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 _____	C 07/11/2018

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 000	INITIAL COMMENTS The standard Medicare/Medicaid and complaint survey started on 07/08/18 and concluded on 07/11/18.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		8/2/18

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

Electronically Signed | 08/02/2018

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/24/17 Based on record review, staff interview, facility policy and procedure, and information received from a complainant, the facility failed to notify the resident representative for 1 of 1 sampled resident (Resident #27) after a change in condition. Failure to notify the resident representative when a new treatment and/or medication is started, does not allow the representative to be fully informed of the resident's status. Findings include: Review of the facility policy titled "Notification of Change" occurred on 07/10/18. This policy, dated November 2016, stated, ". . . A facility must immediately inform the . . . the resident	F 580	1. Resident # 27, family was made aware of the new medication on 5/21/2018. 2. All residents have the potential to be affected by this deficient practice. On 7/25/2018, all current residents records were reviewed for new medications orders and verification of family notification of these changes. No additional deficient practices were identified. 3. Re-education and in-servicing on notification to resident, family and physician with change of condition will be provided to licensed nurses by DNS on 7/25/2018 or prior to next scheduled shift. 4. Chart review audits for resident change of condition with new orders and documentation of family notification will be performed by DON/ or designee	

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F 580	Continued From page 2 representatives(s) when there is: . . . 3. A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment . . ." Review of Resident #27's medical record occurred on all days of survey. Review of current physician's orders identified Levothyroxine 25 micrograms (mcg) one time a day for elevated TSH (thyroid stimulating hormone), ordered on 05/10/18. Resident #27's progress notes stated the following: *05/09/18 11:04 a.m., ". . . Visit with Physician . . . resident was seen today for 90 day recertification. Noted increase fatigue New orders received for labs, . . . Daughter is present at appt. [appointment] and agreed with orders." *05/10/18 4:05 p.m., "Labs/Diagnostics . . . see scanned report for results. TSH [lab value] New orders received" The record identified the facility received a new order for Levothyroxine on 05/10/18, for Resident #27. The medical record lacked documented evidence staff notified the resident representative that the medication had been ordered. An interview occurred on 07/10/18 at 11:35 a.m. with a unit manager (#8). When asked about notification to the family regarding the starting of the new thyroid medication, the member (#8) stated, "no, they were not notified when it was started but she talked with the daughters about it later."	F 580	weekly x 4 weeks, the monthly x 2 months, then quarterly x 3. Audit results will be submitted to the QAPI committee monthly for review and further recommendation as indicated. 5. These deficiencies were corrected on 7/25/2018.	

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F 580	Continued From page 3 Failure of the facility to inform the resident's representative at the time of lab results and new medication ordered does not allow the representative information regarding the most current care being provided to the resident.	F 580		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled residents (Resident #24) with a newly diagnosed mental illness. Failure to complete a change in status	F 644	1. Resident #24 PASARR was completed on 7/13/2018. 2. All residents with a new mental illness diagnosis have the potential to be affected by this deficient practice. All current residents□ diagnosis was reviewed and verification that PASARR were present as required. No other deficiencies were identified.	8/8/18

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F 644	Continued From page 4 assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #24's medical record occurred on all days of survey. The record showed an initial PASARR completed on 09/10/14 and identified no mental illness. Current diagnoses included psychosis, dated 06/14/17. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnosis. During an interview on 07/10/18 at 10:52 a.m., a social services staff member (#1) confirmed the facility failed to submit a PASARR for Resident #24 following the 06/14/17 diagnosis of psychosis.	F 644	3. Re-education provided to HIM and Social Services on PASARR completion and communicating new mental illness diagnoses by the DON on 7/13/2018. HIM or designee will continue to monitor and audit all orders which include Resident diagnosis of mental illness. Mental illness diagnosis will be communicated to Social Services for PASARR review and completion. 4. These audits will be performed by DON or designee weekly x 4 weeks, then monthly x 2 months, and quarterly x 3. Audit results will be submitted to QAPI Committee monthly for review and further recommendation as indicated. 5. These deficiencies will be corrected on 8/8/2018	

