STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING _____ B. WING _____	07/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 07/21/14 and completed on 07/23/14, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000	"Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. For the purposes of any substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with ND State Health Department.	
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review, resident interview, and staff interview, the facility failed to ensure residents are free from abuse for 2 of 2 sampled residents (Resident #3 and Resident #8) who were subjected to verbal abuse by another resident (Resident #5). Failure to ensure residents are free from verbal abuse from other residents, which includes disparaging and derogatory terms, resulted in avoidable psychosocial harm and Resident #3 being removed from his own room to appease/calm Resident #5 thereby not having access to his own room and belongings, and resulted in Resident #8 feeling angry and upset about his roommate. Findings include:	F 223	1. As soon as a suitable room became available resident #5 was moved. This move occurred on March 10, 2014. 2. All residents have the potential to be affected. 3. August 25, 2014 and August 27, 2014 education provided on Abuse and Neglect with emphasis on Resident to Resident verbal abuse. Following the MDS schedule the Social Worker or designee will interview all residents concerning roommate compatibility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Olson — TITLE: Administrator — (X6) DATE: 8-22-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 Review of the facility policy "Abuse and Neglect (Number II.A.1)" occurred on 07/23/14. This policy, revised September 2013, stated, ". . . Policy - The resident has the right to be free from verbal . . . physical and mental abuse . . . Residents must not be subjected to abuse by anyone, including, but not limited to . . . other residents. . . ." Review of the facility policy "Abuse and Neglect (Number II.A.1a)" occurred on 07/23/14. This policy, revised June 2012, stated, "Purpose: * To ensure that the center has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents . . . * To ensure that residents are not subjected to abuse by anyone, including . . . other residents. . . . * To identify and remedy any abusive situations. . . . To ensure that a complete review of existing incidents is documented. . . . Procedure: 1. If a staff member receives an allegation of abuse . . or witnesses suspected abuse . . . the staff member will immediately report this to a supervisor and complete . . . Incident Report. . . . b. If it is an allegation of resident to resident abuse, the residents will be immediately separated and both assured a safe environment. . . ." - Review of Resident # 5's medical record occurred on all days of survey. Medical diagnoses included dementia with behavioral disturbances and intermittent explosive disorder. Resident #5's admission Minimum Data Set (MDS) dated 10/23/13 and his quarterly MDS dated 03/15/14, identified extensive assistance for bed mobility, transfers, and locomotion on and off the unit.	F 223	roommate compatibility per T.C 8/25/14 use DON dd 4. SW or designee will randomly audit 2 times weekly times 2 weeks, then follow the MDS schedule. 5. Completed September 2, 2014.	

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F 223	Continued From page 2 Resident #5's Progress Notes identified the following: *10/29/13 at 9:26 p.m. - " . . . resident [#5] had his wheelchair parked behind the door and was not allowing any staff to enter the room stating multiple times 'get the [expletive] out of here.' Nurse tried taking (sic) to resident to see what was bothering him but he wouldn't say. Nurse tried to explain that staff need to get into the room to put his roommate [Resident #3] to bed but he stated 'he doesn't need to get in here, he doesn't pay a [expletive] dime.' . . . Nurse went back to residents room to see if he would let staff in yet and he had the door closed again and backed his wheelchair up against the door again. . . . Once able to get roommate [Resident #3] in he continued to state 'he doesn't pay a [expletive] dime to be here. I'm not going to be [expletive] babysitting him' . . . He then stated "[Expletive] right I'm not, he's not [expletive] sleeping with me he can go sleep with them.' CNA [certified nursing assistant] and nurse able to get roommate into bed . . . Resident [#5] has shut door again to room." [Resident #3 left alone in room with Resident #5. The next progress note is dated 10:43 p.m., which stated "CNA poked head into room to check on resident and roommate, . . . he stated '. . . get the [expletive] out of here and close the [expletive] door.' Later the nurse went to check on resident . . . just barley (sic) had the door open and he stated 'get the [expletive] out and shut the [expletive] door.'" *10/30/14 at 10:46 p.m. - ". . . when staff tried to bringing (sic) his roommate [Resident #3] into the room to give him his evening NEB Tx [nebulizer treatment] He [Resident #5] said 'What the [expletive] are you bringing him in here for.' Staff stated that [Resident #3] was his roommate and they are going to (sic) him a NEB Tx. He said 'Get	F 223		

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F 223	Continued From page 3 him the [expletive] out of here and your (sic) not going to do anything with him in here get the [expletive] out NOW . . . Staff brought resident [#3] and NEB machine out to the TV area and gave roommate his TX there. . . . Later staff brought the roommate to the room to put him to bed, resident [#5] must have heard him coming (sic) because when staff got to the room resident [#5] had self transferred himself halfway into his WC [wheelchair]. He started yelling obsinities (sic) at the staff and roommate. Then when staff was toileting roommate he tried to lock them into the bathroom. He was very irate. Staff state that they are concerned for the roommate's [Resident #3's] safety." [Resident #3 left alone in room with Resident #5] *10/31/13 at 6:48 a.m. - "CNA came and informed writer that resident [#5]was calling his roommate [Resident #3] names and wanted him out of the room. Went down to room . . . resident [#5] started in agin (sic) saying 'Get him out of here' 'He is nothing but a [expletive] retard' Over and over agin (sic). 'All that he can say is 'Yep' ' Pulled the curtain and asked CNA to get resident [#3] up and dressed and out of the room. Will pass this information to Social Services." *10/31/13 at 11:08 a.m. (Social Service Note) - ". . . talked to the resident [#5] re: his roommate [Resident #3] and his behavior toward him. This resident said that no matter what happens that he is going to hate him [Resident #3] 'till the day that I die.' LSW [licensed social worker] said that this is his roommate's room as well & he needs to respect his roommate's space. 'It's my room and I can do with it as I like. He is a f. . . retard.' " 10/31/13 at 10:01 p.m. - ". . . Later when staff went into room to give roommate [Resident #3] his HS [evening] medications he [Resident #5] began cussing . . . 'I don't give a [expletive] about	F 223		

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F 223	Continued From page 4 that [expletive] retard' . . and on and on he ranted and raved. Then when staff gave roommate his neb treatment he [Resident #5] got mad again because it was too noisy . . ." *11/01/13 at 2:12 a.m. - "Resident [#5] was cussing using the f word and wanted his roommate [Resident #3] off his property. Stated ' . . . that retard off his property' 'If we didn't get that retard off his property right now he is going to kill him.' Removed resident's roommate [Resident #3] to a different room. Resident [#5] calmed down as soon as we removed resident [#3]." *11/01/13 at 10:51 a.m. - Resident [#5] was sent to clinic for medical evaluation R/T [related to] aggressive behavior to R/O [rule out] medical condition which may be causing increased episodes of aggressiveness." (Resident #5 returned to the facility on 11/05/13 after being hospitalized for a urinary tract infection and was started on new medication for behavior) *11/10/13 at 6:30 p.m. - "While wheeling resident's roommate [Resident #3] to bed, roommate states 'this isn't it.' Resident [#5] stated 'yeah this isn't it.' Writer tells resident [#5] that its his roommates room too and resident [#5] starts calling roommate a '[expletive] retard].' . . . 'well its true, he's a [expletive] retard.' Asked resident [#5] to keep his thoughts to himself. Resident states 'I can say what I want'. . ." *11/10/13 at 8:56 p.m. - ". . . He [Resident #5] also is making comments regarding his roommate [Resident #3] again, as staff was walking out of room after giving roommate his HS medicine, he [Resident #5] started to talk quietly . . . He said 'You should stop giving him any medicine' Staff asked why and he replied 'Because then he won't be around much longer.'" *11/11/13 at 10:46 a.m. (social service note) - "Resident [#5] has been having a hard time	F 223		

