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 _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 SOUTH COUNTY ROAD 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 August 31, 2015 and completed on September 3, 2015 the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 246	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, and staff interview, the facility failed to ensure 1 of 10 sampled residents (Resident #9) received reasonable accommodation of individual needs regarding dining room table positioning. Failure to offer and provide appropriate dining room table height limited the residents access to meal items and limited the quality of the dining experience. Findings include: Review of Resident #9's medical record occurred on September 02-03, 2015. The resident's diagnoses included dementia and macular degeneration of the retina (impaired visual	F 246	1) Care plan was updated for Resident #9. Table seating in dining room adjusted to allow more leg room. 2) All residents seated in a wheelchair have the potential to be affected. 3) Education on dining services and table placement including table positioning, distance from table, items on table in reach for resident was provided to staff on September 09, 2015.	10/5/15

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

Electronically Signed | 09/25/2015

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F 246	Continued From page 1 function). The facility quality audit report, dated 08/05/15, stated, ". . . Reviewed all new tables 8-4-15 - Audited for table height - all but 2 tables needing adjusting . . . maintenance working on this as hard to move ['down arrow' down] - will re audit . . . Tables are at their lowest setting. Nothing I can do . . ." Observation in the dining room on 09/01/15 at 12:30 p.m., showed Resident #9 holding her plated food in her lap, and feeding herself from her lap. The resident attempted to reach the food several times on the table. Food dropped from the resident's fork as she tried to bring the food to her mouth. Observation on 09/02/15 at 7:35 a.m., showed Resident #9 in her wheelchair at the dining room table. The resident attempted to eat her hot cereal dropping the food from the spoon onto her lap and the table. She made several unsuccessful attempts to move her wheelchair closer to the table. The resident's wheelchair foot rests, blocked by the other resident's wheelchair foot rests, prevented her from moving her closer to the table. The resident then placed the bowl of hot cereal in her lap in order to eat from it. The height of the dining room table was at the level of the resident's upper chest. Observation on 09/02/15 at 12:20 p.m., showed Resident #9 in her wheelchair at the dining room table. The resident made several unsuccessful attempts to move her wheelchair closer to the table. The resident picked up a bowl of fruit from the table and placed the bowl of fruit in her lap in	F 246	4) Random audits on dining table positioning will be done 3-5 times a week for one week, then weekly X 4 and monthly X 4, then as Quality Assurance Performance Improvement (QAPI) committee deems necessary. Responsible persons include: Restorative Nursing Coordinator and others as designated.	

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F 246	Continued From page 2 order to eat from it. The resident's distance from the table and height of the table made it difficult for the resident to eat directly from the table. During an interview on the morning of 09/03/15, an administrative nurse (#1) confirmed the resident should be able to sit close to the table to easily reach food.	F 246		
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, the facility failed to complete significant change in status assessments (SCSA) for 1 of 1 sampled residents (Resident #8) who experienced a significant improvement in the last 6 months	F 274	1) An annual comprehensive assessment for Resident #8 was done on 7-16-2015. On September 14, 2015 State Resident Assessment Instrument (RAI) Coordinator, informed Unit Manager that no further correction was needed.	10/5/15

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F 274	Continued From page 3 (April-September). Failure to complete a SCSA in response to the resident's improvement limited the facility's ability to identify and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2014, pages 2-20 and 2-23 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement). . . " Review of Resident #8's medical record occurred on all days of survey. Diagnoses included a history of hip fracture. Resident #8's quarterly Minimum Data Set (MDS), dated 1/16/15 identified the resident required extensive assist for bed mobility, transfer, dressing, and toilet use. The quarterly MDS, dated 04/16/15, indicated an improvement in these areas with independence in bed mobility, transfer, and toilet use. The record lacked evidence staff completed a SCSA following Resident #8's improvement in functional status.	F 274	2) All residents experiencing a change in condition have the potential to be affected. 3) Education on recognizing a significant change was provided by the Clinical Rehab Consultant from Good Samaritan Society on September 21, 2015. The current procedure for notifying Unit Coordinators of condition changes was reviewed and revised. Care plan team members will route a Resident Clinical Changes Notification form to the Unit Manager when changes are done in coding that would trigger a significant assessment of the Minimum Data Set (MDS). Team members completing the MDS will also utilize the MDS Report to identify change areas. 4) Monitoring will be done by random audits of MDS coding weekly for 4 weeks, then monthly for 4 months, then as deemed necessary by the QAPI committee. Responsible persons: Director of Nursing and others as designated	
F 278	483.20(g) - (j) ASSESSMENT	F 278		10/5/15

