14. This policy, revised June 2007, stated, ". . . Refunds must be issued when a resident expires . . . Refund checks should be issued immediately at the time of death . . . after accounting for outstanding transactions. No later	F 160	F 160 1. For residents #14 and #23 their individual needs have been met by having their personal trust fund balance refunded to their identified financially responsible party. A list of residents who have passed away in the past 12 months will be reviewed to ensure no other residents have the potential to be affected in this area. This was completed on 7-3-2014. 2. All residents who have passed away and have personal funds deposited with the facility have potential to be affected by this area. 3. On 7-31-2014 the staff responsible for the Resident Trust Account were educated on the procedure titled "Resident Trust Account: General Information" with a focus on the need for the facility to refund the residents' responsible party any personal trust account funds retained by the facility within 30 days after death. System change A new conveyance of funds form will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn L Carda	Administrator	8-13-14

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

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F 160	Continued From page 1 than 30 days per . . . regulations. . . ." Review of a random accounting of conveyance of funds following death occurred on 07/02/14 at 9:25 a.m. with an administrative staff member (#1). Review of resident trust account information identified the following: * Resident #23 expired on 03/29/14. The facility issued a check for the remaining $4.00 on 05/31/14, 63 days later. * Resident #14 expired on 04/06/14. The facility issued a check for the remaining $8.00 on 05/31/14, 55 days later. During an interview on 07/02/14 at 9:25 a.m., a managerial staff member (#1) confirmed the facility failed to convey the residents' funds and a final accounting of the funds to the individual or probate jurisdiction administering the residents' estates, as required. The staff member (#1) explained she "usually waits one-to-two weeks to hear from [Social Services]," she had been "on vacation" during this time period, and she "only works mornings, because of cuts." An email showed staff member (#1) contacted Social Services the afternoon of 06/02/14 [two days after issuing the checks], and received a response the next morning.	F 160	completed to track resident's death and dates funds were returned. The Resident Trust Account staff member will provide a copy of this form to the QA coordinator to ensure compliance in this area. 4. An audit will be created to monitor if any residents have passed away, if they had personal trust account funds deposited with the facility, if the new conveyance form was completed, and if the refund was done within 30 days. The QA coordinator or designee will be responsible for the completion of an audit. The audit will be done weekly times 4, monthly times 3, quarterly times 2 and then as deemed necessary by the QA committee.	8/13/2014
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	**F 248** **See also F 329 and F 428** 1. Residents' #2, #3 and #4 have had their individual needs met by reviewing and revising their activities profile assessment and updating their care plan. Staff is providing meaningful and individualized activity programs specific to their care	

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F 248	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to provide individualized activities consistent with residents' needs, preferences and interests for 3 of 3 sampled residents (Resident #2, #3 and #4) dependent on staff for activities. Failure to provide and implement individualized activity programs may negatively impact residents' quality of life. Findings include: - On the afternoon of 06/30/14, a staff member (#30) stated Resident #3 was on pass with family until 6 p.m. Observation on 07/01/14 at 7:45 a.m. identified Resident #3 sitting on her bed in her room drinking a cup of coffee and eating graham crackers; at 9:10 a.m. wandering up and down the halls fully dressed; taken out on pass with family from 11:30 a.m. to approximately 1 p.m.; attempting to exit the west door by the nurse's station at 4:45 p.m.; and attempting to exit the west door by the nurse's station at 6 p.m. Observation showed a staff member walked her away from the door area. On one occasion staff gave her reading material. Observation showed Resident #3 did not eat meals in the dining room on 07/01/14 nor the breakfast and lunch meal on 07/02/14. Review of Resident #3's medical record occurred on all days of survey. Resident #3's diagnoses included: non-Alzheimer's dementia, depressive disorder and insomnia. An admission Minimum Data Set (MDS), dated 04/27/14, identified Resident #3 with moderate impairment of cognitive abilities, and the presence of wandering	F 248	plan for interests, preferences, and physical status as of 8-1-2014. Resident #4 was taken off bed rest as of 6/27/2014. She has resumed her previous level of activity and is now coming out to activities of her choice. Resident #3's care plan was updated to offer nail care weekly and/or as she prefers. Resident #3 - Non pharmacological interventions have been added to the care plan and are to be attempted and documented prior to administering PRN psychoactive medications. Resident #2 is receiving 1:1 visits, three times per week, by the activity staff. Her care plan has been updated to include these visits and to invite and encourage her to attend activities outside of her room. 2. All residents confined to their room or wander or with exit seeking behaviors have the potential to be affected in this area. 3. System Changes: A list of residents with wandering, exit seeking behaviors and residents on bed rest will be created and communicated to staff by Aug. 13, 2014. Updates will be made at weekday stand-up and on	

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F 248	Continued From page 3 behavior occurring one to three days per week, and independent in activities of daily living (ADL) including walking in room and locomotion on and off the unit. The care plan identified the problem of "dependent on staff for activities, cognitive stimulation, social interaction" related to dementia, "confusion/forgetful. Cognitive deficits" with interventions of "Preferred activities are: crafts, sewing, music groups, sing along, devotions, food preparation, Lutheran services, bingo, manicures; Introduce resident to residents . . . Encourage ongoing family involvement . . . Provide resident with materials for individualized activities as desired. Resident likes . . . crosswords, jigsaw puzzles . . . Topics of interest . . . she used to sing in a trio and played clarinet . . . Offer diversionary activities such as: folding towels, stuffing envelopes, sorting items, watering plants." Review of progress notes identified the resident with frequent wandering and exit seeking behavior. Behaviors escalated to anxiety, agitation and aggressiveness within a month of residing at the facility and nursing staff requested medications to control the behaviors. The record lacked evidence the facility attempted to use non-pharmacological measures to manage the behaviors, including activities. An admission "Activity Interest Data Collection Tool" completed on 04/23/14, identified Resident #3's interests included: * community activities of "Rides, Voting, Children/Youth, Baseball, Basketball, Football, Shopping, Entertainment, Restaurant, and Library * creative activities of self-directed crafts of any	F 248	weekends by the charge nurse. This list of residents will also be used for auditing to ensure compliance in this area. Busy Boxes will be created and available for staff to conduct 1:1 visits, evening activities, and to divert attention for wandering residents. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The education material will include the following: 1) the need for staff to provide and document daily meaningful activities, especially for the listed residents, 2) that activities are based from the resident's "Social History" assessment, "Activities of Interest" assessment and individual preferences to meet their physical, mental, spiritual, and psychosocial needs, and 3) that interventions for each resident can be found on the care plan. Education will include a review for nursing and activity staff to teach staff members on the procedure titled "Activities of Interest". 4. An audit tool will be developed and completed by the QA coordinator or designee weekly times 4, monthly times 2, quarterly times 3, then as deemed	

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F 248	Continued From page 4 kind, crocheting/knitting/tatting; self-directed needlework/quilting/sewing; self-directed poetry; listening to classical, modern and western music; singing in a group and self-directed; self-directed television; self-directed and group movies * educational cognitive activities of checkers, chess, self-directed books, cards of whist, pinochle, canasta, self-directed crossword puzzles, self-directed newspapers, self-directed magazines, group reminisce * physical activities of dancing 1 on 1 or group, self-directed walking, group exercise * social activity of theater, phone use, and talking * spiritual activity of group devotions, group and/or self-directed worship services, group communion * miscellaneous interests of animal/pets, traveling, volunteer activities for a church or school Review of documentation of Resident #3's involvement of activities in the month of June 2014 identified the following: * refusals for participation on 3 of 30 days - refusals included group, educational/cognitive, current events * independent and self-directed on 11 of 30 days; 6 of the self-directed activities identified both social and family visits * wandering in and out of activities 2 of 16 days of involvement with activities (other than refusals and independent/self-directed) * one outdoor stroll * other activities included staff visits, tracking, "converse" for 1:1's (one to one visits with an activity staff member), sensory stimulation, coffee/tea An "Activity Topic Listing" identified sensory	F 248	necessary by the QA committee. The audit will include checking if an activity assessment has been completed, if the activities of interest appear on the residents' care plan, if the goal is appropriate, and if the interventions are individualized for each resident according to the MDS schedule and as needed.	8/13/2014

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F 248	Continued From page 6 week until resident is able to attend out of room activities such as: devotional reading, wordfind, hand massage, pray with her. Offer activities in room." Review of documentation of Resident #2's involvement of activities in the month of June 2014 identified Resident #2 received 1:1 visits on 17 occasions during the month and had nine self-directed activities. Four of the 1:1 visits occurred in one day; two 1:1 visits occurred on four days. Resident #2 attended one group activity of communion. Several of the 1:1 activities were spiritual visits by clergy. Several of the self-directed activities were sensory stimulations of watching TV or listening to the radio. Other self-directed activities included staff visits, and on one occasion "tracking." - Review of Resident #4's medical record occurred on all days of survey and identified diagnoses of a recent pelvic fracture (06/12/14). The quarterly MDS, dated 04/24/14, identified intact cognition, mild depression, and staff assistance for transfers and locomotion. The annual MDS, dated 10/24/13, identified reading, her favorite activities, outdoors, and religion as very important to the resident. The current care plan related to activities stated, ". . . The resident has alteration in musculoskeletal status R/T [related to] fracture of the pelvis (occurred 06/12/14). Bedrest . . . Invite and assist resident to Bingo, manicures, worship services, senior college . . . Provide diversionary activities such as: tic tac toe, music, 1:1 [one-to-one] devotions, hand therapy . . . story and reminisce [sic] . . . report to nurse any change in usual activity attendance patterns or	F 248	necessary by the QA committee. The audit will include checking if an activity assessment has been completed, if the activities of interest appear on the residents' care plan, if the goal is appropriate, if the interventions are individualized for each resident and random checks will be done to see if the interventions are being done for the residents according to the MDS schedule and as needed. Replacement at Page 7	8/13/2014

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F 248	Continued From page 5 stimulation activities could be bird watching, pet visit, beauty shop, TV/radio, manicure/pedicure, outdoor stroll, and other. During interview on 07/01/14 at 3 p.m., an activities staff member (#25) defined "tracking" as watching the movement of people. The staff member stated Resident #3 received 1:1 activities three times a week and these occur for 10-15 minutes maximum. The staff member stated it is difficult to get Resident #3 out for walks, and stated no activities staff work the evening shift except for one day per week. - Review of Resident #2's record occurred on all days of survey. Diagnoses included anxiety disorder, depression, and health problems including a myocardial infarction in May 2014, and pathological vertebrae fracture in June of 2014. Observation on July 01-02, 2014 showed Resident #2 left her room for ambulating in the hall with staff assist, and occupational therapy. Resident #2 was not observed to participate in any of the scheduled activities on those two days. The care plan identified the problem of "potential for a psychosocial well-being problem . . . little interest/pleasure doing things. . . . enjoys spending time in room" with approaches of "Discuss resident's feeling relative to little interest/pleasure doing things. Provide opportunities for resident and family to participate in care. Attempt . . . music, massage. Allow resident time to answer questions and to verbalize feelings, perceptions, and fears as needed. . . . invite/encourage to activities of interest. Offer 1:1 activities 3x [three times] per	F 248		

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F 248	Continued From page 7 refusal to attend activities related to s/s [signs or symptoms] or c/o [complaints of] pain or discomfort. . . ." Observations on June 30 - July 02, 2014 identified Resident #4 in her room on bedrest. All observations during survey showed the resident laying in bed with her eyes closed or reading. The resident ate all of her meals in her room. Review of activity participation logs for June 2014 identified the majority of the time Resident #4 participated in group manicures, religious services, devotions, music activities, and staff and clergy visits prior to being on bedrest, and participated in devotions, music, and staff and clergy visits while on bedrest. During an interview on 06/30/14 at 4:15 p.m., Resident #4 stated she missed going to the group activity "Fancy Nails" on Friday mornings since being on bedrest and identified her current activities included reading independently and sleeping. During an interview on 07/01/14 at 2:45 p.m., an activity staff member (#25) stated since being on bedrest, Resident #4's activities included one-to-one activities in her room three times a week, and included such things as devotions, visiting, and clergy visits. The staff member (#25) confirmed "Fancy Nails" is a group activity and not done individually in resident's rooms. The facility failed to ensure staff provided a meaningful and individualized activity program for Resident #2, #3, and #4 specific to their interests, preferences, and physical status.	F 248		