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F 223	Continued From page 5 adjusting to being in a NF [nursing facility] with a roommate. . . . He has been encouraged that when he can't stand it anymore he can come into the SS [social service] office and talk it out. He said that he felt somewhat better . . . Because of this, a new goal change has been added to his care plan. . . . A new focus re: his verbal behavioral symptoms toward his roommate [Resident #3] has been added. Please notify SS and charge nurse for any improvements or any decline." *11/19/13 at 4:05 a.m. - "CNA was taking resident's roommate [Resident #3] to the bathroom and resident [#5] stated 'Get him the [expletive] out of here,' Resident [#5] would not be redirected. Brought resident's roommate back out to the TV room." *11/19/13 at 12:51 p.m. - (social service note) - ". . . Resident [#5] remains much the same. . . . He is still having adjustment issues from being in the nursing home and having a roommate. . . ." *11/19/13 at 2:22 p.m. (social service note) - "Resident [#5] stated that his roommate [Resident #3] need (sic) to get out of the room and hates him. . . ." *11/19/13 at 11:01 p.m. - ". . . He [Resident #5] wanted to get into his wheelchair. Stated that he was going to lock his door so that retard wouldn't be able to get into the room. At this time resident [#5] is still up, going to make sure that his roommate [Resident #3], the retard, doesn't get into the room tonight. He mentioned that he was going to look into getting a lock for the door to keep the 'retard' out. . . ." *11/29/13 at 9:55 p.m. - CNA reports hearing resident [#5] yelling at his roommate [Resident #3] while she is standing at a hall kiosk charting, resident [#5] was calling roommate names and swearing at him telling roommate to get out, CNA	F 223		

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F 223	Continued From page 6 entered residents room slowly and attempted to redirect. . . resident [#5] refused and became even more agitated, resident [#5] was attempting to get out of bed unassisted to get to his roommate, resident [#5] threatened CNA and grabbed her arm squeezing attempting to hurt her. . . CNA left resident [#5] in room alone to give him time to calm down, as she walked out of room resident [#5] was threatening to come find her and hurt her. . . ." *12/02/13 at 1:21 p.m. (social service note) - "Updated [Resident 5's wife] on the recent behavior incident. SS explained that a room change was discussed, but because the resident feels that the room he is in is all his, no one else's, the same situation may reoccur. The option of [psychiatric hospital] was discussed to see what could be done to help the resident . . . [Wife] is ok with the move to the [psychiatric hospital]. . . ." (Resident #5 was hospitalized from 12/02/13 to 12/20/13 for his behaviors.) Resident #5's care plan during the above time period, October - November 2013, identified "The resident has adjustment issues to admission E/B [evidenced by] verbal behavioral symptoms towards his roommate." Interventions included "Resident will receive daily opportunities for social contact. . . Observe for stressors which may be early warning signs of problem behavior." - Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included dementia with aggressive behaviors. The admission MDS, dated 10/10/13, identified short/long term memory deficits, severely impaired reasoning, delirium, depression (feeling down/bad about self), and required limited-to-extensive assistance with all activities	F 223		

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F 223	Continued From page 7 of daily living (ADLs). Resident #3's care plan, dated October-December 2013, identified the following: * ". . . Interventions: . . . Resident does self transfer at times (11/04/13) . . ." * ". . . Interventions: . . . RESOLVED: PERSONAL ALARM: Wander Guard used to alert staff to residents movement and to assist staff in monitoring movement (11/01/13) . . ." The care plan failed to address the known conflict between Resident #3 and his roommate (#5) which occurred during the time period they shared a room (October 16-December 2, 2013). A progress note, dated 10/15/13, identified, ". . . talked [with] [son] to inform him his Dad would be getting a roommate tomorrow. He was okay with this information. Stated 'I hope this will work out.'" Review of nursing/social service progress notes failed to identify the known conflict between Resident #3 and his roommate (Resident #5) which occurred during the time period they shared a room (October 16-December 2, 2013). During an interview on July 23, 2014 at 12:00 p.m., when asked if the facility was aware of the conflict between Resident #3 and his roommate (Resident #5), a managerial social services staff member (#8) stated, "We were aware it was not a great situation. We were fairly full at the time. Neither one of those guys made a good roommate." When asked what types of behaviors Resident #5 displayed towards Resident #3, the managerial social services staff member (#8) stated, "All verbal, no physical. Staff were real good. They would take [Resident #3] out, so he didn't have to listen to that." When asked how Resident #3 responded to his roommate's	F 223		

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disparaging or derogatory comments, she stated, "[Resident #3] didn't seem to be bothered by it." When asked if Resident #3's family was aware of the conflict between Resident #3 and his roommate (Resident #5), the managerial social services staff member (#8) stated, "Can't say that for sure."

The medical record identified Resident #5:
* Yelled and/or swore at Resident #3 on multiple occasions,
* Threatened "to kill" Resident #3
* Blocked their room, so Resident #3 could not enter,
* Prevented Resident #3 from receiving his NEB treatments in the privacy of his room,
* Attempted to prevent Resident #3 from sleeping and/or receiving toileting cares in the privacy of his room.

Resident #3's medical record provided no evidence the facility addressed the known conflict between these two residents, even though staff reported they were "concerned for [Resident #3] safety." The facility also failed to notify Resident #3's family of the ongoing verbal abuse (numerous disparaging and derogatory statements made by Resident #5) or of the staffs' concerns for his safety.

During interview on 07/22/14 at 4:35 p.m., administrative staff members (# 5, #8, #9, and #10) provided information that Resident #5 was in a room by himself after he returned from his hospitalization (12/20/13) until 12/27/13 when he became roommates with Resident #8.

Resident #5's Progress Notes identified the following:
*12/28/13 at 2:58 p.m. - "[Resident #5] Stated to

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F 223	Continued From page 9 CNA that roommate (sic) [Resident #8] would have to leave the room, because he pays the rent for the whole room. . . . He continued to say roommate (sic) needed to get out." *12/28/13 at 7:18 p.m. - "[Resident #5] Pulled all the bedding off roomates (sic) bed and told CNA that roommate (sic) needed to get out. CNA assisted roommate (sic) [Resident #8] out of the room while nurse spoke to resident [#5] letting him know that his behavior would not be tollerated (sic). . . . Resident [#5] stated he would not share the room with this man (using inappropriate language as he addressed him). " *12/30/13 at 9:09 a.m. (social service note) - "Talked to resident [#5] to see how it's going with his roommate [Resident #8]. He is not too happy about having a roommate, saying that he wishes that the whole room could be his. . . . He wants to have a private room. . . ." *01/02/14 at 9:29 a.m. - "[Resident #5] Sitting in doorway of room in W/C and would not allow roommate (sic) [Resident #8] to enter. Nurse asked him to please move out of doorway. He stated . . . it was his room. . . . [Resident #5] was told that . . . he shared the room . . . and needed to allow him [Resident #8] entrance. He finally backed his chair out of the way and allowed roommate (sic) to enter." *01/02/14 at 5:20 p.m. (social service note) - ". . . He [Resident #5] has had some behaviors since returning from the Center. He believes that he has his entire room to himself because his (sic) is paying for the room, not his roommate [Resident #8]. He has not said anything to his roommate like to the previous roommate [Resident #3], but the resident has made it quite evident that he does not want any kind of roommate. Staff will continue to educate him that he and his roommate both pay for the room. . . ."	F 223		