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F 278	Continued From page 4 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Set (MDS) accurately reflected	F 278	1) The MDS for Resident # 5 was corrected on September 23, 2015. The MDSs for Residents # 1 and # 2 were corrected on September 04, 2015.	

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F 278	Continued From page 5 the resident's status for 3 of 12 sampled residents. One resident (Resident #5) was inaccurately coded for a turning/repositioning program and two residents (Resident #1 and #2) MDS's inaccurately reflected the resident's status who experienced a fall. Failure to accurately code and complete the MDS for these residents limited the facility's ability to develop and implement an individualized care plan consistent with resident needs and functional status, and may affect the level of care provided to residents. Findings Include: The Long-Term Care Facility RAI User's Manual, October 2014, page M-38 and M-39 stated, "M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [such as] repositioning on side, pillows between knees) and frequency (e.g. every 2 hours), Progress notes, assessments, and other documentation (as indicated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention . . ." The Long-Term Care Facility RAI User's Manual, October 2014, Chapter 3, page J-29 - J-32 stated, ". . . J1800 . . . Has the resident had any falls since admission/entry or the prior assessment . . . Code 1, yes: if the resident has fallen since the last assessment . . . J1900: . . . Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of	F 278	2) All residents who obtained a fall, a fall with major injury or were coded for repositioning on the MDS have the potential to be affected. 3) Nursing management reviewed the RAI procedure for coding of falls and turning and repositioning. Education was provided on accuracy of assessments by the Clinical Rehab Consultant from Good Samaritan Society on September 21, 2015. 4) Audits of resident assessments and coding will be done weekly for 4 weeks, then monthly for 4 months then as deemed necessary by the QAPI committee. Responsible persons: Director of Nursing and others as designated.	

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F 278	Continued From page 6 fall-related injury for each . . . J1900A, No Injury . . . Code 0, none . . . Code 1, one . . . Code 2, two or more . . . J1900B, Injury (Except Major) . . . J1900C, Major Injury. . . ." - Review of Resident #5's annual MDS, dated 03/14/15, and a quarterly MDS, dated 06/14/15, identified no pressure ulcers, wounds, or skin problems. Both MDS's identified a turning/repositioning program to manage skin problems during the seven day assessment period. The medical record lacked progress notes, assessments and other documentation to support turning/repositioning program. During an interview on the morning of 09/03/15, an administrative nurse (#1) stated she was unaware of the evidence needed to support the coding of the turning/repositioning on the annual MDS, dated 03/14/15, and the quarterly MDS, dated 06/14/15. - Review of Resident #1's fall assessments identified falls on 05/13/15 (hip fracture), 06/17/15, and 08/07/15. The Discharge Return Anticipated MDS, dated 05/13/15, failed to identify the fall with a major injury. The quarterly MDS, dated 08/13/15, failed to code J1900A as 2 for the two falls with no injury (06/17/15 and 08/07/15). - Review of Resident #2's fall assessments identified a fall on 04/09/15. The quarterly MDS, dated 06/14/15, revealed J1800 coded as 0 for no falls since prior assessment. Staff failed to code the 04/09/15 fall on the quarterly MDS.	F 278		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		10/5/15

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F 280	Continued From page 7 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the plan of care for 5 of 12 sampled residents (Resident #1, #2, #3, #6, and #7). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident. Finding include: Review of the facility's policy titled "Comprehensive Care Plan and Care	F 280	1) The care plans for Residents #1, #2, #3 and #7 were reviewed and revised. Resident #6 was discharged on 09-10-15. The fall focus was added to each care plan. 2) All residents have the potential to be affected. 3) Residents with an identified risk for falls, UTIs, elopement and resident personal devices will have the risk and the appropriate goals and interventions	