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F 253 F 253 SS=E	Continued From page 8 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable interior on 2 of 2 resident living areas/units (East and West). Failure to maintain a clean and sanitary environment does not provide a comfortable living environment for residents. Findings include: An initial tour of the facility occurred on the morning of 06/30/14. Observations showed the following: * Heavy accumulation of dust and debris on bathroom vents; showing little-to-no air exchange - Rooms 200, 206, 208, 209, 210, and 211 The diagnoses of residents living in these rooms, identified during record review, included allergic rhinitis, bronchitis, chronic airway obstruction, chronic sinusitis, cough, shortness of breath, and wheezing. * Accumulation of dust on bathroom vents - Rooms 501, 502, 503, 505, 506, 507, and 509 The diagnoses of residents living in these rooms, identified during record review, included bronchitis, cough, disease of the nasal cavity/sinuses, disease of the pharynx/nasopharynx, respiratory abnormality,	F 253 F 253	F 253 1. All bathrooms vents and personal fans have been cleaned by housekeeping on 7/1/14. The ripped padding on the standing mechanical lifts will be fixed by 8-13-2014. The resident in room 407 was discharged on 7-31-2014 and the matted sheep skin removed from the wheelchair. In room 214 the cushion for the toilet has been replaced with a washable surface. The soiled briefs in room 407, 502, 503, 508, and 510 have been removed. Basins in rooms 407, 502, 503, 508, and 510, and all other resident rooms, have been removed or stored in an alternative place in the room. The hole in closet door in room 309 was repaired on 8-6-2014. Rooms 501 and 509: the walls with gouges will be repaired by 8-5-2014. 2. The entire facility has the potential to be affected in this area. The center will use the GSS form #624 titled, "Resident Room Inspection Report". Every resident's room will be inspected for cleanliness, using this report to document those areas needing further cleaning in each room. Staff will be informed to focus on bathroom vents, assistive devices, personal fans, mechanical lift padding, closet doors and walls for holes and gouges. By educating our staff and changing our systems, we will ensure compliance in this area by providing a sanitary, orderly and comfortable interior for residents. 3. System change: A monthly schedule will be set up by the housekeeping supervisor to ensure the vents/fans are cleaned. The housekeeping and maintenance staff will be given education on the need for a monthly bathroom vent cleaning schedule (or as	

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F 253	Continued From page 9 and shortness of breath. * Accumulation of dust on a personal fan - Rooms 608 * Ripped padding on stand lifts - East and West Units * Matted sheep skin wrapped and taped to the front legs of a wheelchair - Room 407 * Soiled bed protector wrapped and taped to the back of the toilet - Room 214 * Soiled briefs left in the bathroom waste baskets - Rooms 407, 502, 503, 508, and 510 * Basins lying directly on the bathroom floors - Rooms 212, 503, and 510 * Hole in closet door - Room 309 * Gouges in walls - Room 501 and 509 Two administrative staff members (#9 and #10), present during the environmental tour the afternoon of 07/01/14, confirmed the heavy accumulations of dust and debris, the uncleanable surfaces/infection control issues, and the damaged surfaces. Both staff members (#9 and #10) agreed the resident rooms are in need of some housekeeping, and reported staff will repair the stand lifts, door, and walls.	F 253	needed) and making sure to report any wall and/or door damage. Education on this system change will be completed by 8-6-2014. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. Education will be provided from the procedure titled, "Philosophy of Environmental Services," with a focus on the need for all staff to routinely inspect resident rooms for cleanliness, including instructing staff to NEVER leave soiled briefs in the garbage cans in resident room; to NEVER store basins on the floor; and to report anything that is wrong with the vents, personal fans, walls and/or doors. The Maintenance "Fix It" sheet is kept at each nurse's station and staff is expected to put anything that needs maintenance on that sheet. 4. Audits will be created to ensure vents/fans, walls and floors are clean and in good repair, if any padding is torn on the mechanical lifts, if there are any holes in doors, gouges or holes in the walls, and that no basins are on the floor. The audit will be completed by the QA coordinator or designee. The audits will be done weekly times 4, monthly times 2, quarterly times 2, then as deemed necessary by the QA committee.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	**F 280** **See also F 312** 1. Resident #2's care plan has been updated to include the intervention of the COPA Foam dressing for preventing skin breakdown on her spine on 7/7/2014. Resident #6's diet order has been clarified with the primary care physician and her care plan has been updated.	8/13/2014

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F 280	Continued From page 10 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of policies/procedures, and staff interviews, the facility failed to review and revise the resident's plan of care for 4 of 13 sampled residents (Resident #2, #6, #7 and #8). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 07/02/14. This policy, dated September 2012, stated, " Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs, and concerns identified will be addressed . . . The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will deal with the relationship	F 280	Resident #7's care plan has been updated to include documentation of the fall on 2/10/2014 and to address pain as of 8/4/2014. Resident #8's skin has been inspected and has no open areas. The resident's orders and care plan have been updated. 2. All residents have the potential to be affected in this area. By changing our systems and by educating our staff, we will ensure compliance in this area. 3. The MDS coordinators will receive education on 8-7-2014 regarding the procedure titled, "Care Plans" with a focus on the need to communicate care needs and ensure continuity of care for each resident. System change: The center licensed staff members will no longer use paper for documenting resident treatments, including dressing changes and skin monitoring. The licensed staff members will be educated on 8-7-2014 to inform them they need to stop using paper and use only PCC for treatments and care planning. 4. An audit tool will be created to monitor if dressing changes are being input in PCC and documented. Dietary instructions, pain management, and fall	

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F 280	Continued From page 11 of items of services required and facility responsibility for providing these services . . . This plan of care will be modified to reflect the care currently required/provided for the resident." - Review of Resident #2's medical record occurred on all days of survey and identified diagnoses of Alzheimer's dementia and severe degenerative disc disease with bone spurring and spondylitis. Observation on all days of survey showed the resident with a curvature of the upper back. The care plan identified the problem of "potential for pressure ulcer development . . . bony prominence to mid back. . . ." Interventions included ". . . Provide pressure relieving/reducing device on bed, gel cushion in w/c [wheelchair]. . . ." Current physician's orders included, "Copa Foam to spine" as need topically." An Internet website www.allegromedical.com defines Copa Foam as a "soft hydrophilic foam that protects and cushions wounds." The care plan lacked this intervention. On the afternoon of 07/01/14, a staff nurse (#7) stated she performed a dressing change on Resident #2's upper back and the dressing removed was a duoderm dressing. The nurse stated she replaced the dressing with a Copa Foam dressing as ordered. - Review of Resident #6's medical record occurred on all days of survey and identified diagnoses of Alzheimer's disease and dysphagia. The quarterly Minimum Data Set (MDS), dated 05/22/14, identified severely impaired cognition,	F 280	risks are addressed on the care plan. The audit will be completed by the QA coordinator or designee. The audit will be complete weekly for 4 weeks, monthly times 2, quarterly times 3, then as deemed necessary by the QA committee.	8/13/2014

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F 280	Continued From page 12	F 280		

staff supervision for eating, and a mechanically altered diet. Review of the resident's dietary progress notes identified a regular diet, nectar thickened liquids, and food cut into bite-sized pieces.

The current care plan stated, ". . . The resident has nutritional problem or potential nutritional problem DX: dysphagia. Dislikes thicken [sic] liquids . . . Eating-Swallowing: Resident requires nectar thickened liquids . . . Monitor closely/report s/s [signs/symptoms] of swallowing difficulties, coughing, choking. . . ." The care plan failed to identify food cut into bite-sized pieces.

Review of Resident #6's dietary sheet (utilized by dietary staff to indicate how the resident should receive food/beverages) identified nectar thickened liquids but failed to direct staff to cut her food into bite-sized pieces.

- Review of Resident #7's medical record occurred on all days of survey and identified diagnoses of backache, generalized pain, history of falls, altered mental status, and muscle weakness. The quarterly MDS, dated 05/04/14, identified the resident received a scheduled pain medication and no non-pharmacological interventions, had two falls in the last three months, and received two days of active range of motion.

Review of the June 2014 electronic medication administration record (EMAR) identified orders for a 12 microgram Fentanyl patch every 72 hours for back pain and Tylenol 650 milligrams three times a day related to generalized pain.

Review of Resident #7's current care plan

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F 280	Continued From page 13 identified: * "Focus - The resident has a need for restorative intervention due to limited physical mobility E/B [evidenced by] Weakness . . . Interventions - NURSING REHAB #1: Walking in RT [restorative therapy] with 4ww [wheeled walker] and assist of 1 50'- Rest 150'." No specific times per day/week were noted. * "Focus - The resident is at risk for falls R/T [related to] Confusion and choosing to transfer self at times EB History of falls. Fall on 01-18-14. Fall on 03-05-14. Fall on 04-07-14. No injury. Fall on 04-18-14. Fall on 04-20-14. fall on 05-04-14." The care plan failed to identify a fall with injury on 02/10/14 and any interventions. * The care plan failed to identify a focus, goal, or interventions related to the resident's pain issues. - Review of Resident #8's medical record occurred on all days of survey and identified diagnoses of altered mental status, open wound to foot, corns, and callosities. The quarterly MDS, dated 05/16/14, identified the resident at risk for pressure ulcers. Review of Resident #8's EMAR identified a physician's order, dated 06/18/14, stated, "Meplix foam drsg [dressing] to R [right] heel prn [as needed] as needed for R heel spongy macerated area, related to OPEN WOUND FT [foot] . . . Change as needed prn." Review of Resident #8's current care plan identified, "Focus - The resident has potential for pressure ulcer development R/T Hx [history] of ulcers, Immobility, Incontinence E/B need to assess. Blackened area to right heel noted on 05-27-14. . . . Interventions - Treatment to right heel per MD [medical doctor] orders . . . Notify	F 280		

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F 280	Continued From page 14 nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care." Observation of morning cares on 07/01/14, verified a Meplix foam dressing to the right heel. Further observation identified a duoderm dressing to the left coccyx/buttocks. A CNA (#14) assisting the resident indicated the dressing to the coccyx area had been "going on for awhile." During an interview on 07/02/14 at 10:00 a.m., a nursing staff member (#27) verified a duoderm dressing had been applied to the left coccyx/buttocks area to prevent skin breakdown. The nurse indicated there was no open area under the dressing and verified the dressing was not on the EMAR or the care plan. Staff apply as needed and change the dressing when the CNAs report the dressing is falling off. The nurse verified staff changed the dressing on 06/28/14 as written on the dressing. The nurse could not verify when staff stated the dressing. Failure to update the care plan to reflect the residents' most current status has the potential to adversely affect resident care.	F 280		
F 281 SS=E	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: CHOKING INCIDENT	F 281	**F 281** **Part 1 Choking** 1. Resident #6's diet order has been updated as of 7/29/2014. The investigation indicated that the resident was coughing, not choking. No residual harm occurred to this resident from this incident.	

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F 281	Continued From page 15 1. Based on record review, review of professional reference, and staff interview, the facility failed to meet professional standards of quality for 1 of 1 sampled resident (Resident #6) who experienced a choking incident. Failure to properly assess abnormal incidents does not allow for appropriate follow-up of quality of care issues. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 262-263 states, "Long-Term Care Documentation . . . Older adults in long-term care facilities tend to have chronic conditions and generally experience subtle small changes in their condition. However, when problems do occur . . . they are serious and require prompt attention. This points out the importance of keeping . . . charting in long-term facilities current and up to date in the event that the client needs to be transferred for more skilled care and further treatment. . . ." Review of Resident #6's medical record occurred on all days of survey and identified diagnoses of Alzheimer's disease and dysphagia. The quarterly Minimum Data Set (MDS), dated 05/22/14, identified severely impaired cognition, staff supervision for eating, and a mechanically altered diet. Review of the resident's dietary progress notes identified a regular diet, nectar thickened liquids, and food cut into bite-sized pieces. Review of a nursing progress note, dated 05/08/14, stated, ". . . Nectar thick liquids encouraged. Had choking spell at supper last nite [sic] [and] will monitor." Resident #6's medical	F 281	2. All residents have the potential to be affected in this area. By changing our systems and educating our staff, we will ensure compliance in this area. 3. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The staff will be educated from the procedure titled, "Choking" with a focus on the need for staff to properly assess abnormal coughing and/or choking incidents so that appropriate follow up documentation occurs to ensure quality of care. On 7-28-2014 the facility's registered dietician was educated on the need to document the most current diet information. Her progress notes are on the care plan. 4. An audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if a resident has an abnormal incident, if the incident report was completed, if the care team completed the investigation, and that staff performed follow up documentation.	