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F 223	Continued From page 10 *01/08/14 at 11:40 p.m. "This resident's roommate [Resident #8] up at this time to the bathroom when this resident [#5] started hollering 'you dumb [expletive]' multiple times. When staff entered room to see what was going on, roommate was in bathroom and staff told this resident that he did not need to talk to anybody like that he stated 'he's on my property and he needs to get off' . . ." *01/16/14 at 10:22 p.m. - "resident [#5] became upset and short tempered when rommate (sic) [Resident #8] got up to go to the bathroom." *01/17/14 at 1:06 p.m. (social service note) - "Spoke with resident [#5] about giving his roommate [Resident #8] a hard time about using the bathroom. Administered resident education re: the bathroom being shared between the two roommates." *02/18/14 at 8:37 a.m. - "Resident [#5] was yelling 'Get this guy out of my room.' Writer informed resident [#5] he did not have a private room and that was his roommate. Writer was talking to roommate [Resident #8] about his cataract surgery and roommate [Resident #5] stated 'He has surgery? Good I hope he dies.' Reminded resident [#5] that this kinda (sic) talk was inappropriate." *02/20/14 at 4:50 p.m. - "Resident [#5] was yelling obscenities at roommate [Resident #8] when staff entered room. He was in his wheelchair on the roommates side of the room, their wheelchairs were locked together. Roommate had his back scratcher in hand and was about to hit resident [#5] when staff entered the room to intervene." *02/20/14 at 7:15 p.m. - "When staff wheeled residents roommate [Resident #8] into the room after supper, resident [#5] started in again with the obscenities, staff reminded him this was inappropriate."	F 223		

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	355089	A. BUILDING _____ B. WING _____	07/23/2014

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F 223	Continued From page 11 *03/04/14 at 6:53 p.m. - "Resident [#5] in room yelling and swearing at roommate [Resident #8], not letting roommate go by him and use the bathroom. Was calmer a few moments later." *03/09/14 at 1:40 p.m. - "Nurse started roomates (sic) [Resident #8] nebulizer treatment, and resident [#5] yelled at nurse, 'shut that [expletive] thing off. It's too loud' 'If you don't stop that thing, I'll come over there and stop it myself.' Sat with roommate (sic) until treatment was finished. . . . explained . . . needed to be respectful to roommate (sic) and his needs." *03/10/14 at 7:52 a.m. - CNA reported resident [#5] was saying "Look at that Dum (sic) [expletive], he sure thinks he's smart even though he ain't. '[expletive, expletive]' When writer went in to give his roommate [Resident #8] a treatment resident [#5] states 'Turn that [expletive] thing off x 4.' Resident [#5] repeated it x3. . . ." *3/10/14 at 1:00 p.m. - "CNA walked into residents room to find him [Resident #5] grabbing onto the back of roommate's [Resident #8] shirt shaking him saying 'you [expletive], get out of here, I don't want you in my room.' When staff turned on neb treatment for roommate, this resident [#5] stated, 'I am not going to listen to that [expletive] either.' " *03/10/14 at 1:30 p.m. - "Spoke to family regarding private room availability.[Wife] would like to have resident [#5] moved into the private room that is now open. Housekeeping will move resident [#5] . . . today." - Review of Resident #8's medical record occurred on 07/23/14. Medical diagnoses included dementia. Resident #8's quarterly MDS, dated 06/21/14, identified the resident as cognitively intact, and required supervision with	F 223		

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F 223	Continued From page 12 bed mobility, transfers, and locomotion on and off the unit. Review of Resident #8's Progress Notes identified the following: *02/20/14 - "Resident's roommate [Resident #5] had been yelling obscenities at him, he argued back some and roommate went to his side of the room, when staff intervened their wheelchairs were locked together and resident [#8] had his back scratcher in hand ready to hit roommate. Stated that he no longer wanted this guy for a roommate and wants his own room." During interview on 07/23/14 at 11:15 a.m., Resident #8 stated his former roommate [Resident #5] was "mean with me, he stood by the door so I couldn't use the restroom." Resident #8 also stated "he took my bedding off" the bed and "he was always giving me the finger," which the resident stated "made me mad." Resident #8 stated he was not afraid of his roommate and "if they would have let me, I would beat the [expletive] out of him." Resident #8 stated he was "waiting and waiting, and finally they moved him [the roommate]." Resident #5's medical record identified he yelled and swore at his roommate, Resident #8, on multiple occasions. The record also identified Resident #5 blocked the room and bathroom Resident #8 could not enter. After the incident on 02/20/14, a Progress Note stated Resident #8 no longer wanted to have Resident #5 as a roommate. Although Resident #8 expressed his desire to no longer share a room with Resident #5, the facility failed to separate these residents until 03/10/14, 18 days later. Resident #8's medical record provided no evidence staff	F 223		

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F 223	Continued From page 13 addressed the known conflict between these two residents during the time period of December 27, 2013 to March 10, 2014.	F 223		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, group interview, record review, review of facility policy, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity of 4 of 10 sampled residents (Resident #1, #2, #3 and #4) dependent on staff for assistance with Activities of Daily Living (ADLs). Failure to ensure dignity during meals and prior to entering resident rooms does not recognize the individuality of each resident or enhance their quality of life. Findings include: Review of the facility's policy titled "Dignity" occurred on 07/23/14. This policy, revised February 2013, stated, ". . . staff will promote resident . . . dignity in dining by . . . Serving all residents at the table at the same time, so residents can eat together . . . Encouraging residents to wash their hands/face . . . knocking on resident doors and requesting permission to enter . . ." - Review of Resident #1's medical record	F 241	1. Education was provided to staff to assure Resident #4 was able to invite staff into her room after hearing a knock. Breakfast was served for Resident #1 as soon as the oversight was brought to staff member's attention. Faces of Resident #2 and #3 were cleaned by staff. 2. All residents may have the potential to be affected by a staff entering the room without being invited. As the breakfast meal is an open style breakfast served from 0730-0900, all residents are at risk of being at a table with someone having food served to them before the tablemates are served. 3. Education was provided on August 12, 2014 to staff regarding the policy of "Dignity" and "Dining Room Guidelines". A procedure change was made so that any staff will pull the dietary card to order the breakfast when a resident enters the dining room.	

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F 241	Continued From page 14 occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 06/28/14, identified moderately impaired cognition and need for set-up assistance when eating. Observation on 07/22/14 at 7:40 a.m. showed Resident #1 and another unidentified resident sitting in the dining room. Staff passed his tablemate's tray at 7:50 a.m., and then proceeded to serve other residents at nearby tables. His tablemate had finished his meal by the time Resident #1 received his tray at 8:13 a.m. (23 minutes later). Staff failed to ensure all residents present at the same table were served breakfast at the same time. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 04/19/14, identified short/long term memory deficits, moderately impaired reasoning, and need for extensive feeding assistance. Observations showed the following: * 07/22/14 at 8:21 a.m., a certified nursing assistant (CNA) (#17) fed Resident #2 in the dining room. Resident #2 drooled down the right side of her chin. The CNA (#17) failed to wipe her face with a napkin. At one point, Resident #2 used her sleeve to wipe food residue from her chin. The CNA (#17) also used a spoon to scrape food residue from Resident #2's chin, mixing the residue back into the food on the resident's plate, and eventually feeding it to the resident. During this same observation, another CNA (#16) encouraged Resident #2's tablemate to eat by offering her a bite of food and stating "Yummy! Yummy!" The CNA failed to address the tablemate in an age-appropriate manner. * 07/23/14 at 12:20 p.m., an unidentified CNA fed	F 241	4. Director of Dietary, Director of Nursing, Social Worker or designee will audit 2-4 times per week times 1 week, then weekly times 3 weeks, then monthly times 2 months then quarterly times 2 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014. Audit staff knocking on door before enter res. room, and dining room assistance. Per D.O.N. - 8/25/14 T.C. dl.	