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F 280	Continued From page 8 Conferences" occurred on 09/02/15. This policy, revised August 2015, stated, "The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life. . . . The interdisciplinary team will ensure that the care plan is comprehensive by incorporating the following: * All triggered Care Area Assessments (CAAs) staff has decided to proceed on. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included post hip fracture (05/13/15) and right eye blindness. Resident #1's CAA worksheet, dated 05/27/15, stated, "3. Visual Function . . . This area triggered because the resident was born blind in his right eye. He has a prosthetic eye that he cares for himself . . . Staff will monitor and assist as needed. . . ." The current care plan identified a focus for "impaired visual function R/T [related to] blindness right eye. . . ." but failed to identify the resident's prosthetic eye and how staff would monitor care. The CAA worksheet also stated, "11. Falls . . . Resident had fallen and fractured his hip. He is currently on skilled therapies to regain his strength and mobility skills as able. He needs assistance with transfers and toileting as needed . . . Risk factors are Hx [history] of hip fx [fracture] recently muscle weakness . . . may at times have poor safety awareness. . . ." The care plan failed	F 280	care planned, and the care plan will be monitored and revised as applicable. Education was provided to the Interdisciplinary Team on September 21st and 30th , 2015 by the Good Samaritan Society¿s Rehab Skilled Consultant and EMR Nurse regarding care planning, monitoring effectiveness, & revising the care/care plan related to resident falls, UTIs, elopement and resident personal devices. 4) Random audits to include comprehensive assessments and care plans will be done weekly X 3 monthly X 3 months, then as deemed necessary by the QAPI team. Responsible persons: Care plan team, Director of Nursing and others as designated.	

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to identify a focus for falls with goals and interventions relating to the resident's fracture on 05/13/15 and other non-injury falls occurring on 06/17/15, 08/07/15, and 08/24/15.

- Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia.

Resident #2's CAA worksheet, dated 12/22/14, stated, "11. Falls . . . Risk factors are DX [diagnosis] of Dementia, Major depressive disorder, and psychosis. Also hx of some pain . . . can be quite changeable with her mobility possibly due to her dementia. . . ." The current care plan failed to identify a focus for falls with goals and interventions relating to the risk for falls and falls occurring on 11/30/14, 12/18/14, 01/17/15, and 04/09/15.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, and urinary tract infection (UTI).

Resident #3's CAA worksheet, dated 10/07/14, stated, "11. Falls . . . Impaired balance during transitions . . . Risk factors are Dx of Alzheimer's disease. Dementia, debility, fatigue, osteoporosis, and chronic airway obstruction. . . ." The current care plan failed to identify a focus for falls with goals and interventions relating to the risk for falls and falls occurring on 12/20/14 (collarbone fracture), 01/13/15, 01/26/15 (abrasion), 03/15/15, 05/13/15, 05/17/15, 05/27/15, 07/15/15, and 08/30/15.

Review of Resident #3's physician's orders

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identified antibiotics ordered for UTIs on 03/15/15 and 05/27/15. On 08/31/15 staff obtained a telephone order for a urine sample for analysis due to increased anxiety and urinary frequency. The care plan failed to identify a focus and/or goals and interventions related to the resident's history of UTIs.

During an interview on 09/02/15 at 10:10 a.m., two supervisory staff members (#1 and #2) confirmed the care plans did not specifically address the prosthetic eye for Resident #1, falls for Resident #1, #2, and #3, and UTIs for Resident #3.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia, hip fracture and UTI.