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F 281	Continued From page 16 record lacked additional information regarding this incident. During an interview on 07/02/14 at 10:15 a.m., an administrative nurse (#2) confirmed Resident #6's record lacked information regarding the choking incident on 05/08/14 and stated the nurse should have assessed the resident and documented detailed information about the incident. SUCTION MACHINE 2. Based on observation, review of professional reference, and staff interview, the facility failed to ensure a safe environment on 2 of 2 nursing units (East and West Units) with suction machines. Staff's lack of knowledge operating the suction machines in case of an emergency situation placed residents at risk for choking and aspiration. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 1406-1407, stated, ". . . Suctioning . . . When clients have difficulty handling their secretions or an artificial airway is in place, suctioning may be necessary to clear air passages . . ." Observation on 07/02/14 at 10:30 a.m. on the West nursing unit showed a staff nurse (#27) set up the emergency suction machine. The nurse failed to connect the filter tubing to the suction machine and the machine would not provide suction. The nurse reconnected all the tubes and the machine still would not provide suction. After	F 281	**F 281 Part Two:** **Suction Machine** 1. No residents where affected in this area. 2. All residents with a mechanically altered diet have the potential to be affected in this area 3. The suction machines on the east and west units have all necessary parts and tubing in place and ready for use as of 7-31-2014. The suction machines will be placed on a weekly inspection list to ensure they are in "ready to use" proper working condition. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All licensed staff will be expected to complete the required training by 8-13-2014. The staff will be educated from the procedure titled, "Suction machine" with	

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F 281	Continued From page 17 approximately 5 minutes nurse (#27) correctly set up the suction machine. Observation on 07/02/14 at 10:50 a.m. on the East nursing unit showed a staff nurse (#28) set up the emergency suction machine and the machine did not have filter tube. The nurse left to retrieve tubing from a nearby storage area. The nurse returned with connecting tubing, attached the tubing, and the machine failed to provide suction. An administrative nurse (#6) attempted to help set up the suction machine. The nurse (#28) located the suction machine directions, reviewed them, and stated she needed the tubing with the filter. Approximately 12 minutes had elapsed and the suction machine still did not work. At this point, the nurse (#28) stated in an emergency she would go to the other unit and retrieve a suction machine. During an interview on the morning of 07/02/14, an administrative nurse (#2) stated she expected staff to know how to set up the suction machine and nursing staff needed education on the use of the suction machine.	F 281	a focus on the need for nurses to know how to properly set up and work the suction machines, ensuring it has all operating parts. The suction machine will be placed on the weekly inspection schedule. 4. An audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit tool will monitor if the suction machines are set up correctly, ready for use, and if staff can demonstrate competency in the use of the suction machines.	8/13/2014
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	**F309** **Part 1Behavior** **See also F 329 and F 428** Resident #11 was discharged to an Alzheimer's unit on 7-23-2014. The exit door that leads into the garage is in proper working condition and double checked on 8-4-2014 by Dakota Security Systems. Resident #3's drug regimen has been reviewed by the primary care physician.	

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F 309	Continued From page 18 by: RESIDENT BEHAVIORS 1. Based on record review, review of facility policy and procedure, and staff interview the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms for 3 of 4 sampled residents (Resident #3, #11 and #12) with wandering behavior and who received an antipsychotic medication. Failure to thoroughly assess the residents' behaviors, implement individualized interventions and establish on-going monitoring of the behaviors resulted in decreased physical, mental and psychosocial well being and negatively impacted the residents' quality of life. Findings include: Review of the facility policy "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 07/02/14. This policy, dated June 2014, stated, "Purpose: To evaluate behavior interventions and alternatives before using psychopharmacological medications and sedative/hypnotics. . . To eliminate unnecessary psychopharmacological medications and sedative/hypnotics. . ." Review of the facility policy titled "Behavioral Causes and Interventions" occurred on 07/02/14. This policy, dated 2012, stated, "Purpose: to aid in determining causes of behavior and appropriate intervention . . . Causal factors of behaviors: Be a detective! Try to determine what's causing the behavior. Is the behavior related to the resident's physical or emotional health? . . . environment? . . . communication? . . . declining ability to perform tasks? . . . caregivers approach? . . ."	F 309	A psych follow up visit will be held on 8-13-2014. Alzheimer's medications where discontinued on 7-21-2014. Pain management was reviewed and pain medication was increased on 7-24-2014. Resident #12's drug regimen has been reviewed by the consulting pharmacist and primary care physician. Psychiatrist follow up visits occurs monthly and resident will be seen next on 8-13-2014. The care plan interventions will be updated to include the use of a secure care bracelet, have items available to divert attention, offer bathroom, food, 1:1 visits, and invite to group activities. 2. All residents that receive PRN antipsychotic medications and have wandering behaviors have the potential to be affected in this area. 3. The facility's consultant pharmacist will continue to review each resident's drug regimen monthly and report any irregularities or concerns to the primary care physician and DNS. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The education material will educate staff on the procedure titled, "Psychopharmacological Medications and Sedative/Hypnotics" with a focus on the	

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F 309	Continued From page 19 - Review of Resident #11's medical record occurred on 07/02/14. Diagnoses included Alzheimers disease, psychosis, and anxiety. Medications included Seroquel [antipsyhotic medication] 100 mg [milligrams] every day and 50 mg every four hours as needed. The quarterly Minimum Data Set (MDS), dated 04/09/14, identified the resident with severely impaired cognition, and the presence of wandering behavior occurred four to six times a week which intruded upon other residents. Resident #11's current care plan identified, ". . . Focus: The resident has a behavior symptom R/T [related to] alz [alzheimers] dementia E/B [evidenced by] h/o [history of] talks to reflection in mirror-try to get person out of mirror, pace, leaves table often during meals, toilets in inappropriate places, swear/curse, rummage, spit on wall/floor, take apart furnature [sic] resistive/reject care, wander halls/into rooms, exit seeking, throw/smear food. . . . Interventions: Provide opportunity for positive interaction, attention. Stop and talk to him/her as passing by. Resident prefers the following diversional activities (such as watering plants, playing cards, story and reminisce) group activities bingo, social hour, devotions. Non-Pharmacological: offer bathroom frequently, physical/verbal redirection, supervision/reminders to eat, offer snacks . . . redirect to safe place . . . explain purpose of care being done . . . toilet frequently, bring into the bathroom. . . ." Resident #11's Interdisciplinary Progress notes identified the following: * 06/02/14 9:55 a.m. "Had just been to the	F 309	need to thoroughly assess the residents' behaviors, document behaviors, implement individualized non-medication interventions. This will be established by monitoring of the behaviors resulting from decreased physical, mental, and psychosocial well-being which negatively impacted the residents' quality of life. Education will also cover the need to monitor for adverse effects of these medications including fall risk, cognitive changes, stomach upset, weight loss/gain, or other abnormal changes. 4. The audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor residents receiving psychoactive medications, if they are exhibiting behaviors and if the causes of the behaviors have been determined. Individualized goals and interventions will be care planned including non-medication interventions and the need for staff to identify, attempt, and document the results of non-medication interventions prior to administering a PRN antipsychotic medication. Medications will also be reviewed monthly by the consultant pharmacist and behavior management committee.	8/13/2014

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	355095	A. BUILDING _____ B. WING _____	07/02/2014

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bathroom, incontinent bm [bowel movement]. Then came to desk and voided in the garbage."
* 06/04/14 8:50 a.m. "Resident continues to wander up and down the hallway and will walk into other residents rooms. . . ."
* 06/24/14 12:26 p.m. "Resident spitting a number of times along main hallway by offices after lunch. Noted this yesterday also on by [sic] East nurses station. Does not redirect to stop as doesn't know has done it."
* 06/24/14 12:51 p.m. "Resident urinated in another residents room right after dinner and just now has had a bowel movement in another room. Did redirect out of area."
* 06/24/14 1:44 p.m. "Incontinent bm in the laundry room, continues to spit constantly on the floor."
* 06/25/14 9:40 a.m. "Incontinent urine and pulled pants down in hallway."
* 06/25/14 12:46 p.m. "Res. [resident] ate in dining room. Res did began [sic] to spit after the meal and was taken back to the unit."
* 06/27/14 9:34 a.m. "Noted in hallway by dining room trying to pull his slacks down."
* 06/28/14 9:53 a.m. "Very restless, wandering into others rooms, continues to spit everywhere. Prn [as needed] seroquel given."
* 06/29/14 8:54 a.m. "Voiding in the garbage by the water cooler."

During an interview on 07/01/14 at 6:35 p.m. a certified nursing assistant (CNA) (#21) stated approximately a week ago Resident #11 exited the door that leads into the garage. The resident opened the door and entered the garage without the alarm sounding. The CNA redirected the resident into the building and the alarm did sound upon return. She explained and demonstrated how the door does not latch unless closed hard

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F 309	Continued From page 21 (slammed). The nursing interdisciplinary progress notes lacked documentation that Resident #11 exited into the garage. During an interview on the morning of 07/02/14, an administrative nurse (#2) stated staff are unable to intervene and manage Resident #11's spitting and voiding in inappropriate places. Failure to asses, and attempt to determine causative factors for Resident #11's behaviors does not allow the facility to determine patterns in the resident's behaviors and implement individualized interventions to decrease the behaviors. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included non-Alzheimer's dementia, depressive disorder and insomnia. Review of the admission MDS, dated 04/27/14, identified Resident #3 with moderate impairment of cognitive abilities, and the presence of wandering behavior occurring one to three days per week. The MDS identified the wandering did not "place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?" and does not "significantly intrude on the privacy or activities of others." The MDS also identified Resident #3 as independent in activities of daily living (ADL) for bed mobility, transfers, walking in room, locomotion on and off the unit, and dressing. Review of the Care Area Assessment (CAA), dated 04/27/14, identified behavioral symptoms of wandering in the facility and "Has left facility on 5/2/14. . . ." Interventions for the wandering	F 309		

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F 309	Continued From page 22 behavior included "remind of place, redirect, reassure, redirect to safe place/activity/room. Offer to take resident for a walk outdoors. Provide diversionary activity such as folding towels, watching tv, listening to music etc. Secure care used to alert staff to resident's movement and to assist staff in monitoring whereabouts." Review of Resident #3's medical record identified the start dates of the following medications: * 04/28/14: Trazadone increased dose to 50 mg twice a day * 04/30/14: Melatonin 3 mg at bedtime "related to INSOMNIA" * 05/20/14: Trazadone HCL (hydrochloride) 150 mg daily "at bedtime for anxiety" * 05/21/14: Trazadone HCL 50 mg one time per day for depression "related to DEPRESSIVE DISORDER . . ." Scheduled for morning dose. * 06/11/14: Namenda XR (extended release) 7 mg "related to Dementia . . ." * 06/12/14: Aricept 5 mg once a day for "Alzheimer's related to dementia" * 06/18/14: "Risperdal [an antipsychotic medication] 0.125 mg two times a day for agitation . . ." Resident #3's current care plan identified the following: * ". . . has dementia E/B confused to time/place, poor short term memory. . . ." with interventions of ". . . needs supervision/assistance with some decision making [initiated 04/28/14] . . . daughters, are able to assist . . . Cue, reorient and supervise as needed. [initiated 05/23/14] . . . NON-PHARMACOLOGICAL: remind of place/time [initiated 04/29/14]." * ". . . communication problem . . . forgetfulness" with interventions of ". . . Validate resident's	F 309		

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F 309	Continued From page 23 message by repeating aloud. [Initiated 04/22/14]." * ". . . is on antipsychotic medication therapy R/T Dementia w/ [with] behavioral symptoms E/B restlessness, agitation and verbal behavior to staff and others [Initiated 06/19/14]" with interventions of "NON-PHARMACOLOGICAL: Attempt . . . TLC [tender loving care], 1-1 visits, offer snack, take outdoors for walk weather permitting, reassurance. . . . BLACK BOX WARNING - Risperdal . . . Observe for increased mortality in elderly patients with dementia-related psychosis. Potential adverse effects include agitation, anxiety . . . dizziness, drowsiness . . ." * ". . . on antidepressant medication R/T Life events and h/o [history of] insomnia [Initiated 04/22/14]" with interventions of "BLACK BOX WARNING - (trazadone): . . . Potential adverse effects include anxiety . . . dizziness, headache, insomnia, nausea [Initiated 04/22/14]." * ". . . mood problem . . . short temper/easy annoyed, trouble sleeping, fidgety/restless, agitated, angry, anxious, upset [Initiated 06/23/14]" with interventions of . . . NON-PHARMACOLOGICAL: reassure, offer walk outside . . . Let resident express her feelings. Attempt to redirect." * "behavior symptom . . . misplaces her items at times. Eloped from facility. wander/pace facility. call/want to call family repeatedly during the day. exit seek . . . Carries remote for tv and believes it is her telephone and the phone is not working. . . . hit/slap/push/ aggressive towards other, went into another residents room and told resident to shut up as she was hollering. is difficult to redirect. [Initiated 06/23/14]" with interventions of "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Provide	F 309		

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F 309	Continued From page 24 opportunity for positive interaction, attention. If reasonable, discuss resident's behavior. Explain/reinforce to resident why behavior is inappropriate and/or unacceptable. NON-PHARMACOLOGICAL: remind of place, redirect, reassure, redirect to safe place/activity/room. offer walk outside . . . family prefers resident to make calls to them after 5:30 pm, and not all day. [Initiated 06/19/14]" * ". . . potential for elopement R/T impaired cognition and Dementia E/B History of elopement attempts. Left facility unattended on 05-02-14 [Initiated on 04/22/14 and revised on 05/06/14]" with interventions of "Offer to take resident for a walk outdoors. Redirect. Provide diversionary activity such as folding towels, watching tv, listening to music, etc. . . . PERSONAL ALARM . . . used to alert staff to resident's movement and to assist staff in monitoring whereabouts [Initiated 04/22/14]." * ". . . dependent on staff for activities . . ." with interventions of ". . . preferred activities are: crafts, sewing, music groups, sing along, devotions, food preparation, Lutheran services, bingo, manicures. Introduce resident to residents with similar background, interests and encourage/facilitate interaction. Encourage ongoing family involvement. . . . Provide resident with materials for individual activities as desired. Resident likes . . . Crosswords, jigsaw puzzles. Topics of interest may include: she used to sing in a trio and played clarinet, loves to sing. Offer diversionary activities such as: folding towels, stuffing envelopes, sorting items, watering plants. [Initiated 05/07/14]" Interdisciplinary Progress notes stated: * 04/27/14 at 2:20 p.m.: ". . . thinks she is going home, she packed her entire room . . . She	F 309		