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F 241	Continued From page 15 Resident #2 in the dining room. Resident #2 was observed with food residue on her lips. The unidentified CNA failed to wipe her face with a napkin. The unidentified CNA also used a spoon to scrape food residue from Resident #2's lips, tapped the spoon on the table top three or four times to dislodge the food and/or residue sticking to the spoon, and continued to feed the resident using the same utensil. - Review of Resident #3's medical record occurred on all days of survey. Resident #3's physician orders identified a level 2 mechanical texture diet. The quarterly MDS, dated 06/11/14, identified short/long term memory deficits, severely impaired reasoning, and need for limited assistance when eating. The current care plan, addressing Resident #3's nutritional needs, identified, ". . . Interventions: . . . Supervision at meals. Assist PRN [as needed]." A progress note, dated 02/05/14, identified, "Resident is drinking fluids well, isn't taking in solid foods. CNA staff tried mixing the food in a cup with fluids to get him to drink his food. . . ." Observations on 07/22/14 at 12:20 p.m., showed a CNA (#17) sitting in the dining room with her back to Resident #3. Resident #3 stabbed his bun with a fork and ripped large pieces off with his teeth. The CNA failed to provide supervision during the meal. Resident #3 was observed with food residue on his top lip throughout the entire meal. The CNA (#17) failed to cue the resident and/or wipe the food residue from his lip. Following the meal, CNA (#16) transported Resident #3 back to the lounge, noticed the food residue, and wiped his face with a tissue.	F 241		

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F 241	Continued From page 16 - During group interview on 07/21/14 at 3:30 p.m., Resident A stated staff members knock on his room door and enter immediately. Resident B and Resident C stated staff members enter their rooms before being invited in. - Observation on 07/22/14 at 2:15 p.m. showed a CNA (#7) walked into Resident #4's room without knocking. During an interview on the morning of 07/23/14, administrative and managerial nursing staff (#5, #10, and #11) confirmed staff are expected to serve all residents present at the same table at the same time, provide supervision during meals as care planned, adhere to the residents' prescribed diets (not mix different food consistencies), use a napkin to wipe food residue from residents' faces, address residents in a dignified manner, and request permission prior to entering residents' rooms.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 246	1. Occupational Therapy evaluation for wheelchair positioning for Resident #2 was completed on July 29, 2014. Care plan was updated. 2. All residents seated in a wheelchair have the potential to be affected. 3. Education on wheelchair positioning was provided to nursing, activity and restorative staff by Amy Slominski, OTR on August 12, 2012.	

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F 246	Continued From page 17 to provide reasonable accommodations for 1 of 2 sampled residents (Resident #2) seated in a wheelchair with a positioning device. Failure to provide appropriate trunk support had the potential to cause Resident #2 discomfort/pain and difficulty when performing activities of daily living (ADLs). Findings include: Review of the facility's policy titled "Wheelchair Positioning" occurred on 07/23/14. This policy, dated June 2012, stated, ". . . Hips are centered between the armrests and buttocks against the backrest and you can place hand between resident's hips and armrests, Resident in upright positioning and weight bearing equally at hips. (Does not lean to one side.) . . ." Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included dementia, osteoarthrosis, degenerative joint disease, weakness, and chronic pain with arm movement. The quarterly Minimum Data Set (MDS), dated 04/19/14, identified short/long term memory deficits, moderately impaired reasoning, and need for extensive assistance of one person for transfers. The current care plan addressing Resident #2's transfer needs identified, * ". . . Interventions: . . . Transfer to w/c [wheelchair] with half tray for positioning . . . " Observations showed the following: * On 07/22/14 at 9:15 a.m., Resident #2 attended an "exercise" activity in the chapel. She sat throughout the activity leaning heavily to her right side (65 degrees).	F 246	Wheelchair positioning- Per D.O.N. 8/25/14 T.C. dd 4. Restorative Nurse or designee will do random audits 3 times a week for one week, then weekly times 1 month, then monthly times 2 months, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014.	

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F 246	Continued From page 18 * On 07/22/14 at 10:00 a.m., Resident #2 attended a "news" activity, also located in the chapel. She sat throughout the activity leaning even further to her right side (60 degrees). * On 07/23/14 at 8:35 a.m., an unidentified certified nursing assistant (CNA) fed Resident #2 as she sat in her wheelchair leaning to her right side (75 degrees). * On 07/23/14 at 9:33 a.m., Resident #2 attended an "exercise" activity in the chapel. She sat throughout the activity leaning to her right side (75 degrees). * On 07/23/14 at 12:20 p.m., an unidentified CNA fed Resident #2 as she sat in her wheelchair leaning heavily to her right side (65 degrees). Staff failed to reposition Resident #2 into an upright position allowing her to more thoroughly enjoy the activities she participated in and reduce her risk of aspiration and/or discomfort/pain. During an interview on the morning of 07/23/14, administrative and managerial nursing staff (#5, #10, and #11) confirmed residents should be positioned as close to 90 degrees as possible when seated.	F 246		
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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 248	1. Updated resident #3 care plan to include his individual needs and interests. 2. All residents who meet the criteria for 1-1 activity interventions have the potential to be affected.	

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F 248	Continued From page 19 facility policy, and staff interview, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and the physical, mental, and psychosocial well-being of 1 of 3 sampled residents (Resident #3) dependent on staff for assistance. Failure to provide activities that met Resident #3's individual needs and interests, including one-to-one activities, limited his ability to reach his highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility's policy titled "Activity Program" occurred on 07/23/14. This policy, revised June 2012, stated, ". . . The center will provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. . . . Because leisure/recreation are important components of daily life and an integral part of holistic care, therapeutic approaches to activities and programs will be implemented and offered to each resident." Observations showed the following: * 07/21/14 at 3:40 p.m. and 07/23/14 at 8:35 a.m., 9:30 a.m., 10:40 a.m., and 11:55 a.m., Resident #3 sat in a recliner in the lounge. The television, located on the other side of the lounge, was turned on with the volume turned down (barely audible two-to-three feet from the set). * 07/22/14 at 7:40 a.m. and 9:07 a.m., Resident #3 sat in a recliner in the lounge. The television was turned on with the volume turned off. * 07/22/14 at 11:12 a.m., Resident #3 sat in a recliner in the lounge. The television was turned	F 248	3. All staff were educated on August 12, 2014 as to how to locate residents' interests in the Electronic Medical Record. Individual sensory kits will be created for residents in the one-to-one program. 4. Activity Director or designee will complete audits 2 times weekly times 4 weeks, then 1 time monthly for 2 months, then quarterly times 2 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014 Audit individual resident's activities. Per D.O.N. 8/25/14 T.C. dl	