Review of Resident #7's current progress notes identified the following:
* 07/03/15, 9:22 a.m., "Late Entry: resident was noted to be outside in the wheelchair it is unclear how she got outside . . ."
* 07/22/15, 4:27 p.m., "This afternoon resident was found by staff outside by herself. She told nurse that she was looking to go home . . ."
* 08/07/15, 12:04 p.m., ". . . Resident had been outside this morning 2 times. It appears she got out by herself. We discuss [sic] having a wanderguard bracelet on her. Of all the times she has been out side she had gone to the end of the walk way 2 times and 2 times she was just sitting outside . . ."
* 08/29/15, 4:30 p.m., "Late Entry: Activity staff found resident between the front doors this afternoon, she used the handycap [sic] button and got through the first door, staff asked her

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where she was going. Resident replied that she was trying to get to the second floor. . . ."

Review of Resident #7's current care plan stated, "Focus: the resident has a behavior symptom R/T dementia dx E/B [evidenced by] wandering. Goal: Resident will have fewer episodes of wandering behavior weekly by review date. Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate locations as needed. BEHAVIOR #1 wandering into other resident's rooms: re-orient resident to surroundings."
The current care plan failed to identify that the resident had exited the facility unattended and/or goals with specific interventions regarding the resident's elopements.

Resident #7's CAA worksheet, dated 10/14/14, stated, "6. Urinary Incontinence and Indwelling Catheter . . . Resident is at risk r/t she has dementia and had a UTI. She also has a hip fx . . . Resident is at risk r/t she has a UTI which has caused her to have urinary urgency. . ."

Review of Resident #7's progress notes from March 1, 2015 through September 1, 2015 identified the resident had been treated for a UTI on 03/10/15, then the antibiotic changed on 03/16/15 and was completed on 03/23/15. Another UTI was identified on 05/12/15 and treated with antibiotics. The current care plan failed to identify a focus and/or goals and interventions related to the resident's history of UTIs.

Resident #7's CAA worksheet, dated 10/14/14,

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

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F 280	Continued From page 12 stated, "11. Falls . . . Resident had fallen before admit when she fractured her rt [right] hip. She did also fall on 10/14/14 with no injury. She is unsteady on her feet . . ." Review of Resident #7's progress notes from March 1, 2015 through September 1, 2015 identified 12 falls. The current care plan failed to identify a specific problem area for falls which included goals and interventions relating to the her risk for falls. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included traumatic fracture of hip (08/15/15), muscle weakness, and dementia. Resident #6's CAA worksheet, dated 08/31/15, stated, "11. Falls . . . Resident requires assistance for transfers from bed to w/c [wheelchair] with full lift with 2 assist. She also receives an antidepressant 7 days per week and monitor for side effects . . . rationale for care plan decision . . . Risk factors S/P [status post] right hip fracture with skilled PT [physical therapy] and OT [occupational therapy] services to regain mobility as able, Dementia, anxiety disorder, pain related to recent hip fx and hx of depressive disorder. Also muscle weakness related to recent fx . . ." The care plan failed to identify a focus for falls with goals and interventions relating to the resident's fracture on 08/15/15 and other non-injury falls occurring on 01/06/15, 01/16/15, 01/17/15, 02/10/15, 03/05/15, 05/28/15, 06/02/15, 06/08/15, 06/17/15, and 07/28/15.	F 280		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		10/5/15

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F 323	Continued From page 13 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: ELOPEMENT 1. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide a safe environment for 1 of 2 residents (Resident #7) who wandered outside the facility. Failure to monitor, provide for a safe environment, and develop a plan of care placed the resident at risk for injury. Findings include: Review of the facility policy titled "Elopement" occurred on 09/03/15. This policy, dated September 2012, stated, ". . . Elopement- When a resident who needs supervision leaves the premises or a safe area without authorization, (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. . . Policy: The center will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. . . Each center will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. . . All occurrences will be documented and all follow-up required by state	F 323	ELOPEMENT 1) The care plan was reviewed and updated for Resident #7. A Wanderguard bracelet was applied to Resident # 7. 2) Any resident who has exhibited exit-seeking behavior is at risk. 3) Education was provided at general staff meeting on September 09, 2015 on elopement policy and procedure. The "Elopement Checklist Worksheet" will be utilized for residents at risk for elopement, as directed in the Good Samaritan Society Nursing Services Manual on Elopement Procedures. 4) Random audits of MDSs and care plans, monitoring for measures in place for residents at risk for elopement, will be done 2 X weekly for 4 weeks, then monthly for 2 months then as deemed necessary by the QAPI committee. Responsible persons: Social Worker and others as designated.	