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F 309	Continued From page 25 wanted to go sit outside and wait . . . hasn't gotten angry or non compliant with staff, just has to be redirected." * 05/02/14 at 3:05 p.m. eloped from the facility * 05/03/14 at 8:02 p.m.: ". . . is more restless this evening and states thinks it is breakfast time. Has called daughter on cellphone and repeated self on phone several times regarding when she is coming. Able to find room on own. Has wandered up and down hallway and to east side." * 05/04/14 at 3:38 a.m.: ". . . slept very little during noc [night] and has been up in room and had taken sheets off of bed . . . Bed made and encouraged resident to rest a while before breakfast. Secure Care on and no attempt made to elope but believes she is leaving in am [a.m.] and reported this to am nurse so can be monitored closely." * 05/08/14 at 12:44 p.m.: ". . . is very agitated at noon. . . . Tries doors around facility. Sensor on. Doors locked. Refused to eat dinner. Daughter was here in facility this AM." * 05/16/14 at 1:49 p.m.: ". . . continues to wander throughout facility and has had periods of increased anxiety and agitation as that she is not able to go outside. Resident is also upset because her cell phone no longer has a charger. Staff continues to check on resident every 15 mins [15 minutes] due to increased risk of elopement. Will continue to monitor." * 05/19/14 at 12:34 p.m.: "Faxed [provider] as family has concerns with resident and they have asked that she see [psychiatrist]. She continues to pace all over the building. she wont [sic] even sit long enough to get a hot pack, so asked MD [medical doctor] if she would consider increasing her trazadone to TID [three times a day]. or what else they would recommend." * 05/20/14 at 6:40 p.m.: ". . . is constantly pacing	F 309		

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F 309	Continued From page 26 the hallaways [sic] . . . nurse tried to reinforce today that phone doesn't [sic] need to be carried to meals, she got upset. Spoke to daughter . . . and intent [sic] to take the cellphone home and that they will either call at a specific time or we will call them at a specific time . . . [provider] faxed back the following order 50 mg Trazadone [antidepressant that also causes drowsiness] at 8am and 150mg trazadone at 8pm. Will monitor her moods and behavior, she doesn't know her boundaries as she is constantly coming behind nurses station with issues of her cellphone." * 05/22/14 at 12:47 p.m.: ". . . continues to pace the hallways . . ." * 05/24/14 at 1:02 p.m.: "Staff was leaving out back west door and resident attempted to follow, when staff reminded her that she was not allowed outside without supervision, she started screaming at staff member and turned around hollering down to her room. This is a new behavior for her." * 05/25/14 at 2:26 p.m.: "Resident does a lot of waundering [sic] and pacing the hall. She is constantly concerned about her cell phone, staff discover [sic] 6 water pitchers in her bathroom and they were removed. . . . had to mind her in a 30minute [sic] window that she needed to get dressed . . . after 10x . . . changed her clothing. . . ." * 06/01/14 at 2:49 p.m.: ". . . has been wandering the facility all day. . . . has needed to be re directed several times. . . . Resident was reminded that this facility was her home. . . . is noted to have some increased aggiation [sic] in regards to another resident who keeps asking for her help and then yells at resident for helping her or for doing things wrong. Resident was given TLC [tender loving care] and was re directed but at [2:10 p.m.] resident was seen by staff member	F 309		

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F 309	Continued From page 27 slapping a resident across the ear. Will continue to monitor." Review of the incident did not identify the corrective action taken in order to avoid reoccurrences. * 06/03/14 at 11:02 p.m.: ". . . restless this evening . . . Anxious . . . Following nurse frequently on med pass with concerns. Had verbal exchange with another resident and told other resident 'I'm not authorized to care for you.' . . . Will check with unit care coordinatory [sic] regarding massage therapist as noted upper back very tense." * 06/08/14 at 1:34 p.m.: ". . . has been extremely anxious, trying to use her remote as a telephone then getting upset, pacing the halls . . . she even gets to the point that she is aggressive. She then carried around her computer and wondered if she couldn't [sic] make a call with that. Did leave a message . . . to see if computer could be connected so she could skype with daughters." * 06/10/14 at 2:19 p.m.: ". . . has been non stop today . . . asking for . . . phone book. . . went into another residents room and told resident to shut up as she was hollering. . . . as the day progresses she gets more aggressive toward others. . . ." Additional progress notes between 06/12/14 and 06/26/14 identified the facility staff approach to Resident #3's behaviors as "Does not respond well to re-direction . . ."; ". . . continues to wander . . . was reoriented several times without luck. . . ."; ". . . continues to need to be re directed and becomes angry with staff. . . . call staff liars several times . . . when they reminded her that she lives here . . ."; ". . . increased anger and agitation this shift . . . re directed several times . . . and becomes upset with staff. . . . attempted to engage resident in different activities . . . but will only focus on tasks for about 5mins [5 minutes] to	F 309		

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F 309	Continued From page 28 10min . . ."; ". . . very difficult to redirect. . . ." * 06/18/14: "[Psychiatrist] notified of resident's continued agitation et [and] restlessness, attempts of leaving facility. Meds reviewed et Risperidal [anti-psychotic medication] 0.125 mg was ordered bid [two times a day]." * 06/19/14 at 12:36 p.m.: ". . . continues to come to nurses station . . . The fequency [frequency] is becoming very less, but she is extremely bored so will see if activities, daughter and nurse can come up with some ideas to keep her busy or intreigied [sic] in." * 06/25/14 at 11:15 p.m.: "Care Plan Review . . . 60 day . . . She had her initial visit with [psychiatrist] . . . put her on Namenda et Aricept [both used for treatment of dementia symptoms]. He was again notified on 6/18/14 due to increased behaviors et he then ordered Risperdal 0.125 mg bid [two times a day]. . . . was put on antipsychotic medication et now is followed per [psychiatric provider]." * 06/26/14 at 4:43 p.m.: ". . . has been out west side exit twice in the last couple of hours. came back in easily but upset. . . . Tried redirection with conversation and activity, neither helped. . . ." During an interview on 07/02/14 at 10:45 a.m., a staff member (#8) stated Resident #3's behaviors have worsened since admission. The staff member stated specific interventions are put on residents' care plans and the behavior committee will "ask/determine" if the behaviors are occurring at specific times of day and what other interventions staff can try for the next month. The staff member stated staff review the residents' medication use with input from the provider (psychiatrist or resident provider). The staff member stated the behavior committee reviews resident behavior from information documented	F 309		

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F 309	Continued From page 29 on a "Follow Up Question Report." Review of the Resident #3's question report between June 20 and June 30, 2014 identified specific behaviors, i.e. pushing, screaming at others, and exit seeking. The computer generated report lacked the entry of (and presence of) the triggering event, interventions utilized or attempted, and the effectiveness of those interventions. Progress notes from a behavior committee meeting held regarding Resident #3 on 05/13/14 stated, ". . . New admission . . . Has dementia. H/O [history of] attempting to leave building unattended and get lost. Wears secure care bracelet and continues to wander daily. No behaviors reported." The notes did not address the exit seeking behavior, including elopement outside of the facility, and include an evaluation for the effectiveness of the current plan of care. Failure to assess Resident #3's behavior, determine possible causative factors, implement individualized interventions, and evaluate these interventions for Resident #3's behaviors resulted in the increase in the Trazodone, the initiation of Risperdal, and the initiation of two medications for treatment of her dementia. The utilization of medications to control Resident #3's behaviors placed the resident at risk for adverse effects from those medications. - Review of Resident #12's medical record occurred on 07/02/14 and diagnoses included psychosis and dementia. The quarterly MDS, dated 06/24/14, identified severely impaired cognition, hallucinations, delusions, daily occurrences of verbal behaviors directed toward others, other behaviors not directed toward others, rejection of care, and wandering.	F 309		

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F 309	Continued From page 30 The current care plan stated, ". . . Focus: The resident has impaired cognitive function R/T dementia, psychosis E/B cognition fluctuates, forgetful/confused to time/place/dated . . . signs of delirium at times, delusions and hallucinations at times, often look for kids, husband, parents, school . . . Interventions: Reminisce with resident using photos of family and friends . . . Resident needs limited supervision/assistance with decision making . . . Resident is able to: speak clearly in complete sentences and reminisce . . . Cue, reorient and supervise as needed, reminders, verbal cues, and physical assist needed, remind of date/place . . .Invite and assist resident to Bingo, music groups, reading groups, manicures, ladies night . . . Provide diversionary activities: enjoys work tasks such as washing dishes, cleaning tables, folding/sorting socks, folding towels, water plants . . . Focus: The resident has a mood problem R/T dementia, pain, psychosis E/B mood fluctuates . . . moderate depression . . . C/O [complaints of] little interest/pleasure doing things, depressed, tired, poor appetite, trouble concentrating, think better dead . . . upset with 'children,' weepy, fidgety/restless, angry/upset at others who try to help her with her walker, agitated, short temper/easy annoyed . . . Intervention: . . . Non-pharmacological: allow to voice feelings, allow to rest, reassure, offer snacks, repeat as needed, remind to complete meals . . . Focus: The resident has a behavior symptom R/T dementia, psychosis E/B not easily redirected, h/o refuse fww [front-wheeled walker], dress/undress several times, put shoes on the wrong feet, angry at residents and speak negative to them, left shoes at nurses station and accuse staff of stealing them, go into other resident rooms and	F 309		

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	355095	A. BUILDING _____ B. WING _____	07/02/2014

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F 309	Continued From page 31 angry at them, pull recliner into hall and pack to go home, attempt to elope, yell at 'children' to behave, swing arm in attempt to hit staff, slap staff, take O2 [oxygen] off other resident, shake other resident w/c [wheelchair], wanders, paces, scream at tohers [sic], rummage, exit seek, reject care . . . Intervention: . . . Provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by . . . Attempt non-pharmacological interventions, attempt to redirect, explain cares and why they are being done . . . Focus: The resident has potential for elopement R/T dementia, psychosis E/B h/o attempting ot [sic] leave the building and go to school. Exit seeking behavior . . . Intervention: . . . Redirect . . . Provide diversionary activity snacks, activities . . . Wander Guard used to alert staff to resident's movement and to assist staff in monitoring movement . . . Focus: The resident uses psychopharmacological medications R/T psychosis E/B hallucinations . . . Intervention: . . . Attempt non-medication approaches, offer snacks, 1-1 [one-to-one] visits, participation in activities . . . reminscing [sic], talk about her family/life . . . Focus: The resident uses anti-anxiety medications R/T Adjustment issues E/B Anxiety disorder . . . Intervention: . . . Non-pharmacological: Attempt non-pharmacological interventions, encourage her to finish meals, reminise [sic], 1-1 visits, bingo with assistance, activities with assistance, reassurance. . . ." Resident #12's current medications included Seroquel 50 mg three times daily and every four hours as needed, Ativan (antianxiety) 0.25 mg every four hours as needed, Trazodone 12.5 mg twice daily, and Zoloft (antidepressant) 12.5 mg daily.	F 309		

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F 309	Continued From page 32 Review of Resident #12's June 2014 interdisciplinary progress notes identified the following: *06/04/14 at 9:58 a.m. - "Resident continues with increased confusion which ususally [sic] starts after dinner. Little success with redirection. Continues to become upset with staff when they try to correct her." *06/04/14 at 9:48 p.m. - "Resident continues with confusion. Looking for granddaughter tonight and was informed she went home . . . because it is late. Attempting to redirect to room at this time. Will monitor and offer medications as needed for anxiety." *06/12/14 at 3:22 p.m. - "resident talking to herslef [sic]. yelling at a bucket thinking it was her child. saying to this worker that her kids don't listen anymore since talking to us, they think they can get away with anything. cna reported [Resident #12] ripping O2 [oxygen] tubing off other resident face and shaking another residents w/c [wheelchair]." *06/12/14 at 9:27 p.m. - ". . . Continues with agitation taking two staff to prevent resident from socially inappropriate behavior with going into other resident's rooms and being angry with them." *06/12/14 at 10:09 p.m. - "Resident wandering throughout shift in and out of resident's rooms, laundry room and repeated attempts to elope. Angry at other residents and speaking negative to residents and difficult to redirect. Walking up and down hallways yelling at the 'children' to behave with no children present. Upsetting residents. PRN Ativan given and ineffective. Two staff to attempt to redirect at times. Swinging arms at staff d/t [due to] being angry to hit staff. [name of Dr.] faxed with concern."	F 309		