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/24/17 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide respiratory care consistent with standards of practice for 1 of 3 sampled residents receiving oxygen (Resident #15). Failure to ensure oxygen is administered, assessed and monitored, and tubing changed weekly as ordered may complicate a resident's respiratory status. Findings include: Review of the facility policy titled "Oxygen Administration With Nasal Cannula, Face Mask or Face Tent" occurred on 07/10/18. This policy, revised October 2017, stated, ". . . To administer various levels of oxygen concentration . . . in a safe manner . . . assess resident for at least 15 to 30 minutes after beginning of therapy . . . observe resident for tolerance of oxygen therapy and for any adverse symptoms . . . Disposable equipment should be changed weekly . . . and	F 695	1. The Resident #15 oxygen tubing was changed on 7/11/2018. Resident #15 oxygen saturation was obtained and documented on 7/11/2018 2. All residents receiving oxygen and respiratory care have the potential to be affected by this deficient practice. 3. Re-education and in-servicing will be provided to nursing staff by DNS on oxygen administration, tubing / mask / supply changes, and resident monitoring with documentation on 7/25/2018 or prior to next scheduled shift . A non-medical record duties checklist has been created listing duties to be completed and signed by nursing service on the night shift. 4. Audits will be conducted by DNS or designee reviewing completion of non-medical record duties checklist and spot checks of residents tubing and disposable supplies being changed by proper date. Medical record audits will be completed to verify documentation of oxygen saturation readings for residents receiving oxygen. These audits will be	8/8/18

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F 695	Continued From page 6 marked with date and initials . . . record when oxygen therapy started, type of administration used, flow rate . . . Document resident's reaction and tolerance to therapy. . . ." Review of Resident #15's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) and hypoxia. Current physician's orders included oxygen at 2 liters per minute (LPM) via nasal cannula as needed. Observation on 07/09/18 at 8:45 a.m. showed Resident #15 resting on her bed with oxygen on at 2 LPM via nasal cannula, and tubing not labeled with date and time of last change. A staff nurse (#2) entered the resident's room and placed an oxygen saturation monitor on her finger and stated, "Her oxygen is at 94%. Yes, we help her put it on [the nasal cannula] at times and she frequently takes it off. Yes, she uses her oxygen as needed." Observation on 07/10/18 at 12:25 p.m. showed Resident #15 resting on her bed, with oxygen on at 2 LPM via nasal cannula and tubing not labeled with date and time of last change. Review of the electronic medical record (EMR) showed the last documented oxygen saturation for Resident #15 was on 04/18/18. The EMR failed to show documentation of oxygen monitoring and assessments and oxygen tubing changes. During an interview on 07/10/18 at 10:52 a.m., an administrative nurse (#3) stated she expected staff to document assessments of Resident #15's	F 695	completed weekly x 4 weeks, monthly x 2 months, and quarterly x 3. Audit results will be submitted to QAPI committee monthly for review and further recommendation as indicated. 5. These deficiencies will be corrected on 8/8/2018	

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F 695	Continued From page 7 oxygen use and weekly tubing changes.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 1 sampled resident (Resident #27) remained free of unnecessary medication. Failure to adequately determine the need for a medication through monitoring, tracking, and attempting non-pharmacological interventions before the initiation of a medication, does not allow the resident to remain free from additional medication side effects.	F 757	1. Resident #27 had Sleep Assessment UDA completed on 7/12/2018. Resident #27 care plan was updated on 7/20/2018 to include non-medication interventions for insomnia. 2. All residents have the potential to be affected by this deficiency. 3.Re-education and in servicing will be provided to nursing staff on resident monitoring and assessment prior to	8/8/18