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F 323	Continued From page 14 and federal regulations will occur. . . ." Review of Resident #7's record occurred on all days of survey. Diagnoses included dementia. Information provided by the facility at the beginning of the survey, identified the resident as one who wanders into other resident rooms and/or outside of the facility. Review of Resident #7's quarterly Minimum Data Set (MDS), dated 06/07/15, identified severe cognitive impairment. Review of Resident #7's current progress notes identified the following: * 07/03/15, 9:22 a.m., "Late Entry: resident was noted to be outside in the wheelchair it is unclear how she got outside . . ." * 07/22/15, 4:27 p.m., "This afternoon resident was found by staff outside by herself. She told nurse that she was looking to go home . . ." * 08/07/15, 12:04 p.m., ". . . Resident had been outside this morning 2 times. It appears she got out by herself. We discuss [sic] having a wanderguard bracelet on her. Of all the times she has been out side she had gone to the end of the walk way 2 times and 2 times she was just sitting outside. Niece reported that resident has history of being outside and enjoyed a garden. It was discussed that we should give her the opportunity to be outside more with supervision. We will hold of [sic] putting on a wanderguard bracelet. Niece was in agreement with this." * 08/29/15, 4:30 p.m., "Late Entry: Activity staff found resident between the front doors this afternoon, she used the handycap [sic] button and got through the first door, staff asked her where she was going. Resident replied that she	F 323	TRANSFERS 1) A Mobilization Support Data Collection User-Defined Assessment was done on each shift to assess the mobility throughout the day for Resident #7. The care plan for Resident #7 was updated. 2) All residents requiring transfer assist have the potential to be affected. 3) Education regarding following care plans and the procedure to assess transfers provided to nursing and activity staff on September 09 and 24, 2015. 4) Random audits of observations of transfer and record review will be done 3-5 X weekly, then weekly X 1 month, then monthly X3, then as deemed necessary by the QAPI committee. Responsible persons: Rehab Coordinator and others as designated.	

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F 323	Continued From page 15 was trying to get to the second floor. . . ." Review of Resident #7's current care plan stated, ". . . Focus: the resident has a behavior symptom R/T [related to] dementia dx [diagnosis] E/B [evidenced by] wandering. Goal: Resident will have fewer episodes of wandering behavior weekly by review date. Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate locations as needed. BEHAVIOR #1 wandering into other resident's rooms: re-orient resident to surroundings." The current care plan failed to identify that the resident had exited the facility unattended and/or goals with specific interventions regarding the resident's elopements. During an interview on the afternoon of 09/02/15, an administrative nurse (#1) stated, "we discussed the resident going outside with the family and they did not want a wanderguard used." During an interview on the morning of 09/03/15, an administrative nurse (#3) stated, "[Resident #7] did not get off the porch." When asked if an elopement event report had been completed for Resident #7, the staff member (#3) stated, "no." The facility failed to develop an approach or interventions for staff to implement to provide for the safety of Resident #7 who exited the building unattended. TRANSFERS 2. Based on observation, record review, and staff	F 323		

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F 323	Continued From page 16	F 323		

interview, the facility failed to ensure the use of the appropriate devices during transfers for 1 of 5 sampled residents (Resident #7) observed during transfers. Failure to consistently use the appropriate transfer devices for the resident increases the risk for falls, pain, and injury to the resident.

Findings included:

Review of Resident #7's record occurred on all days of survey. Diagnoses included dementia. Review of a quarterly MDS, dated 06/07/15, identified extensive assist of one person for transfers.

Review of Resident #7's current care plan stated, ". . . Focus: the resident has an ADL [activity of daily living] self care performance deficit R/T HX [history] of rt [right] total hip E/B needs assist with cares . . . Interventions: TRANSFER: Resident requires one staff participation with pivot transfers to w/c [wheelchair] or toilet. To use stand aid in AM. . . ."