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F 248	Continued From page 20 on, and audible. (On one of eight observations.) Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included dementia with aggressive behaviors. The quarterly Minimum Data Set (MDS), dated 06/11/14, identified short/long term memory deficits, severely impaired reasoning, delirium, and need for limited-to-extensive assistance with all activities of daily living (ADLs). The current care plan addressing Resident #3's individualized activity needs identified the following: * ". . . Interventions: . . . Provide Sensory 1 to 1 bedside/in-room visits and activities, if unable to attend out of room events. Encourage ongoing family involvement. Invite resident's family to attend special events, activities, meals, Offer to turn on TV, music in room when resident chooses not to participate in organized activities: Likes t.v. noise even though has poor eyesight. Topics of interest may include: Farming." The activity progress notes identified the following: * 06/11/14, "Reviewed the care plan and feel it is appropriate at this time. We will continue sensory 1:1 and group. His favorite activities are watching TV (This conflicts with the care plan entry; "Likes t.v. noise even though has poor eyesight.") and wheeling around on his own." * 06/18/14, "After [Resident #3's] care plan today we decided to take him off of sensory group. He wheels out and does not enjoy staying with the others." * 06/19/14, "Reviewed his care plan and it does not need any changes at this time."	F 248		

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F 248	Continued From page 21 During an interview on 07/23/14 at 11:45 a.m., a managerial nursing staff member (#11) stated staff provide Resident #3 one 1:1 activity per week, and confirmed he no longer attended the sensory group activities which were offered up to three times per week. The "July 2014 Activities" calendar identified the facility offered "Sensory 1:1" sessions on the 300 and 400 wings one-to-two times per week. The facility provided a copy of the "Activities Documentation Survey Report" upon request. When asked to explain the data contained in the report, both activity and nursing staff members (#10, #11, #12, #13) were unable to do so. The report showed staff offered activities (1:1 and other activities) to Resident #3 up to five times per day on 29 of 31 days in May, 27 of 30 days in June, and 21 of 22 days in July. During an interview on 07/23/14 at 10:41 a.m., when asked for a list of Resident #3's interests/preferred activities, an activity staff member (#12) stated, "He's a hard one to get. He's always in the chair. We do 1:1s with him, sensory type stuff. He loves to listen to me whistle, and he likes ice cream." When asked how often "Sensory 1:1" sessions are provided and the length of each session, she stated, "One time per week, 5-15 minutes." This conflicts with "Activities Documentation Survey Report" which showed staff offered activities to Resident #3 up to five times per day and/or up to seven days a week. During an interview on 07/23/14 at 10:50 a.m., when asked for a list of Resident #3's interests/preferred activities, an activity staff	F 248		

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F 248	Continued From page 22 member (#13) stated, "He's real tough. We do sensory type stuff, books, tractors." She added, "He's often in the lounge, and well, the tv is on." When asked how often "Sensory 1:1" sessions are provided and the length of each session, she stated, "One time per week, 10-15 minutes." This again conflicts with "Activities Documentation Survey Report" which showed staff offered activities to Resident #3 up to five times per day and/or up to seven days a week. Observations during survey showed staff failed to provide meaningful and individualized activities specific to Resident #3's physical and/or cognitive abilities. Other than meals, Resident #1 sat and/or laid in a recliner in the lounge with the television on in the background; often with no audible sound.	F 248		
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 by: POSITIONING FOR SAFE INTAKE 1. Based on observation, record review, review of professional literature, and staff interview, the facility failed to provide the care and services necessary to attain the highest degree of safety	F 309	POSITIONING FOR SAFE INTAKE 1. There was no evidence of a negative consequence following the providing of fluids for Resident #1 and #3 or for the assist and supervision during mealtime for Resident #2 and #3. Staff has since been educated on positioning residents for safe intake and supervision during meals. 2. All residents who may require assist with positioning for safe intake or supervision may be at risk.	

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F 309	Continued From page 23 possible during meals and while offering liquids at bedside for 3 of 3 sampled residents (Resident #1, #2, and #3) observed being assisted with oral intake. Failure to ensure Resident #1, #2, and #3 were positioned properly, Resident #2 was alert enough to eat/drink, and the staff members feeding the residents were properly trained, resulted in Resident #1 and #3 aspirating and placed Resident #2 at risk of aspirating. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 47, 125, 128 and the educational handouts identified, ". . . Signs of pharyngeal dysphagia are coughing or choking during a meal . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ." - Review of Resident #1's medical record occurred on all days of survey. Medical diagnoses included multiple sclerosis. The quarterly Minimum Data Set (MDS), dated 06/28/14, identified moderately impaired cognition and need for supervision during meals. Observation showed the following: * On 07/21/14 at 3:42 p.m., a certified nursing assistant (CNA) (#15) assisted Resident #1 into bed. The CNA (#15) then gave him a drink of water. The head of the bed was raised to an approximate 30 degree angle (placing Resident #1 at an increased risk of premature loss of food/liquid over the back of his tongue). Resident	F 309	3. Education was provided by Amy Slominski, OTR to nursing, activity and restorative staff on August 12, 2014 regarding positioning residents for safe intake and supervision during meals. 4. DNS, Restorative Nurse or designee will audit randomly 2-4 times per week times 1 week, then weekly times 3 weeks, then monthly times 2 months, then quarterly times 2 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014. Audit res.' position when staff offers fluids/food. Per D.O.N. 8/25/14 T.C. dl. NON-PHARMACOLOGICAL INTERVENTIONS 1. The "as needed" antipsychotic medication for Residents #3 was discontinued on June 20, 2014. 2. A query was run to determine which residents have orders for "as needed" antipsychotic medications who may be at risk. Two residents have the potential to be affected. The "as needed" medications will be reviewed by the residents' psychiatrist on his next scheduled visit.	

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F 309	Continued From page 24 #1 immediately began coughing (an indication he had poor vocal fold closure and secretions had entered his airway). Staff failed to ensure the resident was at or as close to 90 degrees as possible prior to offering liquids. - Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included dementia and reflux. The quarterly MDS, dated 04/19/14, identified short/long term memory deficits, moderately impaired reasoning, and need for extensive assistance of one person during meals. Observations showed the following: * On 07/22/14 at 12:25 p.m., Resident #2 sat next to an assisted table in the dining room, dozing in her wheelchair. A CNA (#15) gave her a drink of water without first trying to awaken the resident (placing Resident #2 at an increased risk of aspirating due to her unresponsive state), and cued her to swallow. When Resident #2 made no effort to swallow the water, the CNA (#15) cued her a second time, and proceeded to give her another sip of water. * On 07/22/14 at 12:35 p.m., Resident #2 continued dozing in her wheelchair. A CNA (#16) gave her a bite of ground meat without first trying to awaken the resident (placing Resident #2 at an increased risk of aspirating due to her unresponsive state), and cued her to swallow. As Resident #2 made a slight chewing motion with her teeth, the CNA (#16) cued her a second time, and proceeded to give her a bite of vegetable. Staff failed to ensure the resident was alert enough to eat/drink prior to offering liquids and/or solids. * On 07/23/14 at 8:35 a.m., an unidentified CNA fed Resident #2 in the dining room as she sat in	F 309	3. Education was provided to facility nurses on August 12, 2014 regarding "Psychopharmacological Medications and Sedative/Hypnotics" Policy with focus on use of non-pharmacological interventions. 4. DNS, Restorative Nurse or designee will audit randomly 2-4 times per week times 1 week, then weekly times 3 weeks, then monthly times 2 months, then quarterly times 2 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014. Audit non-pharmacological interventions used prior to administer antipsychotic medications. Per D.O.N. 8/25/14 T.C. dl	

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F 309	Continued From page 25	F 309		

her wheelchair leaning to her right side (75 degrees).
* On 07/23/14 at 12:20 p.m., an unidentified CNA fed Resident #2 in the dining room as she sat in her wheelchair leaning heavily to her right side (65 degrees).
Staff failed to reposition Resident #2 into an upright position thereby reducing her risk of aspiration.

- Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included dementia, gastrointestinal reflux, and nutritional deficiency. The quarterly MDS, dated 06/11/14, identified short/long term memory deficits, severely impaired reasoning, and need for limited assistance during meals.

The current care plan addressing Resident #3's nutritional needs identified,
* ". . . Interventions: . . . Supervision at meals. Assist PRN [as needed]."

Observations showed the following:
* On 07/21/14 at 3:42 p.m., a CNA (#14) assisted Resident #3 into bed. The CNA (#14) then gave him a drink of water. The head of the bed was raised to an approximate 25 degree angle (placing Resident #3 at an increased risk of premature loss of food/liquid over the back of his tongue). Resident #3 demonstrated a delayed cough (an indication he had poor vocal fold closure and secretions had entered his airway). Staff failed to ensure the resident was at or as close to 90 degrees as possible prior to offering liquids.
* On 07/23/14 at 12:20 p.m., Resident #3 sat at a table for residents requiring assistance, unattended, as he ate dinner. During the

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F 309	Continued From page 26 observation, staff failed to provide supervision as care planned. During an interview on the morning of 07/23/14, administrative and managerial nursing staff (#5, #10, and #11) confirmed staff should ensure residents are alert and/or sitting as close to 90 degrees as possible prior to offering them foods/liquids, and confirmed staff should provide supervision during meals when care planned. The facility failed to 1) ensure Resident #2 was alert enough to eat, 2) position Resident #1 and Resident #3 as close to 90 degrees as possible prior to offering them liquids, 3) supervise Resident #3 during meals as care planned, and 4) recognize signs/symptoms of dysphagia/aspiration (coughing/choking). Failure to implement the above interventions resulted in the residents aspirating and/or being at risk of aspiration during oral intake. NON-PHARMACOLOGICAL INTERVENTIONS 2. Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 1 of 3 sampled residents (Resident #3) who received as needed (PRN) medications for behaviors prior to attempting non-pharmacological interventions. Failure to identify target behaviors, assess the reason/causative factor(s) for the behaviors, and develop and implement creative individualized interventions to decrease the behaviors prevented Resident #3 from obtaining his highest practicable physical, mental, and psychosocial well-being. Findings include:	F 309		

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F 309	Continued From page 27 The facility failed to provide a policy specific to the administration of prn antipsychotic medications upon request. - Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included dementia with aggressive behaviors. The quarterly Minimum Data Set (MDS), dated 06/11/14, identified short/long term memory deficits, severely impaired reasoning, delirium, and need for limited-to-extensive assistance with all activities of daily living (ADLs). The current care plan addressing Resident #3's behavior symptoms identified the following: * ". . . Interventions: . . . going into other resident's rooms and other areas: offer snack, warm blanket, need for toilet, and/or recliner." The physician's orders identified, "11/12/13, Seroquel 25 mg [milligrams]. Give 1 tablet by mouth as needed for aggition [sic]/agression . . . ." The medication administration record (MAR) and the corresponding progress notes identified the following: * 11/13/13 at 12:34 a.m., ". . . Gave at [11:30 p.m.] resident keeps trying to leave the building. He states 'Their [sic] is a fire out there.' . . . ." * 11/14/13 at 9:21 p.m., ". . . Given for increased restlessness. . . ." * 11/20/13 at 9:57 p.m., ". . . increased restlessness and wandering. taking off tab alarm on w/c [wheelchair] and walking down the length of hallway to the tv area in the center of the building. . . ." * 12/03/13 at 3:15 a.m., ". . . Resident still restless	F 309		

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F 309	Continued From page 28 and trying to leave facility. PRN seroquel given. . . . does wander in to other residents room and can be restless. This seems to be mainly in the evening and night shifts. When they have tried alternatives, like toileting him, giving him food and water, and walking him and this is not effective they may use a PRN dose of Seroquel. " * 12/13/13, ". . . He sleeps some nights in his own bed but on other nights he can be restless. He is given food, fluids, walked and taken to Bathroom. If this is not effective he is given a PRN Seroquel." * 12/21/13 at 12:39 a.m., ". . . Resident aggitated and restless in day room. Resident continues to state 'I gotta get going' and continues to try to get up on own without support of staff." * 01/06/14 at 1:33 a.m., No entry regarding reason for administration. * 02/06/14, ". . . PRN Seroquel for episodes of aggression. . . ." * 02/14/14 at 11:54 p.m., ". . . resident in recliner in common area and is very loud - he is complaining of hie [sic] right great [sic]. given seroquel 25 mg [po] [orally] for his hollering. . . ." * 06/13/14 at 11:47 p.m., No entry regarding reason for administration. * 06/16/14 at 12:39 a.m., No entry regarding reason for administration. * 06/18/14 at 12:03 a.m., ". . . resident roaming into other resident's rooms. . . ." * 06/20/14 at 12:44 a.m., ". . . Resident very restless and wandering the halls. Goes into other resident's rooms looking for the bathroom. . . ." The record identified staff failed to attempt non-pharmacological interventions prior to administering Resident #3's prn Seroquel on 11 of 20 occasions (greater than 50% of the time). During an interview on 07/23/14 at 11:45 a.m., a	F 309		

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F 309	Continued From page 29 managerial nursing staff member (#11) confirmed she would expect staff to identify the non-pharmacological interventions attempted prior to administering Resident #3's anti-psychotic medication. Failure to attempt non-pharmacological interventions prior to administering an anti-psychotic medication did not allow staff to evaluate what interventions were most effective to manage Resident #3's behavior.	F 309		
F 318 SS=D	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, and staff interview, 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 1 of 6 sampled residents (Resident #2) 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	1. The Restorative Dining Program for Resident #2 was discontinued on July 28, 2014 2. There are no other residents on a Restorative Dining Program at this time. 3. Education was provided to staff on Restorative Dining Program procedures on August 12, 2014. 4. Restorative Nurse or designee will perform audits on Restorative Dining Programs as programs become care planned. Restorative documentation of other programs will be audited randomly 3 times a week for one week, then weekly times 4 weeks, and monthly times 4 months, then quarterly and as deemed necessary by the QA Committee. 5. Completed September 2, 2014.	

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F 318	Continued From page 30 The facility failed to provide a policy specific to their restorative therapy program upon request. Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included dementia, osteoarthrosis, degenerative joint disease, weakness, and chronic pain with arm movement. The quarterly Minimum Data Set (MDS), dated 04/19/14, identified short/long term memory deficits, moderately impaired reasoning, and need for extensive assistance of one person during meals. The current care plan addressing Resident #2's dining needs identified, * ". . . Goals: . . . Resident will be able to: fed [sic] self with limited assistance and cues. . . . Interventions: . . . Eating/Swallowing RA [Restorative Aide] program Dining BRK [breakfast] 6 days/wk [week] for hand over hand assistance and verbal cues. . . . Eating/Swallowing RA Dining program Dinner 6 days/wk for hand over hand assistance and verbal cues. . . ." A therapy note, dated 06/25/14, identified, ". . . Due to Resident's [reduced] cognition she feeds herself [at] times and req [requires] 100% fed other times Resident is [at] a feeding table and when Res [Resident] able to feed self she has a tray that attached directly on her w/c [wheelchair]. Staff is aware of this and use PRN [as needed]. . . ." Observations showed the following: * 07/22/14 at 8:18 a.m., Resident #2 sat six inches from the dining room table, due to the lap tray on her left side. Resident #2 leaned forward, picked a grape from the plate sitting in front of	F 318		