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F 309	Continued From page 33 *06/14/14 at 8:34 a.m. - "T^rying [sic] to dress self and putting coat, [sic] arms on her legs. Very weepy and no change with prn ativan. . . ." *06/14/14 at 7:01 p.m. - ". . . Upset with children, heard talking in loud voice to 'children' stating that they weren't behaving and better straighten out. Upset because they aren't finding their shoes. 'Get up and get that on, or I am sending you home.'" *06/15/14 at 10:21 a.m. - "Has pulled her recliner out into the hallway and is packing to go home." *06/15/14 at 4:04 p.m. - ". . . Walking fast paced in hallway dragging her walker behind her stating she is looking for the men and the kids. Going from exit to exit looking outside. Unable to redirect stating that staff is wrong and that 'he needs to get rid of some kids. I need to see if they are going by.'" *06/28/14 at 12:06 p.m. - "trying to go to dinner and got in argument with male resident and pushed him away in his wheelchair." During an interview on 07/02/14 at 10:30 a.m., a social services staff member (#8) stated when Resident #12 has behaviors, staff members should implement interventions included on the resident's care plan. Resident #12's medical record lacked evidence staff implemented the interventions in the resident's current care plan when she exhibited behaviors. The facility failed to accurately assess and monitor Resident #12's behaviors and failed to implement individualized non-pharmacological interventions to address Resident #12's behavioral and psychological symptoms of dementia.	F 309		

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F 309	Continued From page 34 CHOKING INCIDENT 2. Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for 1 of 1 sampled resident (Resident #6) who experienced a choking episode during a meal. Failure to cut Resident #6's food in bite-sized pieces has the potential to result in additional choking episodes and harm to the resident. Findings include: Review of Resident #6's medical record occurred on all days of survey and identified diagnoses of Alzheimer's disease and dysphagia. The quarterly Minimum Data Set (MDS), dated 05/22/14, identified severely impaired cognition, staff supervision for eating, and a mechanically altered diet. Review of Resident #6's progress notes identified the following: *03/03/14 - "Dietician Assessment and Planning: Dysphagia, aspiration pneumonia. Constipation. No teeth or dentures . . . Regular diet, regular consistency, nectar thick liquids. Dysphagia, difficulty EATING-SWALLOWING: Resident eats per self with supervision. Does not like thickened liquids, but says they are okay . . . set up as needed, cut up food into bite size pieces, alternate food et [and] liquids, remain upright 30 minutes after eating per recommendation of speech therapist. . . ." *05/08/14 - ". . . Nectar thick liquids encouraged. Had choking spell at supper last nite [sic] [and] will monitor." Resident #6's medical record lacked additional information regarding this incident.	F 309	See next page — replaced	

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

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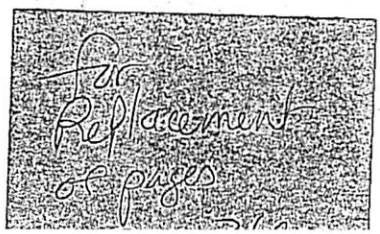

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/201
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OMB NO. 0938-039

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F 309	Continued From page 35 (Refer to F281) *05/27/14 - ". . . DX [diagnosis]: dysphagia . . . cut up food into bite size pieces . . . Swallowing problem. . . ." The current care plan stated, ". . . The resident has nutritional problem or potential nutritional problem DX: dysphagia. Dislikes thicken [sic] liquids . . . Eating-Swallowing: Resident requires nectar thickened liquids . . . Monitor closely/report s/s [signs/symptoms] of swallowing difficulties, coughing, choking. . . ." The care plan failed to identify food cut into bite-sized pieces. (Refer to F280) Review of Resident #6's dietary sheet identified nectar thickened liquids but failed to direct staff to cut her food into bite-sized pieces. Observation of lunch on 07/01/14 showed Resident #6 received a pork chop and gravy, creamed peas, mashed potatoes, and pumpkin pie. Staff failed to cut the resident's food into bite-sized pieces. Observation of supper on 07/01/14 showed Resident #6 received two breaded chicken strips, a lettuce salad, and potato rounds. Staff failed to cut the resident's food into bite-sized pieces. During an interview on 07/01/14 at 2:55 p.m., a dietary staff member (#31) stated the staff member sitting at Resident #6's assisted dining table should cut her food into bite-sized pieces.	F 309	4. An audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if a resident has an abnormal incident, if the incident report was completed, if the care team completed the investigation, and that staff performed follow up documentation.	8/13/2014
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	**F312** 1. Resident #4's nails were checked and trimmed on 7-3-2014 and her preference	

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F 312	Continued From page 36 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 resident and staff interview, the facility failed to provide the necessary services to maintain proper grooming for 1 of 1 sampled resident (Resident #4) on bedrest. Failure to thoroughly clean and trim a resident's nails does not promote the resident's dignity or maintain proper hygiene. Findings include: Review of Resident #4's medical record occurred on all days of survey and identified diagnoses of osteoarthritis and a recent pelvic fracture (occurred on 06/12/14). The quarterly Minimum Data Set (MDS), dated 04/24/14, identified the resident as cognitively intact. The current care plan stated, ". . . The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] limited mobility EB [evidenced by] Musculoskeletal impairment . . . Resident requires 1 staff participation with bathing. 6/16/2014 Daily bedbath due to bedrest . . . Resident requires 1 staff participation with personal hygiene. . . ." During an interview on 06/30/14 at 4:15 p.m., Resident #4 stated since being on bedrest, staff failed to clean and trim her fingernails. The resident stated she asked multiple staff on several occasions to assist in grooming her nails.	F 312	is that they be checked weekly thereafter and that has been done. 2. All residents on bed rest for more than one week have the potential to be affected in this area. A list of residents who are care planned to have a bed bath and residents that are currently on bed rest will have their nails inspected and trimmed weekly and as needed. 3. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The staff will receive education from the procedure titled "Nail Care" with a focus on the need for staff to inspect and trim bed rest residents' nails to their preferred length weekly and/or as needed on their bath day. 4. An audit will be created to monitor 5 random bedrest residents, including the list of resident identified as #2, to assure that the residents' nails are kept at the resident preferred nail length. The audit will be completed by QA Coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. 8/13/2014	

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F 312	Continued From page 37 Observation on June 30 - July 02, 2014 showed Resident #4 had long, untrimmed fingernails. During an interview on 07/02/14 at 10:15 a.m., an administrative nurse (#2) stated staff trim residents' nails during their whirlpool bath and confirmed Resident #4 received bed baths since being on bedrest.	F 312		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Council Meeting minutes, and group, family, and staff interviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 5 of 7 sampled residents (Resident #1, #2, #3, #7, and #10) with orders for restorative therapy (RT). Failure of facility staff to provide the therapy program as care planned has the potential for residents to experience reduced mobility and increased pain/discomfort. Findings include:	F 318	**F 318** 1. Residents'#1, #2, #3, #7, and #10 are receiving their restorative programs as of 7-21-2014 according to their care plan. 2. All residents on restorative programs have the potential to be affected in this area. 3. Restorative staff is no longer being pulled to cover the floor unless deemed necessary in an emergency by the DNS. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The staff regulation titled "Restorative Nursing" education material will cover the need for residents to receive, and staff to document, the frequency of each resident's individualized restorative program as written in their care plan and to not pull restorative staff to cover the floor unless an emergency is deemed by the DNS.	

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F 318	Continued From page 38 Review of the Resident Council Meeting minutes, dated 03/27/14, identified, ". . . therapy sometimes might be closed due to pulling therapy workers to help out on the floor. . . ." During the group interview on 07/01/14 at 10:00 a.m., when asked if the facility provided RT services on a consistent basis, Resident #A (identified by the facility as interviewable) stated, "Not steady, you can't count on it [RT] happening." During interviews on 07/01/14 between 8:00 a.m. to 9:00 a.m., five certified nursing assistants (#11, #12, #13, #14, and #15) reported the facility reassigns RT staff to assist with cares on the floors whenever the facility is short staffed. They further stated when staff are reassigned, RT services are not provided or rescheduled. During an interview on 07/01/14 at 2:10 p.m., Resident B's family member reported the facility is often short staffed, and the RT staff will be reassigned to assist with cares on the floors. The family member expressed frustration and/or concern regarding Resident B having decreased range of motion secondary to receiving inconsistent RT services. During an interview on 07/01/14 at 2:40 p.m., three therapy staff members (#16, #17, and #18) confirmed when the facility is short staffed, RT staff will be reassigned to assist with cares on the floors, and RT services will not be provided or rescheduled. During an interview on 07/01/14 at 2:50 p.m., a managerial nursing staff member (#19) reported nursing staff plan the RT programs, and typically	F 318	4. The audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if the restorative room is open and if restorative programs are documented appropriately.	8/13/2014

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F 318	Continued From page 39 recommend staff provide services three-to-five times per week. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included limited physical mobility related to confusion/cognitive loss, knee pain, and a history of falls. The quarterly Minimum Data Set (MDS), dated 04/30/14, identified severely impaired cognition and limited-to-extensive assistance required for all Activities of Daily Living (ADLs). The care plan identified the following interventions, ". . . [revised 06/02/14] RESTORATIVE: Provide restorative nursing program to maintain improved strength and balance. . . . [initiated 10/22/13] Active range of motion to UE [upper extremity] tasks with small pegs x 15 min [minutes], Transfers training with Nu-step [equipment] at level 2 for 15 min for strengthening to assist with transfers, Ambulate in RT 50-200' [feet] with FWW [front wheeled walker] and assist of 1, Walk list to walk 50-200 ft [feet] BID [twice daily] with FWW and assist of 1." The care plan failed to identify the frequency with which staff were to provide Resident #1 RT services. The "Therapy Services Log" identified staff treated Resident #1 24 times between April 01, 2014-June 30, 2014. She should have received RT services 39-to-65 times (based on a frequency of three-to-five times per week). - Review of Resident #10's medical record occurred on July 1-2, 2014. Diagnoses included deconditioning, gait/balance problems, limited physical mobility related to osteoarthritis and dementia. The quarterly MDS, dated 06/20/14,	F 318		

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F 318	Continued From page 40 identified severely impaired cognition, limited-to-extensive assistance required for all Activities of Daily Living (ADLs), and functional impairment of upper extremity. The care plan identified the following interventions, ". . . [revised 10/01/13] RESTORATIVE: Provide restorative nursing program to maintain improved strength and balance. . . . [initiated 10/22/13] Active range of motion doing bilateral pulleys x 5 min, Nustep x 15 min for strengthening to assist with transfers, Walk in RT with FWW and 1 assist 50-200', Walk on walk list 50-200' with FWW with contact guard assist BID." The care plan failed to identify the frequency with which staff were to provide Resident #10 RT services. The "Therapy Services Log" identified staff treated Resident #10 24 times between April 01, 2014-June 30, 2014. He should have received RT services 39-to-65 times (based on a frequency of three-to-five times per week). - Review of Resident #3's medical record occurred on all days of survey. Resident #3's diagnoses included: non-Alzheimer's dementia, depressive disorder and insomnia. Resident #3's progress notes, dated 05/07/14 identified an order by the provider for hot packs two times a day for 20 minutes. The current care plan identified ". . . need for restorative intervention due to . . . musculoskeletal impairment . . . back discomfort" with interventions of "NURSING REHAB [rehabilitation] OTHER: Hot packs to low back x's [times] 20 minutes" The care plan failed to identify the frequency of the hot packs.	F 318		

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F 318	Continued From page 41 Review of progress notes identified nursing staff offered or provided hot packs for Resident #3; twice during the week for 05/11/14; three times during the week of 05/18/14; two times during the week of 05/25/14; not at all the week of 06/01/14; four times the week of 06/08/14; none the week of 06/15/14; and three times the week of 06/22/14. The daily documentation indicated no restorative offered/provided between 06/15/14 and 06/25/14. - Review of Resident #2's record occurred on all days of survey. Resident #2's care plan identified "a need for restorative intervention due to ADL self-care performance deficit/limited physical mobility R/T deconditioning. . . . Weakness" with interventions of "NURSING REHAB #1: Resident to ambulate on walk list with Assist of 1 and 4ww [four wheeled walker] 50-150 [feet two times a day]." The care plan identified the problem initiated on 01/31/14 and target date of 09/18/14. Review of April, May and June logs showed no restorative therapy provided for Resident #2 between April 1 and April 13, 2014. Review of a "Therapy Services Log" showed the name of several residents on the log with no specific RT program identified for each resident. - Review of Resident #7's medical record occurred on all days of survey and diagnoses included muscle weakness (generalized), moderate cognitive impairment, history of falls, and abnormality of gait. Review of the current care plan identified, "Focus - The resident has a need for restorative	F 318		