During the survey the following observations occurred for Resident #7:
*08/31/15 at 4:30 p.m. showed a certified nurse aide (CNA) (#7) used a mechanical stand lift to transfer the resident from her wheelchair onto the toilet and back to her wheelchair which conflicts with the resident's care plan.
*09/01/15 at 10:30 a.m. showed a CNA (#8) transfer the resident using a gait belt from her wheelchair onto the toilet, back to her wheelchair, and then onto her bed which conflicts with the resident's care plan.
*09/01/15 at 11:25 a.m. showed a CNA (#8)

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F 323	Continued From page 17 transfer the resident using a gait belt from her bed into her wheelchair which conflicts with the resident's care plan. During interviews on the afternoon of 09/01/15 regarding the method staff use to transfer Resident #7, a CNA (#11) stated, "it depends on how she stands" and a CNA (#10) stated, "I use the stand aid." During an interview on 09/01/15 at 11:10 am., an administrative nurse (#1) identified the stand aid as the "device without a motor" and "[Resident #7's name] uses that to transfer." Staff were observed to use a mechanical stand lift on 08/31/15. The facility staff failed to follow the plan of care for Resident #7's transfers and used a different device for transfers.	F 323		
F 327	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide fluids to maintain adequate hydration for 1 of 6 sampled residents (Resident #3) observed during cares. Failure to offer fluids frequently to residents who cannot access fluids independently placed residents at risk for dehydration, constipation, and/or urinary tract	F 327	1) Immediate individual instruction was given to staff regarding fluids offered during cares for Resident #3. 2) Residents who are unable to access fluids independently are at risk. 3) Education regarding hydration of	10/5/15

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F 327	Continued From page 18 infections (UTIs). Findings include: Review of the facility's policy titled "Hydration of Residents" occurred on 09/02/15. This policy, dated September 2012, stated, ". . . Fresh water will be available to the residents at bedside . . . Staff will be trained on the importance of hydration. . . ." Observation on 08/31/15 at 4:40 p.m. showed two certified nursing assistants (CNA) (#4 and #5) toileted Resident #3 in her bathroom and transported her to the facility lounge. The CNAs failed to offer the resident fluids during cares. Observation on 09/01/15 at 9:25 a.m. and 11:25 a.m. showed a CNA (#6) provided personal care to Resident #3 in her room and failed to offer the resident fluids during cares. Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia, constipation, and urinary tract infection (UTI). The quarterly Minimum Data Set (MDS), dated 06/20/15, identified severely impaired cognition, extensive assist of one for eating, and a UTI in the last 30 days. Resident #3's physician's orders identified antibiotics ordered for a UTI on 03/15/15 and 05/27/15. Progress notes indicated on 08/02/15 - ". . . has been requesting to toilet every 20-35 minutes while awake . . . push fluid and cranberry juice and monitor. . . ." 08/04/15 - ". . . UTI . . . Fluids encouraged between meals per assist. . .	F 327	resident was provided to staff on September 09, 2015 by Sara Goodman, LRD. Instruction given regarding responding to urinary infections to include the nurses' use of a "Custom Alert" in Point Click Care Dashboard. The alert will inform nursing and activity staff of the presence of urinary infections so as to encourage resident fluid intake. 4) Observational audits of cares provided by staff will be done 3-5 weekly X 2, weekly X 4 , then monthly X 2, then as deemed necessary by the QAPI committee. Responsible persons: Staff Development Coordinator and others as designated.	

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F 327	Continued From page 19 ." 08/17/15 - "Continues to request frequent trips to bathroom . . . Encourage fluids with assist . . . UTI focus removed from plan of care as treatment is complete. Staff will continue to monitor for symptoms. . . ." On 08/31/15 staff obtained a telephone order for a urine sample due to increased anxiety and urinary frequency. During an interview on 09/02/15 at 5:00 p.m., two supervisory staff members (#1 and #3) indicated staff should follow the standard of care and offer fluids during resident care.	F 327		