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F 318	Continued From page 31 her, and put it in her mouth . . . At 8:21 a.m., a certified nursing assistant (CNA) (#17) sat down next to Resident #2 and fed her breakfast. The CNA failed to move Resident #2's plate closer (on the lap tray) so she had access to it, and failed to provide hand-over-hand assistance/cues during the meal. * 07/22/14 at 12:25 p.m. and 12:35 p.m., Resident #2 sat near the dining room table, left lap tray in place. Two CNAs (#15 and #16) made attempts to feed Resident #2. The CNAs made no effort to provide hand-over-hand assistance/cues. * 07/23/14 at 8:35 a.m. and 12:20 p.m., Resident #2 sat near the dining room table, left lap tray in place. An unidentified CNA fed Resident #2. The CNA failed to move Resident #2's plate closer (on the lap tray) so she had access to it, and failed to provide hand-over-hand assistance/cues during the meal. The facility provided a copy of the Restorative Therapy "Documentation Survey Report" upon request. The report showed staff provided Resident #2 hand-over-hand assistance/cues during meals 2 out of 3 days of survey. This conflicts with direct observations of staff feeding Resident #2. During an interview on the morning of 07/23/14, administrative and managerial nursing staff (#5, #10, and #11) confirmed staff should provide hand-over-hand assistance/cues during meals when care planned.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 32 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/18/13. Based on observation, record review, review of manufacturer's recommendations, review of facility policy, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 1 of 4 sampled residents (Resident #2) observed during sit-to-stand lift transfers. Failure to ensure staff used a mechanical lift appropriately placed the Resident #2 at risk for a fall and/or injury during transfers. Findings include: Review of the manufacturer's guideline "EZ Way stand Operator's Instructions" occurred on 05/07/14. The instructions, revised 03/11/09, stated, ". . . The EZ Way stand was designed specifically for toileting and changing briefs of patients. The EZ Way stand can also be used for transferring the patient from . . . toilet or bed . . . Patients should be able to bear some weight, have upper body strength . . . and be able to follow simple commands. If a patient does not meet each of these three criteria, the EZ Lift total body lift must be used. . . ." Review of the facility policy titled "Mechanical Lift"	F 323	1. Occupational Therapy evaluation was completed on July 29, 2014 for Resident #2. No changes were made to the care plan. 2. All residents who are care planned to use mechanical lifts have the potential to be affected. 3. Education on proper use of mechanical lifts was provided to nursing, activity and restorative staff by Amy Slominski, OTR on August 12, 2014. Competency verification checklists will be completed for staff members during their anniversary month. 4. Restorative Nurse or designee will perform random audits for mechanical lift use 3 times a week for one week, then weekly times 4 weeks, then monthly times 4 months, then quarterly and as deemed necessary by the QA Committee. 5. Completed September 2, 2014.	

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F 323	Continued From page 33 occurred on 07/23/14. This policy, revised January 2014, stated, ". . . Sit-to-Stand: For residents who demonstrate leg strength for weight bearing and are able to hold torso in an upright position . . . Must be able to cognitively follow cues and cooperate with procedure." Review of Resident #2's medical record occurred on all days of survey. Medical diagnoses included dementia, osteoarthrosis, degenerative joint disease, weakness, and chronic pain with arm movement. The quarterly Minimum Data Set (MDS), dated 04/19/14, identified short/long term memory deficits, moderately impaired reasoning, and need for extensive assistance of one person for transfers. The current care plan addressing Resident #2's transfer needs identified, * ". . . Interventions: . . . Resident requires weight bearing support transfers with stand lift, 1 staff assist . . ." Observations showed the following: * 07/22/14 at 10:43 a.m. and 2:10 p.m., a certified nursing assistant (CNA) (#16) transferred Resident #2 from the toilet to her wheelchair using the sit-to-stand lift. The resident did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #2's axillae (armpits), her shoulders raised to ear level. * 07/22/14 at 4:17 p.m., a CNA (#2) transferred Resident #2 from her bed to the toilet using the sit-to-stand lift. The resident did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #2's axillae, her shoulders raised to ear level.	F 323		

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F 323	Continued From page 34 Staff failed to cue Resident #2 to stand, ensure she was able to bear weight throughout the stand lift transfers, and report her inability to bear weight to the nurse. During an interview on the morning of 07/23/14, administrative and managerial nursing staff (#5, #10, and #11) confirmed a resident should be able to bear own weight if a sit-to-stand lift is used.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy, the facility failed to ensure acceptable parameters of nutritional status for 1 of 2 sampled residents (Resident #7) who experienced weight loss. Failure to implement interventions or evaluate the effectiveness of current interventions may have contributed to Resident #7's significant weight loss. Findings include:	F 325	1. Resident #7's weight has remained stable over the last 173 days. Interventions in place have been successful in preventing any further weight loss. 2. A report will be run to identify the residents who may be at risk of significant or insidious weight loss. 3. On August 12, 2014, education was provided to nursing staff and on August 27, 2014, additional education will be provided to the Nutrition Risk committee. Education provided included definition of insidious weight loss, a review of the policy and procedures of the Nutrition Risk committee, and interventions for prevention of further weight loss.	

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F 325	Continued From page 35 Review of the facility policy titled "Monitoring Residents for Impaired Nutrition and Nutritional Risk" occurred on 07/23/14. This policy, revised August 2012, stated, "Purpose: To identify and monitor residents with impaired nutrition or at nutritional risk. Policy: The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight . . . . Procedure: . . . 4. The DDS [director of dietary services] or designee will review resident weights monthly or more often to identify residents with significant weight loss/gain (5 percent in 30 days, 7.5 percent in 90 days or 10 percent in 180 days) or insidious weight loss or gain. Insidious weight loss or gain refers to a gradual unintended, progressive weight loss or gain over time. . . . " Review of the facility policy titled "Interventions for Nutritional Risk of Residents" occurred on 07/23/14. This policy, revised August 2012, stated, "Purpose: To provide staff guidelines for interventions for residents at risk for nutritional decline. Procedure: 6. Suggestions for staff: . . . Liberalize a therapeutic diet to encourage intake; Substitutions and alternate menu choices per individual preferences; Fortified or high-calorie/high-protein diet; . . . Medical nutritional supplement only when absolutely necessary . . . ; Snacks between meals; Beverage cart between meals; . . . Offer finger foods; Provide smaller, more frequent meals . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included nutritional marasmus [protein energy malnutrition], diabetes, and Alzheimer's disease. The care plan, dated 01/13/14, stated, "Focus: The resident has the potential for a nutritional	F 325	4. Dietary Supervisor or designee will perform audits to monitor weights and interventions 1 time weekly for 4 weeks, then monthly times 1, then quarterly times 2, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014.	