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F 318	Continued From page 42 intervention due to limited physical mobility E/B [evidenced by] Weakness Date initiated: 3/6/2014 . . . Goals - Resident will maintain current level of mobility able to walk with walker and 1 person assist for 50-150' through review date. Target Date: 8/4/2014 . . . Interventions - NURSING REHAB #1: Walking in RT with 4ww (wheeled walker) and assist of 1 50'-Rest 150' Revision on: 4/17/2014." The quarterly MDS, dated 05/04/14, identified two days of active range of motion during the seven day look back period. Review of a "Therapy Services Log" for April, May and June 2014 identified Resident #7 received a total of four days of restorative and refused on three other days. Observation on 07/02/14 at 11:20 a.m., showed the RT therapy gym closed. A therapy staff member (#17) confirmed the reassignment of RT staff to assist with cares on the floors.	F 318		
F 323 SS=E	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: ELOPEMENT	F 323	**F323** **Part 1 Elopement** **See also F 309** 1. Resident #3's individual needs are being met by addressing elopement risk on the care plan with individualized interventions to prevent the chance of an elopement, including assessing for a causative factor or contributing to wandering. Her Alzheimer's medications have been discontinued and a pain pill has been routinely scheduled instead of only PRN for her daily discomfort. Staff offers	

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F 323	Continued From page 43 1. Based on observation, review of facility policies and procedures, record review, and staff interview, the facility failed to provide adequate supervision and monitoring to safeguard 1 of 1 sampled resident (Resident #3) who eloped from the facility. Failure to provide adequate supervision and monitoring of Resident #3's wandering behavior resulted in Resident #3 leaving the facility unattended; without the facility's knowledge; and placed Resident #3 at risk for further elopement and subsequently at risk serious injury and harm. Findings include: Review of the facility policy titled "Elopement" occurred on 07/02/14. The policy, dated September 2012, stated: "PURPOSE: to provide protection for residents at risk for elopement DEFINITION . . . When a resident who needs supervision leaves the premises or a safe area without authorization . . . and/or any necessary supervision to do so. . . ." Review of the facility procedure titled "Elopement" occurred on 07/02/14. The procedure, dated September 2012, stated: "PURPOSE: To assess and identify residents at risk for elopement; To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and individual resident risk, including the need for supervision; evaluating/analyzing hazards and risks; implementing interventions, including adequate supervision, consistent with a residents' needs, goals, plan of care . . . To minimize risk for elopement through	F 323	her knitting, diverts her attention with the busy box and checks the secure care bracelet every shift to ensure the resident hasn't taken it off. The wandering and exit seeking behaviors have decreased with these changes. 2. All residents that display exit seeking behaviors have the potential to be affected in this area. By changing our systems and educating our staff, we will ensure compliance in this area. 3. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The education material will educate staff on the procedure entitled "Elopement", focusing on the need to assess and determine a possible cause of the behavior, review medications, determine if the resident is in pain, and implement individualized intervention to prevent all residents from eloping. Each department will be educated by 8-13-2014. Dakota Security was in the building on 8-4-2014. All doors were found to be working appropriately when the locking mechanisms were checked. 4. An audit tool has been developed and will be completed by QA coordinator or designee weekly times 4, then monthly	

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F 323	Continued From page 44 individualized interventions . . . PROCEDURE: 1. . . . assessed to determine . . . risk for elopement . . . 2. identify all residents who are at risk of elopement on the care plan with interventions specific to the resident to minimize individual risk. 3. . . . provide verbal information . . . about the need for resident/family to sign in/out at the nurse's station when leaving the center . . . 4. Care plan team members should consider the following: a. Wandering behavior - the movement may be goal directed . . . or may be non-goal directed or aimless. . . . 8. Residents who attempt elopement after admission . . . Track wandering behavior/elopement attempts in POC [plan of care] . . ." Observations of Resident #3 on 07/01/14 identified the following: *9:10 a.m. - fully dressed and wandering up and down the hall; *11:30 a.m. - 1:00 p.m. - taken out on pass with family; *4:45 p.m. - attempting to exit the west door by the nurse's station; *6:00 p.m. - attempting to exit the west door by the nurse's station Review of Resident #3's medical record occurred on all days of survey. Resident #3's diagnoses included: non-Alzheimer's dementia, depressive disorder and insomnia. Review of an admission Minimum Data Set (MDS), dated 04/27/14, identified Resident #3 with moderate impairment of cognitive abilities, and the presence of wandering behavior occurring one to three days per week. The MDS identified the wandering did not "place the resident at significant risk of getting to a	F 323	times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will include checking to see if the resident has experienced any wandering or exit seeking behaviors, if the cause of the exit seeking has been assessed, if the care plan has identified the risk for elopement, and if the care plan lists individualized interventions that would prevent the risk of elopement.	8-13-2014

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F 323	Continued From page 45 potentially dangerous place (e.g., stairs, outside of the facility)?" and does not "significantly intrude on the privacy or activities of others." Review of the Care Area Assessment (CAA), dated 04/27/14, identified behavioral symptoms of wandering the facility and "Has left facility on 5/2/14. . . ." Interventions for the wandering behavior included "remind of place, redirect, reassure, redirect to safe place/activity/room. Offer to take resident for a walk outdoors. Provide diversionary activity such as folding towels, watching tv, listening to music etc. Secure care used to alert staff to resident's movement and to assist staff in monitoring whereabouts." Resident #3's current care plan addressed the wandering behavior as: * ". . . potential for elopement with interventions of "Offer to take resident for a walk outdoors. Redirect. Provide diversionary activity such as folding towels, watching tv, listening to music, etc. . . . PERSONAL ALARM . . . used to alert staff to resident's movement and to assist staff in monitoring whereabouts [Initiated 04/22/14]." A facility report identified an incident with Resident #3 on 05/02/14 at 3:05 p.m. The report stated, "Nurse was alerted by ward clerk that resident's daughter called and stated that resident just called her and stated that she was looking at a stop sign trying to find her (daughter's) house. Stated she wanted to go and take a walk and visit her daughter." The immediate action taken was a search by facility staff within the building and "on the grounds in case she returned." The report stated at 3:13 p.m. Resident #3 was "brought back to the facility by another resident's daughter who saw her." The facility investigation of the	F 323		

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F 323	Continued From page 46 door alarms within the facility identified "A family member stated that the door had locked earlier and she entered the code for resident to leave. Family member stated 'she looked like she belonged outside.'" The report, reviewed by the provider and an administrative staff member, lacked corrective action to prevent reoccurrences. Review of interdisciplinary progress notes identified the following: * 05/16/14 at 1:49 p.m.: ". . . continues to wander throughout facility and has had periods of increased anxiety and agitation as that she is not able to go outside. . . continue to monitor." * 05/20/14 at 6:40 p.m.: ". . . is constantly pacing the hallaways [sic] . . . [provider] faxed back the following order 50 mg [milligrams] Trazadone [antidepressant that also causes drowsiness] at 8am [8 a.m.] and 150mg trazadone at 8pm. . . ." * 05/22/14 at 12:47 p.m.: ". . . continues to pace the hallways . . ." * 05/24/14 at 1:02 p.m.: "Staff was leaving out back west door and resident attempted to follow, when staff reminded her that she was not allowed outside without supervision, she started screaming at staff member and turned around hollering down to her room. This is a new behavior for her." * 05/25/14 at 2:26 p.m.: "Resident does a lot of waundering [sic] and pacing the hall. . . ." * 06/01/14 at 2:49 p.m.: ". . . has been wandering the facility all day. . . ." * 06/08/14 at 1:34 p.m.: ". . . pacing the halls . . ." * 06/10/14 at 2:19 p.m.: ". . . has been non stop today . . ." Additional progress notes between 06/12/14 and 06/26/14 identified staff approach to Resident	F 323		

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F 323	Continued From page 47 #3's behaviors "; ". . . continues to wander through out . . . has attempted elopement x 3 but has not left premises. . . . continues to wander throughout facility . . . re directed several times . . . attempted to engage resident in different activities . . . but will only focus on tasks for about 5mins [5 minutes] to 10min . . ."; ". . . very difficult to redirect. . . .". * 06/26/14 at 4:43 p.m.: ". . . has been out west side exit twice in the last couple of hours. came back in easily but upset. . . . Tried redirection with conversation and activity, neither helped. . . ." Failure to determine causative/contributing factors which allowed Resident #3's elopement on 05/02/14 limits the facility from preventing further elopements. TRANSFERS AND ASSISTIVE DEVICES 2. Based on observation, record review, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 3 of 6 sampled residents (Resident #1, #7 and #10) and 7 supplemental residents (Resident #16, #17, #18, #19, #20, #21, #22), observed without wheelchair foot pedals in place. Failure to apply foot pedals to wheelchairs during staff-assisted transport may result in falls and/or injuries to the residents. Findings include: - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included limited physical mobility related to confusion/cognitive loss, osteoarthrosis, knee pain, and a history of falls. The quarterly Minimum Data Set (MDS), dated 04/30/14,	F 323	**F 323 Part 2** **Transfer and Assistive Devices** 1. Resident's #1, #7, #10, #16, #17, #18, #19, #20, #21, and #22 will have a bag on the back of their wheelchair to store foot pedals. These residents will have the foot pedals on or are to be cued during transport. 2. All residents who are in wheelchairs have the potential to be affected in this area.	

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F 323	Continued From page 48 identified extensive assistance required for transfers. Observation on 07/01/14 at 4:35 p.m. showed a certified nurse assistant (CNA) (#21) transported Resident #1 from the nurse's station to her room in her wheelchair. Resident #1's feet/shoes caught and bounced on the floor as staff transported her in the chair. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included generalized pain and muscle weakness, abnormality of gait, history of falls, and an altered mental status. The quarterly MDS, dated 05/04/14, identified extensive assistance required for transfers. Observations showed the following: * On 06/30/14 at 4:30 p.m., a CNA (#32) transported Resident #7 down the hallway to the activity room in her wheelchair without foot pedals in place. Her feet/shoes made an audible noise as they slid along the surface of the floor. * On 07/01/14 at 8:00 a.m., an unidentified CNA transported Resident #7 down the hallway to the west nurses' station from the dining room in her wheelchair without foot pedals in place. The resident's feet/shoes made an audible noise as they slid along the surface of the floor. * On 07/01/14 at 4:30 p.m., a CNA (#20) transported Resident #7 down the hallway to the lounge in her wheelchair. Resident #7's feet/shoes made an audible noise as they slid along the surface of the floor. - Review of Resident #10's medical record occurred on July 1-2, 2014. Diagnoses included deconditioning, limited physical mobility related to	F 323	3. System change The facility ordered wheelchair leg rest bags to go on the back of resident wheelchairs for residents that require staff assistance for people that can't hold their feet up. Each department will be educated on the need to have and use wheel chair foot pedals or cue residents to lift feet up when staff provides assistance during transport. This is be completed by 8-13-2014. Education will be provided in a written format with a comprehensive test to reach compliance in this area. 4. An audit tool will be developed and will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will check 5-7 random residents for chair foot pedals available on the wheelchairs of those who need them, if the foot pedals are being used or if cueing is being done for those who don't need foot pedals. For those who don't need foot pedals, the audit will check if the feet remained off the floor.	8-13-2014

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F 323	Continued From page 49 osteoarthritis and dementia. The quarterly MDS, dated 06/20/14, identified extensive assistance required for transfers. Observation on 06/30/14 at 4:55 p.m. showed a CNA (#22) transported Resident #10 down the hallway to the dining room in his wheelchair. Resident #10's feet/shoes slid along the surface of the floor as staff transported him in the chair. - Review of Resident #16's medical record occurred on July 1-2, 2014. Diagnoses included Alzheimer's disease, osteoporosis, pain, muscle weakness, and history of fractures. The quarterly MDS, dated 06/15/14, identified extensive assistance required for transfers. Observations showed the following: * On 06/30/14 at 4:55 p.m., a CNA (#23) transported Resident #16 down the hallway to the dining room. Resident #16's feet/shoes slid along the surface of the floor as staff transported her in the chair. * On 07/01/14 at 8:10 a.m., a CNA (#12) transported Resident #16 down the hallway. Resident #16's feet/shoes made an audible noise as they slid along the surface of the floor as staff transported her in the chair. - Review of Resident #17's medical record occurred on July 1-2, 2014. Diagnoses included cerebral palsy, bone/cartilage disorder, contractures and pain. The quarterly MDS, dated 05/28/14, identified extensive assistance required for transfers. Observations showed the following: * On 06/30/14 at 5:05 p.m., a CNA (#21) transported Resident #17 down the hallway to the	F 323		

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dining room. Resident #17's feet/shoes slid along the surface of the floor as staff transported her in the chair.
* On 07/01/14 at 8:05 a.m., a CNA (#24) transported Resident #17 down the hallway to an activity. Resident #17's feet/shoes slid along the surface of the floor as staff transported her in the chair.