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F 757	Continued From page 8 Findings include: Review of Resident #27's medical record occurred on all days of survey. Diagnoses include dementia, depression with anxiety, and insomnia. Current physician's orders identified Trazodone (an antidepressant medication) 25 milligrams (mg) at bedtime for restlessness related to insomnia, Paxil (an antidepressant) 40 mg give one time a day, Ativan (an antianxiety medication) 0.5 mg one time a day. Review of Resident #27's admission orders, dated 02/16/18, identified a diagnosis of UTI (urinary tract infection) and Cipro (an antibiotic) 250 mg twice a day for 7 days. The nursing progress notes identified the last dose administered on 02/23/18. Fax communications to the physician from the facility stated the following: *02/22/18, ". . . Resident restless, agitated at HS [hour of sleep]. States can't sleep at night . . . [question mark] med at HS . . . Physician . . . trazodone 50 mg PO [by mouth] q [every] hs insomnia . . ." *02/28/18, ". . . Started on Trazodone 50 mg [1] po @ [at] HS 2/23/18 fall 2/26/18 0230 am. Noted not able to ambulate today. PT [physical therapy] recommended to d/c [discontinue] . . . Physician . . . Decrease Trazodone to 25 mg po @ HS . . . 3/1/18 . . ." Resident #27's progress notes stated the following: *02/16/18 2:05 p.m., ". . . admitted . . . DX [diagnosis] UTI and weakness. . ." *02/17/18 3:03 p.m., ". . . Resident is going to be	F 757	requesting or initiating new medications and inclusion of appropriate non-medication interventions in care plan. Re-education included GSS Nursing Services P&P on Unnecessary Medications revision 7/17 with includes Non pharmacological interventions are considered and used when indicated, instead of or in addition to medication and documented in the PN □ Health Status. Education will be provided by DNS on 8/8/2018 or prior to next scheduled shift. 4. Medical record audits will be completed for residents with new medication orders to verify monitoring and assessments are documented and care plans are updated with non-medication interventions, and medications are administered as per P&P and physician order. These audits will be performed by DON/ or designee weekly x 4 weeks, then monthly x 2 months, and quarterly x 3. Audit findings will be reported to QAPI Committee monthly for review and further recommendations as indicated. 5. These deficiencies will be corrected on 8/8/2018	

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F 757	Continued From page 9 moving to room [room number] . . ." *02/18/18 1:05 a.m., "Resident alert and responsive with usual confusion. Continues with generalized weakness. At bedtime resident did not want to lay in bed by window and wanted to sleep in bed by the door which was like her previous room. Resident allowed to sleep in bed of her choice and will assess in am . . ." *02/22/2018 8:44 p.m., ". . . Resident anxious angry and confused and states was moved several times and can't find her bed and she hopes this doesn't happen to other patients. Resident allowed to vent feelings. HS cares done and snack offered earlier but refused. Back rub given. Resident states she is unable to sleep. Offered to have her sit up in main lounge area but refuses. Will monitor. Has bed and w/c [wheelchair] alarm. Call light within reach . . . Tylenol 650mg given . . . Will ask Dr. on rounds for sleep aid." *02/23/18 10:23 a.m., "order for 50mg trazodone at HS every night for restlessness . . ." *02/26/18 2:41 a.m., "The resident was found lying on her left side on the floor next to her bed, with her feet tangled in the bedclothes and still on the bed when CNA [certified nursing assistant] responded to the resident's bed alarm sounding. She companied of pain in her elbow, left hip, and knees. . . . She stated that she rolled over and fell out of bed . . ." *02/26/2018 9:52 a.m., "Communication with Resident/Family . . . [family member name] talked about trazodone and if she would have another fall or becomes more tired during the day she would like trazodone discontinued. . . ." *2/28/2018 2:23 p.m., ". . . Late Entry. . . PT wanted to know if any med changes Trazodone 50mg at hs and has been weaker, will get a order	F 757		

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F 757	Continued From page 10 to DC. Later after a 2 hour nap was able to do everything OT [occupational therapy] asked her to do in therapy." *03/01/18 9:58 a.m., "Care Conference Note . . . in attendance at the care conference family, . . . discussed trazodone. has tried medications to help her sleep in the past. [family member] stated [resident] always wakes at 11:30/ midnight at home and bathroomed [sic]/ snack prior to going back to bed. would like trazodone stopped if becomes groggy" *03/01/18 10:45 a.m., "new order received to decrease Trazodone to 25 mg po at HS." Resident #27's nursing progress notes, dated 02/16/18 to 02/22/18, stated on four evenings, "has been resting well." During an interview on 07/10/18 at 2:00 p.m., a unit manager (#8) confirmed Resident #27 started on Trazodone on 2/23/2018 as she has a history of not sleeping well. When asked about further documentation regarding not sleeping well since admission or other interventions attempted, the staff member supplied no further information. The facility failed to track or trend the resident's sleep patterns, attempt other non-pharmacological interventions, or allow the resident to adjust to the environment before adding a medication without adequate indications which placed Resident #27 at risk for side effects and potential falls.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		8/8/18