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F 325	Continued From page 36 problem R/T [related to] DM [diabetes mellitus], swallowing problem and dementia, E/B [evidenced by] need for therapuetic [sic] & mechanically altered diet, and need for assistance during meals. . . . Interventions: . . . Eating-Swallowing: Resident requires CCHO [consistent carbohydrate], Level 1 dysphagia puree diet, with honey thickened liquids. . . . Provide assistance at meals. . . . Occasionally will have coconut oil supplement mixed into food." Resident #7's most recent quarterly dietary profile assessment, dated 04/14/14, indicated the resident experienced a recent decline in intake for meals and fluids, and the resident was not provided nutritional supplements or an individualized snack schedule. The dietary assessment failed to address an action plan regarding Resident #7's reduced intake. Resident #7's Weights and Vitals Summary showed the following weights: 08/21/13: 136 pounds 10/16/13: 132 pounds 12/18/13: 131 pounds 02/12/14: 126 pounds 03/12/14: 123 pounds 04/16/14: 119 pounds - 10 % loss in 180 days 05/14/14: 116 pounds - 10 % loss in 180 days and 7.5% loss in 90 days 06/11/14: 118 pounds - 10 % loss in 180 days 07/23/14 : 117 pounds During an interview on 07/23/14 at 11:00 a.m., a dietary supervisor (#6) stated all pureed diets contain enriched cereal and mashed potatoes enriched with protein powder, which the resident gets daily. This staff member was unable to provide the date Resident #7 began a pureed	F 325		

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F 325	Continued From page 37 diet. Resident #7's progress notes included: * 01/13/14, dietary quarterly note - "Resident continues on a consistent CHO diet, Level 1 puree with nectar thickened liquids. . . ." * 04/14/14, dietary quarterly note - ". . . Appetite has declined recently and has had episodes of refusing to eat . . . Weight is 119# [pounds]; has experienced a slow and steady decline . . . Will continue to monitor for any further weight loss and intervene as necessary." * 05/07/14, weight change note - ". . . WEIGHT WARNING: Value: 113.0 [pounds] . . . Response: Will try the high cal [calorie]/high pro [protein] pudding daily and will add other interventions PRN [as needed]." * 05/20/14, nutritional status - ". . . Resident has been receiving Ensure pudding daily and weight is up 3# this week. . . ." * 07/02/14, nutritional status - ". . . Weight has been stable over the past two months. . . . Ensure pudding ordered and signed by resident's physician to be given TID [three times daily] with meals on 7/2/14. . . ." Resident #7's weight indicated an insidious loss of 17 pounds from August 2013 to April 2014, and a significant loss of 10% in April, May and June, 2014. Failure to evaluate the effectiveness of current interventions in a timely manner and implement additional interventions prior to 05/07/14 may have contributed to Resident #7's significant weight loss.	F 325		

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F 371 F 371 SS=D	Continued From page 38 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's kitchen cleaning schedule, and staff interview, the facility failed to store food in a safe and sanitary manner in 1 of 1 nutrition center refrigerator (Charting Room refrigerator). Failure to discard items after the labeled "use by" date placed residents at risk of food borne illness. Findings include: Observation on July 22, 2014 at 3:30 p.m. of the charting room refrigerator showed the following: * Two Ensure puddings with use by dates of 04/01/14 (112 days prior) * One Hormel Fiber Basics Orange Juice Blend with Fiber with use by date of 07/08/14 (14 days prior) * Four Activa yogurts with use by dates of 07/13/14 (9 days prior) Review of the facility's "PM COOK CLEANING SCHEDULE" identified a daily charting room stocking list. The "Charting Room Stocking List"	F 371 F 371	1. Expired items were immediately removed from the charting room refrigerator when concern was brought to the attention of the Dietary Supervisor on July 22, 2014. 2. All residents have the potential to be at risk. 3. Met with Dietary staff on August 12, 2014 to review and revise procedure for completing the "Charting Room Stocking List". List was updated to cut back on items so stock is rotated effectively. Dietary staff is to document any expired items that are removed from the fridge on the "Charting Room Stocking List". 4. Dietary Supervisor or designee will audit daily for one week, then one time a week for 2 weeks, then 1 time monthly for 2 months, then quarterly for 2 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014. Audit Food expiration dates in charting room. Per D.O.N. 8/25/14 T.C. dl	

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F 371	Continued From page 39 stated ". . . TO BE STOCKED EVERY NIGHT; Remove items if over 7 days old . . ." During an interview on 07/22/14 at 4:40 p.m., an administrative dietary staff member (#6) stated she expects staff to check the charting room refrigerator daily for expired items.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	1. Immediate staff instruction on proper hand hygiene was given on July 23, 2014. Residents #6 and #7 have not had any infections since this incident. 2. All residents receiving assistance have the potential to be affected. 3. Facility staff in all departments were instructed on August 12, 2014 during an in-service on proper hand hygiene and infection control referencing the 'Patient Safety Poster, Your 5 Moments for Hand Hygiene' from the World Health Org. Posters have been placed in the facility to reinforce the need of proper hand hygiene practices. 4. Infection Preventionist or designee will conduct audits on random shifts and departments 3 times weekly times 2 weeks, then weekly for 4 weeks, then quarterly for 4 quarters, then as deemed necessary by the QA Committee. 5. Completed September 2, 2014.	

Audit hand hygiene with pericares.
Per D.O.N. 8/25/14 T.C. dl

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F 441	Continued From page 40 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 07/18/13. Based on observation, record review, and review of facility policy, the facility failed to follow standard infection control practices for 2 of 3 sampled residents (Resident #6 and #7) observed during perineal cares which involved stool. Failure to perform hand hygiene following perineal cares has the potential to cause or spread an infection within the facility. Findings include: Review of the facility policy titled "Hand Hygiene and Handwashing" occurred on 07/23/14. This policy, revised June 2014, stated, "Guidelines: . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based rub . . . : . . . after having direct contact with a resident's skin, after having contact with body fluids . . . , after removing gloves. NOTE: Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses	F 441		

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F 441	Continued From page 41 included history of urinary tract infection (UTI), history of open wounds to extremities, and use of a urinary catheter. On 07/22/14 at 8:48 a.m., observation showed a certified nurse aide (CNA) (#1) cleansed Resident #6's perineal area following a bowel movement, removed the gloves, and assisted her to the sink where Resident #6 washed her hands. The CNA then wheeled Resident #6 to her side of the room, turned the television on and changed the channel, placed the television's remote control in reach of the resident, removed the wheelchair foot rests, placed the call bell within reach, and then washed her hands. The CNA (#1) failed to perform hand hygiene after completing perineal cares and removing gloves, and before completing other tasks. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included history of UTI. On two occasions, 07/21/14 at 4:45 p.m. and 07/22/14 at 4:50 p.m., observation showed two CNAs (#2 and #3) assisted Resident #7 with toileting. One CNA (#2) cleansed Resident #7's perineal area following incontinence of urine and stool, then removed the gloves. Both CNAs placed a new brief, adjusted the resident's pants, placed the full body mechanical lift sling under the resident in bed, put shoes on his feet, connected the sling to the lift, transferred the resident into his chair, and placed the supporting pillows by his extremities. The CNA (#2) combed Resident #7's hair. On both occasions the CNA (#2) failed to perform hand hygiene after completing perineal cares and removing gloves, and before completing other tasks. On 07/22/14, the CNA	F 441		

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F 441	Continued From page 42 (#2) also failed to perform hand hygiene prior to exiting the resident's room. On 07/22/14 at 10:50 a.m., observation showed two staff (CNA #4 and licensed nurse #5) assisted Resident #7 with toileting. The CNA (#4) cleansed Resident #7's perineal area following incontinence of urine and stool, then removed her gloves. Both staff placed a new brief, adjusted the resident's pants, and placed the full body mechanical lift sling under the resident in bed. The CNA (#4) left the room to retrieve the lift and performed hand hygiene upon returning to the room. The CNA (#4) failed to perform hand hygiene after completing perineal cares and removing gloves, and before completing other tasks.	F 441		