- Review of Resident #18's medical record occurred on July 1-2, 2014. Diagnoses included dementia, muscle weakness, and pain. The quarterly MDS, dated 04/22/14, identified extensive assistance required for transfers.

Observation on 06/30/14 at 5:05 p.m. showed an administrative nursing staff member (#2) transported Resident #18 down the hallway to the dining room in her wheelchair. Resident #18's feet/shoes slid along the surface of the floor as staff transported her in the chair.

- Review of Resident #19's medical record occurred on July 1-2, 2014. Diagnoses included Alzheimer's disease and muscle weakness. The quarterly MDS, dated 03/31/14, identified extensive assistance required for transfers.

Observation on 06/30/14 at 5:05 p.m. showed an unidentified CNA transported Resident #19 down the hallway in her wheelchair. Resident #19's feet/shoes caught and bounced on the floor as staff transported her in the chair.

- Review of Resident #20's medical record occurred on July 1-2, 2014. Diagnoses included dementia, Parkinson's disease, muscle weakness, and osteoarthrosis. The quarterly MDS, dated 05/20/14, identified extensive

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F 323	Continued From page 51 assistance required for transfers. Observation on 07/01/14 at 4:30 p.m., showed a CNA (#20) transported Resident #20 down the hallway to the dining room in his wheelchair. Resident #20's feet/shoes made an audible noise as they slid along the surface of the floor as staff transported him in the chair. - Review of Resident #21's medical record occurred on July 1-2, 2014. Diagnoses included pain. The quarterly MDS, dated 06/05/14, identified extensive assistance required for transfers. Observation on 07/01/14 at 4:30 p.m., showed an administrative activities staff member (#25) transported Resident #21 down the hallway to the dining room in his wheelchair. Resident #21's feet/shoes caught and bounced on the floor as staff transported him in the chair. - Review of Resident #22's medical record occurred on July 1-2, 2014. Diagnoses included dementia, muscle weakness, involuntary movements, and pain. The quarterly MDS, dated 05/05/14, identified extensive assistance required for transfers. Observation on 07/01/14 at 4:30 p.m., showed a CNA (#26) transported Resident #22 down the hallway to the dining room in his wheelchair. Resident #22's feet/shoes caught and bounced on the floor as staff transported him in the chair. During all of the above observations of staff members transporting residents, the staff members failed to place foot pedals on the residents' wheelchair, cue them to lift their	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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 323	Continued From page 52 feet/shoes, and ensure their feet/shoes cleared the floor during transport to avoid catching their feet on the flooring and potentially causing pain and/or injury. During an interview on the morning of 07/02/14, an administrative nursing staff member (#2) agreed staff should have provided cues and/or utilized assistive devices (wheelchair foot pedals) during transport. HAZARDOUS CHEMICALS 3. Based on observation, review of product labels, review of facility policy and procedure, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 2 of 2 resident living areas/units (East and West) storing chemicals. Failure to secure hazardous chemicals placed residents with memory loss and/or wandering behaviors at risk of exposure to those chemicals. Findings include: Review of the facility policy/procedure titled "Housekeeping and Laundry Departments: Safety Rules" occurred on 07/02/14. This policy, revised September 2012, stated, ". . . Do not leave any chemicals unattended in resident room or in any area to which residents have access. Store chemicals in a locked area. . . ." An initial tour of the facility occurred on the morning and in the afternoon of 06/30/14. Observations showed the following: * Resident Room 212: 2 cans Lysol Disinfectant Spray on a tv stand * Resident Room 509:	F 323	**F 323 Part 3** **Hazardous Chemicals** 1. No residents are involved in this area. The Lysol spray has been removed from room 212 and room 509. The can of Citrus Blast Air Freshener, the can of Dust –Off Electronics Compressed Gas and lint cleaner, Lysol IC Foaming Disinfectant, Lysol disinfecting spray, and the Clorox Disinfectant wipes have been placed in a locking cupboard. The Lysol disinfecting sprays in the East unit bathing room and the soiled utility room have been placed in locking cupboards. 2. All residents have the potential to be affected in this area. 3. Education will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The education materials will educate staff on the need to have	

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F 323	Continued From page 53 1 can Lysol Disinfectant Spray on a tv stand * Clean Utility Room, East Unit: 1 can Claire Citrus Blast Metered Air Freshener on an open shelf 1 can Dust-Off Electronics Compressed Gas Dust and Lint Cleaner on an open shelf 1 can Lysol IC Foaming Disinfectant Cleaner on an open shelf 1 can Lysol Disinfectant Spray on an open shelf 1 container Clorox Disinfectant Wipes on an open shelf * Bathing Room, East Unit: 1 can Lysol Disinfectant Spray in an unlocked cupboard * Soiled Utility Room, West Wing: 1 can Lysol IC Foaming Disinfectant Cleaner in an unlocked cupboard The product labels stated the following: * Dust-Off Electronics Compressed Gas Dust and Lint Cleaner ". . . Inhalation of high concentrations of vapor is harmful and may cause heart irregularities, unconsciousness, or death. . . . deliberate inhalation may cause death without warning. . . . Liquid contact can cause frostbite. . . . Higher exposures may lead to irritation of nose, throat, and lungs with cough, difficulty breathing or shortness of breath, temporary alteration of the heart's electrical activity with irregular pulse . . . Gross overexposure may be fatal. . . ." * Claire Citrus Blast Metered Air Freshener ". . . Contact may irritate or burn eyes. Eye contact may result in corneal injury. . . . concentrating and inhaling the product can be harmful or fatal. . . . Ingestion may cause gastrointestinal irritation, nausea, vomiting and diarrhea. . . ." * Lysol Disinfectant Spray and Lysol IC (Infection Control) Foaming Disinfectant Cleaner ". . .	F 323	chemicals stored under lock. Any item that states "Keep out of the reach of children" needs to be locked up. This will be completed by 8-13-2014. 4. The audit will be completed by QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor the facility randomly in utility rooms and resident care areas for any unlocked chemicals that state, "keep out of the reach of children" on the can or bottle, that these items need to be kept under lock and key.	8/13/2014

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F 323	Continued From page 54 Moderately irritating to the eyes. . . . Slightly irritating to the skin . . . concentrating and inhaling the contents may be harmful or fatal. . . . May be harmful if swallowed. . . . Symptoms may include redness, edema, drying, defatting and cracking of the skin. . . ." Symptoms of overexposure to both products include "headache, dizziness, tiredness, nausea and vomiting." * Clorox Disinfectant Wipes ". . . May cause moderate eye irritation. Prolonged skin contact may result in minor irritation." The staff identified seven residents with memory loss and wandering behaviors currently living within the facility. Two administrative staff members (#9 and #10), present during the environmental tour the afternoon of 07/01/14, confirmed they expect staff to keep chemicals locked and out of reach of these residents.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	**F 329** **See also F 428** 1. Resident #3's individual needs have been met by having the resident's drug regimen reviewed by the consultant pharmacist and primary care physician. The Alzheimer's medications have been discontinued. The resident's gait has not changed since admission. Gait disturbance is related to hip pain, not medications. Resident pain is being address by being on a scheduled pain medication instead of just PRN use. Resident # 8's individual needs will be met by having the primary care physician	

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F 329	Continued From page 55 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/24/13. Based on observation, record review, facility policy review, professional reference review, and staff interview, the facility failed to monitor and assess for adequate indications for use of medications for 3 of 7 sampled residents (Resident #3, #7 and #8) who received psychotropic medications in an attempt to control behaviors and had dosages of the drugs increased without evidence of attempts by the facility to minimize the behavior through effective non-pharmacological interventions. Providing psychotropic medications without appropriate monitoring and assessing for adequate indications for their continued use resulted in the residents receiving unnecessary medications. Findings include: Review of the facility policy "Psychopharmacological Medications and Sedative/Hypnotics" occurred on 07/02/14. This policy, date 06/14, stated, "Purpose: To evaluate behavior interventions and alternatives before using psychopharmacological medications and	F 329	document a risk/benefit statement by 8-13-2014. Resident #7 will have the physician document a risk/benefit statement by 8-13-2014 as no changes to the medications are recommended at this time. 2. All residents on antipsychotic medications have the potential to be affected in this area. (A list of residents on psychoactive medications will be available to the consultant pharmacist.) 3. The facility physicians will receive education by 8-13-2014 on the federal regulation that if a family wishes no changes in medications, this is not an acceptable reason for not reducing or changing psychoactive medications. Education to staff will be provided in a written format with a comprehensive test to reach compliance in this area. All staff will be expected to complete the required training by 8-13-2014. The education material will cover the procedure "Psychopharmacological Medications" with a focus on teaching staff to make sure physicians document a risk/benefit statement if no changes are recommended to psychoactive medications. They cannot document "per family wishes." 4. An audit tool will be developed and completed by the QA coordinator or	

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F 329	Continued From page 56 sedative/hypnotics. . . . To eliminate unnecessary psychopharmacological medications and sedative/hypnotics. . . . Procedure: Non-Emergency Administration. . . . 1. Before administering of non-emergency psychopharmacological and/or sedative/hypnotics, the following must be completed: a. Documentation in PCC-POC (Plan of Care) observations of mood symptoms or behaviors that cause the resident distress and/or endanger the resident or others and response to interventions used. b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used. . . . 2. If, after reviewing the mood and behavior documentation, the behavior committee and/or care plan team determines psychopharmacological medications and sedative/hypnotics may be necessary, the reduction committee must be notified. 3. If the reduction committee determines that a medication is warranted, then the committee nurse will ensure the following is completed: a. Contact the physician and describe the behavior, attempted interventions/alternatives and behavior committee recommendations. b. Obtain an order for an appropriate medication, in an appropriate dose, and for corresponding diagnosis, as well as medical symptom for the physician. . . . 9. Throughout the administration of the psychopharmacological medications . . . . the following must be completed: a. Mood and behavior documentation must continue in order to indicate the effect the medication has on the behavior. b. Monitor for side effects of the medication. . . . d. Monitor for effectiveness and potential adverse consequences."	F 329	designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if the residents' drug regimen was reviewed monthly by the consultant pharmacist and primary care physician has documented a risk/ benefit statement as to why a psychoactive medication should not be reduced or changed.	8/13/2014

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F 329	Continued From page 57 The "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 1360-1362, stated, ". . . Trazodone . . . . Indications . . . Depression . . . Insomnia . . . Adverse Reactions . . . drowsiness, dizziness, nervousness, fatigue, confusion . . . weakness . . . insomnia, syncope [fainting] . . ." Page 1192-1194, stated, ". . . Risperdal . . . Indications . . . Schizophrenia . . . Adverse Reactions . . . dizziness . . . impaired concentration . . . fatigue, depression, nervousness . . ." - Review of Resident #3's medical record occurred on all days of survey. Resident #3's diagnoses included: non-Alzheimer's dementia, depressive disorder and insomnia. Observations of Resident #3 on 07/01/14 included the following: *7:45 a.m. - sitting on her bed in her room drinking coffee and eating graham crackers; *9:10 a.m. - fully dressed and wandering up and down the halls; *11:30 a.m. - 1:00 p.m. - taken out on pass with family; *4:45 p.m. - attempting to exit the west door by the nurse's station; *6:00 p.m. - attempting to exit the west door by the nurse's station Review of an admission Minimum Data Set (MDS), dated 04/27/14, identified Resident #3 with moderate impairment of cognitive abilities, and wandering behavior occurring one to three days per week. The MDS identified the wandering did not "place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?" and does not "significantly intrude on the privacy or activities of	F 329		

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F 329	Continued From page 58 others." The MDS identified Resident #3 as independent in activities of daily living (ADL) for bed mobility, transfers, walking in room, locomotion on and off the unit, and dressing. Review of the Care Area Assessment (CAA), dated 04/27/14, identified Resident #3 received Melatonin for insomnia and Trazodone for depression; wandering behaviors with interventions of "Wears a secure care [bracelet for wandering to avoid exit out of facility] . . . Interventions: remind of place, redirect, reassure, redirect to safe place/activity/room. Offer to take resident for a walk outdoors. Provide diversionary activity such as folding towels, watching tv, listening to music etc. Secure care used to alert staff to resident's movement and to assist staff in monitoring whereabouts." Review of Resident #3's medical record identified the use of the following medications on: * 04/28/14: Trazodone increased dose to 50 mg (milligrams) twice a day * 04/30/14: Melatonin 3 mg at bedtime "related to INSOMNIA" * 05/20/14: Trazodone HCL (hydrochloride) 150 mg "at bedtime for anxiety" * 05/21/14: Trazodone HCL 50 mg one time per day for depression "related to DEPRESSIVE DISORDER . . ." Scheduled for morning dose. * 06/11/14: Namenda XR (extended release) 7 mg "related to Dementia . . ." * 06/12/14: Aricept 5 mg once a day for "Alzheimer's related to dementia" * 06/18/14: "Risperdal [an antipsychotic medication] 0.125 mg two times a day for agitation . . ." Interdisciplinary Progress notes identified	F 329		