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F 760	Continued From page 11 medication errors. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/24/17 Based on record review, review of facility policy, resident interview and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #43) who experienced a significant medication error. Failure of staff to administer medications as ordered may have a negative impact on a resident's quality of life. Findings include: Review of the facility policy titled "Medication Administration, Including Scheduling and Medication Aides" occurred on 07/10/18. This policy, revised October 2017, stated, ". . . to administer medications correctly and in a timely manner . . . Administer medication within at least 60 minutes on each side of ordered time . . . Document that the medications was given as soon as possible after administration. . . ." Review of Resident #43's medical record occurred on all days of the survey. Diagnoses included congestive heart failure. A physician order stated, ". . . Isosorbide mononitrate extended release [ER] 30 milligrams (mg) take 1.5 tablet daily, Lasix 20 mg daily, Lexapro 20 mg daily, Metoprolol Succinate ER 25 mg daily, Brilinta 90 mg one capsule two times a day, Calcium-Vit D 600-400 mg take 1 tablet two times a day, Docusate sodium 100 mg one capsule two times a day, Ranexa ER 500 mg one capsule two	F 760	1. Resident #43, was administered medications on discovery or next scheduled dose. Resident #43 was monitored and had no ill effect from missed or delayed medication administration. 2. All residents have the potential to be affected by this deficient practice. All medication carts were audited on 7/11/2018 and found no other residents affected by this deficiency. 3. Licensed nurses will be re-educated and in-serviced by DNS on medication administration policy and procedure on 7/25/2018 or prior to next scheduled shift. Licensed nurses will be instructed to check at the end of their shift to verify all scheduled medications have been given or documented on as appropriate by use of the Point Click Care Dashboard. 4. Medication Administration records and medication carts will be audited by DNS and unit coordinators or designee for proper medication administration and documentation. PCC Missed and Late Medication Report will be reviewed. These audits will be conducted daily x 4 weeks, weekly x 4 weeks, then monthly x 2 months, and quarterly x 3 quarters. Audits will be submitted to QAPI Committee monthly for review and further recommendation as indicated. 5. These deficiencies will be corrected on 8/8/2018	

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	355095	A. BUILDING _____ B. WING _____	C 07/11/2018

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F 760	Continued From page 12	F 760		

times a day, Oxycodone HCL 5 mg one capsule two times a day, Tylenol arthritis 650 mg three times a day. . . . ."

On 07/10/18 at 4:00 p.m., review of Resident #43's electronic medication administration record (EMAR) showed the following medications had not been administered on the morning of 07/09/18:
* Isosorbide mononitrate ER 30 mg
* Lasix 20 mg
* Lexapro 20 mg
* Metoprolol Succinate ER 25 mg
* Brilinta 90 mg
* Calcium-Vit D 600-400 mg
* Docusate sodium 100 mg
* Ranexa ER 500 mg
* Oxycodone HCL 5 mg
* Tylenol arthritis 650 mg

The EMAR identified "8-Other/See Nurses Notes. . . ." as the reason Resident #43 did not receive her medications. A nurse's note, dated 07/09/18, stated, "Resident had morning bath and ate in room. Resident medications became to late to give and the resident didn't feel she needed them."

During an interview on 07/10/18 at 4:45 p.m., Resident #43 stated, "I don't refuse to take any medications." When the resident was asked what time she took her bath on 07/09/18 she stated, "Oh, it was about 8:30 a.m., because I still had time to go to therapy afterwards."

During an interview on 07/11/18 at 10:13 a.m., an administrative nurse (#3) stated, "the expectation is for medication pass to take place within the

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F 760	Continued From page 13 one hour window before or after the scheduled administration time. On bath days, I expect medications to be given within that same amount of time."	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		8/2/18

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F 842	Continued From page 14 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility	F 842	1. Resident #28 was re-assessed upon discovery and had returned to baseline.	

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F 842	Continued From page 15 failed to ensure a complete and accurately documented medical record for 1 of 1 sampled residents (Resident #28). Failure to have a complete and accurate medical record limited staff's access to the most recent medical information. Findings include: Review of the facility policy titled "INTERACT - Change in Condition Evaluation (CICE)" occurred on 07/10/18. This policy, revised May 2016 stated, ". . . To improve communication between nurses . . . monitoring a change in condition . . . A change in Condition Alert can be created to communicate or remind nurses to keep a closer eye on a resident when something seems different, but there is not a significant enough change to complete a full Change in Condition Evaluation. . . ." Review of the facility policy titled "Medication Administration, Including Scheduling and Medication Aides" occurred on 07/10/18. This policy, revised October 2017, stated, ". . . Administer medications within at least 60 minutes on each side of ordered time. . . ." Observation on 07/08/18 at 11:56 a.m., showed Resident #28 sleeping in his wheelchair (WC) at the dining table during the noon meal. An unidentified certified nursing assistant (CNA) was observed attempting to wake the resident with verbal and physical stimuli. The resident did not awaken. A staff nurse (#2) arrived with the resident's noon medication. The nurse attempted to wake the resident with verbal and physical stimuli. The resident did not awaken. The nurse	F 842	Resident #28 did have a second episode of change of condition, documented and resulted in hospitalization. 2. All residents have the potential to be affected by this deficient practice. All current residents were evaluated and no other residents were found with a change of condition not reported or documented. 3. Re-education and in servicing will be provided to licensed nurses by DNS on monitoring residents for change of condition, documentation and communication to care team, resident, family and physician. Education provided on 7/25/2018 or prior to next scheduled shift 4. Point Click Care alerts, 24 hour report and progress notes will be audited to reflect residents□ current condition with proper notifications. Audits will be performed by DON/ or designee weekly x 4 weeks, then monthly x 2 months, and quarterly x 3 quarters. Audit results will be submitted to QAPI Committee monthly for review and further recommendations as indicated. 5. These deficiencies will be corrected on 7/25/2018	

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F 842	Continued From page 16 (#2) stated to the CNA that she would assist her to lay the resident down and to reheat his tray later. During an interview on 07/08/18 at 11:58 a.m., a staff nurse (#4) stated, "No this is not typical of him [Resident #28] to be this tired." The medical record was reviewed on all days of the survey. A current physician order stated Sinemet Tablet 25-250 milligrams (mg) give 1 tablet four times a day at 05:30 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m. The record showed Resident #28's medication of Sinemet was administered at 11:00 a.m. on 07/08/18. This charting does not reflect the above observation made by this surveyor. The nurses notes lacked documentation of a change in Condition Alert for Resident #28 and accurate charting of the late medication administration. During an interview on 07/09/18 at 9:50 a.m., a staff nurse (#2) stated she had given Resident #28 his medication that afternoon (07/08/18). The nurse verified she failed to document a change in Condition Alert and the late medication administration. During an interview 07/10/18 at 02:30 p.m., an administrative nurse (#3) stated, "Yes, I would expect nursing to document a resident's change in condition and late medication administration."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		8/2/18

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F 880	Continued From page 17 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 18 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 8 sampled residents (Residents #27 and #28). Failure to follow infection control practices of hand hygiene during and after toileting/personal care has the potential to spread infection to other residents, personnel, and visitors. Findings include:	F 880	1. Resident #27 and #28 did not exhibit ill effects from this deficient practice. Employees # 7, 8, 10, 12, and 13 were given immediate re-education on hand hygiene during and after toileting / personal cares. 2. All residents have the potential to be affected by this deficient practice. 3. Re-education and in-servicing will be provided to all nursing department staff on proper hand hygiene by DNS on	