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F 329	Continued From page 59 frequent occurrences of Resident #3's wandering behavior and attempts to exit the facility (wanderguard placed on admission); agitation on 05/08/14; no behaviors identified by the behavior committee meeting on 05/13/14; increased anxiety and agitation on 05/16/14; on 05/20/14, an order for 50 mg Trazodone at 8 a.m. and 150 mg at 8 p.m. with a notation "she doesn't know her boundaries as she is constantly coming behind nurses station with issues of her cellphone;" screaming at staff when not allowed to leave the facility; "some" increased agitation "in regards to another resident who keeps asking for her help and then yells at resident [#3] for helping her or for doing things wrong. . . . seen by staff member slapping a resident across the ear" on 06/01/14; anxiousness, verbal exchange with another resident on 06/03/14; "went into another residents room and told resident to shut up as she was hollering" on 06/10/14. Progress notes between 06/12/14 and 06/26/14 identified staff approaches as "Does not respond well to re-direction . . . continues to wander through out . . . was reoriented several times without luck. . . .continues to need to be re directed and becomes angry with staff. . . . call staff liars several times . . . when they reminded her that she lives here . . . increased anger and agitation this shift . . . re directed several times . . . and becomes upset with staff. . . . attempted to engage resident in different activities . . . but will only focus on tasks for about 5mins [5 minutes] to 10min . . . very difficult to redirect. . . ." The medical record lacked an assessment including tracking of behaviors, resident specific approaches, and the evaluation of the approaches/interventions utilized. The record identified nursing staff requested increased doses	F 329		

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F 329	Continued From page 60 of the Trazodone (on 05/19/14 as Resident #3 "continues to pace all over the building . . . so asked MD [medical doctor] if she would consider increasing her trazodone to TID [three times a day]." The record included a 60 day care plan review identifying Resident #3's initial visit with a psychiatrist ". . . put her on Namenda et Aricept [both used for treatment of dementia symptoms]. He was again notified on 6/18/14 due to increased behaviors et he then ordered Risperdal 0.125 mg [two times a day]. . . . now is followed per [psychiatric provider]." The lack of identifying target behaviors, assessment/identification of the cause for the targeted behaviors, implementation of appropriate non-pharmacological interventions, accurate/complete monitoring of the frequency of the behaviors, and established goals to minimize behavior and the use of behavior modifying/controlling medications, prohibits Resident #3 from service necessary to maintain individuality and maximum allowable/appropriate control over her day-to-day life, routine, and goals. - Review of Resident #7's medical record occurred on all days of survey and diagnoses included altered mental status, anxiety, insomnia, pain, muscle weakness, and a history of falls. The quarterly MDS, dated 05/04/14, identified moderate cognitive impairment, minimal depression, feeling tired or having little energy for twelve to fourteen days, and trouble falling or staying asleep, or sleeping too much occurring two to six days during the fourteen day assessment period.	F 329		

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F 329	Continued From page 61 Review of the June 2014 electronic medication administration record (EMAR) identified the following medications: * "Trazodone HCL Tablet Give 50 mg by mouth at bedtime for insomnia . . . Start Date- 04/29/2014" * "RisperDAL Tablet 0.5 mg (RisperiDONE) Give 1 tablet by mouth as needed for insomnia, anxiety . . . May have BID [two times per day] prn [as needed] -Start Date- 03/05/2014" Review of the current care plan identified: * "Focus - The resident is on antipsychotic medication therapy R/T [related to] restlessness and psychosis . . . Interventions - Monitor for a significant decline in function and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear . . . ." * "The resident is on antidepressant medication therapy R/T Life event E/B [evidenced by] need to assess for any adverse reactions from medication . . . Interventions - BLACK BOX WARNING - Desyrel (Trazodone): Observe for increased risk of suicidal thinking and behavior. Potential adverse effects include anxiety, constipation, diarrhea, dizziness, headache, insomnia, nausea." * "The resident has a mood problem R/T anxiety . . . minimal depression . . . C/O [complains of] sleeping too much and tired/little energy. OBS [observed] fidgety, restless, agitated, anxious, trouble sleeping, slow, cry/wheepy . . . Interventions . . . NON-PHARMACOLOGICAL: reassure, allow to voice moods, offer snack/activity if unable to sleep/restless, use non-hurried/gentle approach." Review of the March, April, May, and June 2014 EMARs verified staff administered Risperdal 0.5 mg PRN without identifying behaviors related to	F 329		

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F 329	Continued From page 62 insomnia/anxiety or non-pharmacological interventions attempted: * Two times in March * Five times in April * Twenty-one times in May * Sixteen times in June The "CONSULTANT PHARMACIST'S MEDICATION REVIEW" form, dated 06/19/14, stated, "MEDICATION(S) INVOLVED: Risperdal. IRREGULARITY OR COMMENTS(S): Resident has been using PRN frequently - Risperdal is not recommended as a PRN med [medication] - Current diagnosis is Insomnia - This is not an approved indication. SUGGESTED COURSE(S) OF ACTION: Please consider scheduling Risperdal and consider alternate diagnosis . . . IMPLEMENTATION TIME FRAME: Review with the resident's physician during his/her next visit, but no later than two (2) months." During an interview on 07/02/14 at 8:30 a.m., a nursing supervisor (#2) stated staff should have documented the reason for giving Risperdal and any non-pharmacological interventions attempted before administering the medication. The nursing supervisor failed to notify the physician of the pharmacist's comments. - Review of Resident #8's medical record occurred on all days of survey and diagnoses included anxiety, depression, and chronic pain. The quarterly MDS, dated 05/16/14, identified severely impaired cognition, fluctuating behaviors of inattention and disorganized thinking, and severe depression. A "CONSULTANT PHARMACIST'S MEDICATION REVIEW" form, dated 5/29/14, stated,	F 329		

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F 329	Continued From page 63 "MEDICATION(S) INVOLVED: 1) Ativan 0.25 mg BID [twice daily] . . . IRREGULARITY OR COMMENT(S): Last GDR [Gradual Dose Reduction] 6/2013 recommend to address q [every] 6 months. SUGGESTED COURSE(S) OF ACTION: Please consider dose reduction or document why not appropriate. FOLLOW-UP OR ACTION TAKEN . . . B. Recommendation is REJECTED and the basis for this is . . .: Family has requested No change in meds. . . ." The form was signed by the pharmacist, director of nursing, certified physician's assistant, and the physician. During an interview on 07/02/14 at 10:00 a.m., a nursing supervisor (#2) verified the reason for the rejection of the GDR for Ativan was correct and had no further documentation regarding a medical reason for the continued use of Ativan by the physician.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of a professional reference, record review, and staff interview, the facility	F 428	**F 428** **Also see 329** 1. Resident #3's individual needs have been met by having the residents' drug regimen reviewed by the consultant pharmacist and primary care physician. The Alzheimer's medications have been discontinued. The resident's gait has not changed since admission. Gait is related to hip pain, not medications. Resident pain is being address by being on a scheduled pain medication instead of just PRN use. 2. All residents on antipsychotic medications have the potential to be affected in this area.	

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GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

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F 428	Continued From page 64 failed to ensure the pharmacist completed a thorough evaluation of 1 of 13 sampled resident's (Resident #3) medication regimen for irregularities and staff reported those irregularities to the attending physician and the director of nursing and acted upon. Failure to complete this review resulted in not addressing the use of medication as to why or how the benefit of medications, with potential for clinically significant adverse consequences, outweighed the risk. Findings include: The American Geriatrics Society (AGS) in 2012 updated the criteria for the use of potentially inappropriate medication use in older adults and stated: "This clinical tool . . . has been developed to assist healthcare providers in improving medication safety in older adults. Our purpose is to inform clinical decision-making concerning the prescribing of medications for older adults in order to improve safety and quality of care. The goal of this clinical tool is to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs). This should be viewed as a guide for identifying medications for which the risks of use in older adults outweigh the benefits. . . ." Review of Resident #3's medical record identified wandering and exit seeking behavior upon admission and no other behaviors. Six days following admission the physician ordered the following psychopharmacological medications: * 04/28/14: Trazodone increased dose to 50 mg (milligrams) twice a day * 04/30/14: Melatonin 3 mg at bedtime "related to INSOMNIA" * 05/20/14: Trazodone HCL (hydrochloride) 150	F 428	3. The facilities consulting pharmacist was educated on the procedure titled, "Psychopharmacological Medications" on 7-30-2014. The focus of the education was on the need to review all antipsychotic medications for appropriate diagnosis, the need for routine GDR (gradual dosage reduction), targeted behaviors, monitoring for adverse effects, and multiple medications in one drug classification, if a risk/benefit statement is needed when no changes are going to be made to the medications and cannot include "because of family wishes," and to report any abnormalities to the DNS and primary care physician. 4. An audit tool will be developed and completed by the QA coordinator or designee weekly times 4, then monthly times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if the residents' drug regimen was reviewed monthly by the consultant pharmacist and primary care physician; if the resident has an appropriate diagnosis for the medication classification; if the resident is having any adverse effects; and if recommendations were made.	8/13/2014

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F 428	Continued From page 65 mg "at bedtime for anxiety" * 05/21/14: Trazodone HCL 50 mg one time per day "related to DEPRESSIVE DISORDER . . ." (Scheduled for morning dose) * 06/11/14: Namenda XR (extended release) 7 mg "related to Dementia . . ." * 06/12/14: Aricept 5 mg once a day for "Alzheimer's related to dementia" * 06/18/14: "Risperdal [an antipsychotic medication] 0.125 mg two times a day for agitation . . ." Interdisciplinary progress notes on 05/28/14 at 10:46 a.m. identified one week after the increase in the Trazodone: "Resident was walking up and down the hall as she normally wanders but today is holding on to the railing tight and leaning and unsteady she normally walks up and down hallway with no problems." Review of Resident #3's care plan identified the "BLACK BOX WARNING" for Trazodone of ". . . Potential adverse effects include anxiety . . . dizziness, headache, insomnia, nausea." Other central nervous system adverse reactions as identified in the Nursing 2013 Drug Handbook included drowsiness, fatigue, weakness, and syncope. The record included a "Consultant Pharmacist's Medication Review" dated 05/29/14. The pharmacist did not identify the specific drugs of Melatonin and Trazodone including the indications and potential risks to Resident #3. The review did not address Resident #3's unsteady gait displayed after the increase in the Trazodone dose. The medical record lacked evidence of a	F 428		

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F 428	Continued From page 66 pharmacy review in June 2014. The medical record lacked specific targeted behavior being tracked and monitored prior to the use of this antipsychotic medication. During interview on 07/02/14 at 11 a.m., a consultant pharmacist (#29) stated she would expect the pharmacist review the Trazodone in relation to the resident's behaviors (non-pharmacological verses pharmacological) and for adverse effects.	F 428		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.	F 494	**F494** 1. No residents were cited in this area. Staff member #6 has a ND CNA certification verified on 7-3-2014. 2. All residents have the potential to be affected in this area. All current nursing assistants will have their certification reviewed for current status by 8-13-2014. 3. Education was provided to the HR staff member by the Rehabilitation Skilled Consultant from the GSS National Campus on 7-31-2014 regarding the State requirements of 483.151-483.154 or determined competent as provided in 483.150 (a) and (b),. Center HR staff will focus on the need to check all nursing assistants' certification prior to the staff member providing direct patient care. 4. The audit will be completed by DNS or designee weekly times 4, then monthly	

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F 494	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on review of state nurse aide registry files, facility payroll reports, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 5 certified nurse aides (CNAs) (Individual A) reviewed was eligible to work within the state of North Dakota. Failure to ensure certification of caregivers placed residents at risk of receiving care from unqualified staff. Findings include: Review of the facility policy/procedure titled "Orientation of Pool Staff" occurred on 07/02/14. This policy, revised March 2010, stated, ". . . Pool agencies are required by our service agreement to document criminal background clearance . . . verification of Nursing Assistant registry . . ." Review of the facility policy/procedure titled "Abuse and Neglect" occurred on 07/02/14. This policy, revised September 2013, stated, ". . . The center will not knowingly employ individuals who have . . . had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. . . ." On the morning of 07/02/14, a managerial staff member (#6) reported she was unable to locate a copy of her North Dakota certification. Review of thestate nurse aide registry file, maintained by the Division of Health Facilities, identified Individual A failed to obtain certification within the state of North Dakota.	F 494	times 2, then quarterly times 3 and/or as deemed necessary by the QA committee. The audit will monitor if all nursing assistant staff have an active ND nursing assistant certification prior to providing direct patient care.	8/13/2014

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F 494	Continued From page 68 As requested on the morning of 07/02/14, a managerial staff member (#1) provided the facility's payroll report showing the hours Individual A worked without being certified in North Dakota. Individual A worked 82 hours from 06/10/14 through 06/30/14.	F 494		