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F 880	Continued From page 19 Review of the facility polity titled "Hand Hygiene and Handwashing" occurred on 07/10/18. This policy, revised January 2018, stated, ". . . To ensure appropriate hand hygiene technique for clinical use . . . Before having direct contact with residents . . . after removing gloves. . . ." - Observation on 07/09/18 at 8:29 a.m. showed two certified nursing assistant's (CNAs) (#12 and #13) transferred Resident #28 from his wheelchair (WC) to bed using a full body mechanical lift. The CNA (#13) performed perineal care, changed her gloves and continued to provide perineal care. The CNA failed to perform hand hygiene between her glove changes. - Observation on 07/09/18 at 12:20 p.m. showed two CNAs (#12 and #13) transferred Resident #28 from his WC to bed using a full body mechanical left. The CNA (#12) performed perineal cares, changed her gloves, and continued to provide perineal care. The CNA failed to perform hand hygiene between glove changes. - Observation on 07/10/18 at 4:21 p.m. showed two CNAs (#7 and #8) performed a check and change on Resident #28. The CNA (#7) performed perineal cares, changed her gloves, and continued to provide perineal care. The CNA failed to perform hand hygiene between glove changes. During an interview on 07/11/18 at 8:35 a.m., an administrative nurse (#3) stated the expectation is that staff wash their hands upon entry and exit to resident rooms and between glove changes.	F 880	7/25/2018 or prior to next scheduled shift. 4. Observation audits, watching hand hygiene technique, will be performed by DON/ or designee weekly x 4 weeks, then monthly x 2 months, and quarterly x 3 quarters. Audit results will be submitted to QAPI Committee monthly for review and further recommendation as indicated. 5. These deficiencies will be corrected on 7/25/2018	

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F 880	Continued From page 20 - Observation on 07/09/18 at 8:52 a.m. showed a CNA (#10) assisted Resident #27 to ambulate into the bathroom using a gait belt and walker. After the CNA (#10) performed pericare, she removed her gloves, pulled up the resident's pants, and assisted the resident to sit back into the wheelchair. The CNA then transferred the resident to her recliner and left the room without performing hand hygiene. - Observation on 07/09/18 at 12:16 p.m. showed a CNA (#10) applied a gait belt and assisted Resident #27 from her wheelchair to the toilet. The CNA (#10) assisted the resident to stand, reapplied a brief, pulled up her pants, and assisted her back to the wheelchair. The CNA (#10) transferred the resident to bed and covered her with a blanket, then performed hand hygiene. The CNA failed to perform hand hygiene after toileting and before completing other tasks. During an interview on the morning of 07/11/18, a unit manager (#8) confirmed CNAs should complete hand hygiene after providing care and ensuring the resident is safely in the wheelchair.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy, the facility failed to ensure emergency equipment remained in safe operating condition for 3 of 3 suction machines (West and East	F 908	1. Connector tubing was re-stocked with suction machine #1. 2. All residents have the potential to be affected by this deficient practice. The	8/2/18

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F 908	Continued From page 21 wing). Failure to ensure the suction machine remained functional in the event of an emergency situation placed residents at risk for choking and aspiration. Findings include: Review of the facility policy titled "Suctioning: Endotracheal and Tracheostomy" occurred on 07/10/18. This policy, revised April 2013, stated, ". . . Assemble equipment and make sure suction equipment is clean and in good working condition. . . ." Observation of the suction machine, stored in the West wing, occurred on 07/11/18 at 9:36 a.m. with a licensed nurse (#5). Observation showed the nurse attempted to connect the tubing to the machine. The nurse failed to connect the tubing correctly and the machine did not produce suction. Observation on 07/11/18 at 9:43 a.m., showed a licensed nurse (#4) retrieved the suction machine cart from the East wing which held two suction machines. The licensed nurse attempted to connect the tubing to one of the machines. The nurse failed to connect the tubing correctly and the machine did not produce suction. The nurse (#4) reported to an administrative nurse (#6) who stated the connectors were missing for all three suction machines.	F 908	facility has 2 suction machines. Suction machine #1 had all necessary supplies present after re-stocking connector tubing. Suction machine #2 was found to have all supplies present for correct operation. 3. Equipment check logs were developed for nursing staff to check equipment for ready use daily. Re-education and in servicing will be provided by DNS to nursing staff on maintaining equipment functionality and the equipment check logs. Education will be provided on 7/25/2018 or prior to next scheduled shift 4. Audits will be conducted by visually inspecting suction machines and supplies along with verifying completion of equipment check logs. Audits will be performed by DON/ or designee weekly x 4 weeks, then monthly x 2 months, and quarterly x 3 quarters. Audit results will be submitted to QAPI Committee monthly for review and further recommendations as indicated. 5. These deficiencies will be corrected on 7/25/2018	