STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355122	A. BUILDING _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	212 3RD AVENUE WEST RICHARDTON, ND 58652

(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 02/03/14 and completed on 02/06/14, the sample included 2 residents for complete review, 5 residents for focused review, and 1 closed record for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000	F 157 #1 Resident #8 is no longer in the facility. Resident #2's nurse re-educated on timely notification of family for hospital admission or resident change in status. Face sheet reviewed to ensure appropriate family telephone numbers are available for staff to notify. Resident #13 is no longer in the facility. #2 All residents with a change in status have the potential to be affected. #3 Implementation of policy titled "Assessment of Resident and Notification of Physician and Responsible Party Regarding Resident Change in Condition". All nurses will be educated on notification of family for hospital admission or resident change in	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4-3-14

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the physician and/or family member for 1 of 1 sampled resident (Resident #2) and 1 of 1 discharged resident (Resident #8) transferred to the intensive care unit (ICU), and 1 supplemental resident experiencing an unresponsive episode (Resident #13). Failure to notify the physician and/or family member of the residents' medical condition limited the physician's and/or family member's ability to make informed decisions regarding medical care and contributed to Resident #8's admission to the ICU. Findings include: - Resident #8's closed medical record, reviewed on February 5-6, 2014, identified diagnoses including congestive heart failure, chronic obstructive pulmonary disease, and atrial fibrillation. A quarterly Minimum Data Set (MDS), dated 09/14/13, identified the resident with a Brief Interview for Mental Status score of 15, indicating the resident cognitively intact. Resident #8's Nurse's Notes identified the following: * 09/14/13 at 8:00 p.m.: "Resident spent shift resting in bed . . . Resident c/o [complained of] decreased appetite and upset stomach which he said he had been dealing with 'for about 10 days.' . . ."	F 157	F 157 continued status, & notification of physician with changes in resident status. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Assessment of Resident and Notification of Physician and Responsible Party Regarding Resident Change in Condition" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 157	Continued From page 2 * 09/15/13 at 6:10 a.m.: "Wanting to go to hospital. Says 'they will give me IV's [intravenous] to help.' Had emesis of lg [large] amt [amount] light green bile. Enc [encouraged] to eat et [and] try to get moving. Did agree to take Mylanta." The record lacked evidence facility staff informed the physician of Resident #8's request to be hospitalized and lacked any further assessment or vital signs for the next 18 hours. * 09/16/13 at 12:40 a.m.: "Resident had small bright yellow/lime green colored emesis at this time. . . . Resident was cool & [and] clammy & also pale. Productive cough noted of yellow/green sputum. Resident stated, 'I want to go to the hospital, someone has to figure out what's wrong [with] me.' Resident reassured that appropriate actions would be taken in the AM [morning] when clinic/hospital was open. Resident acknowledged waiting til [sic] morning. . . ." * 09/16/13 at 7:10 a.m.: "Res [resident] c/o still [not] feeling well & c/o [not] being able to keep even H2O [water] down. . . ." * 09/16/13 at 8:40 a.m.: "Will cont [continue] to monitor. Res c/o nausea and refusing to eat. Stated, '. . . I still think I need to see the Dr. [doctor].' Encouraged res to try & eat something to help [decrease] nausea. Refused at this time." The record lacked evidence facility staff informed the physician of Resident #8's request to be hospitalized until 09/16/13 at 10:15 a.m. when the record stated, "Message left for clinic to call back." This message to the clinic occurred approximately 28 hours after the resident initially requested to be hospitalized. The record identified a nurse practitioner saw the resident on 09/16/13 at 2:00 p.m. and ordered medication for nausea but lacked any further assessment or vital	F 157		

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F 157	Continued From page 3 signs recorded for another 18 hours. On 09/17/13 at 8:00 a.m. the record stated, "VS [vital signs] BP [blood pressure] 88/50, P [pulse] 61 . . . Resident stated that 'I want to go to the hospital. I think they'll be able to figure out what's wrong [with] me.' . . ." At 12 noon, the facility transferred Resident #8 to a nearby hospital where he was admitted to the ICU for treatment of digoxin (medication used for heart failure) toxicity and sepsis (infection in the bloodstream). The record showed Resident #8 returned to the facility on 09/22/13. The facility's failure to promptly notify the physician of Resident #8's repeated requests to "go to the hospital" contributed to delayed diagnosis of the digoxin toxicity and sepsis which resulted in the resident's admission to the ICU. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included cardiomyopathy, congestive heart failure, chronic stage IV kidney disease, acute kidney failure, and edema. The significant quarterly MDS, dated 11/29/13, identified Resident #2 was cognitively intact and required extensive assistance for all Activities of Daily Living (ADLs) except eating. Resident #2's Nurse's Notes identified the following: * 08/23/13 2:00 a.m., "Up to BR [bathroom]. Voided dark yellow 400 cc [cubic centimeters] . . . Requested 'one Tylenol' . . . Resident raised voice when talking about so much pain. Has 2+ edema to legs [and] 3+ pitting to feet." * 08/23/13 at 2:00 p.m., "N.O. [new order] per [Nurse Practitioner]: Apply Pram dressing to RT	F 157		

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F 157	Continued From page 4 [right] shin along [with] Bactroban [topical antibiotic] and apply ACE wraps [compression wraps] to BLE [bilateral lower extremities] BID [twice daily] [and] PRN [as needed]." * 08/26/13 at 10:25 a.m., "Received call from [Nurse Practitioner] [with] the following orders: [Increase] Lasix to 80 mg [milligrams] PO [orally] BID . . . Will continue to monitor." * 08/27/13 at 3:30 p.m., "Call received from [Physician] stating resident being sent to [ER] in [a town near Richardton] from the clinic [with] request for transfer [with] our van. . . ." * 08/27/13 at 7:15 p.m., "Resident's family has been notified about Resident's admit to ICU. Her [Son] was called [and] informed. He said he would inform rest of family. [Hospital] was called at 7:00 p.m. to confirm admitance [sic]." * 08/27/13 at 10:10 p.m., "Resident's family has asked to be notified immediately if any changes occur, resident gets transferred, hospitalized [and]/or has clinic appoint [appointment]. Family upset that they were not told until hrs [hours] after transfer . . ." During an interview on the morning of 02/06/14, an administrative nursing staff member (#3) confirmed the facility staff failed to notify family members of Resident #2's hospital admission when they received notification from the clinic. - Review of State Agency (SA) files prior to the facility survey showed the facility reported an incident involving Resident #13 on 10/23/13. Review of the facility's investigation of the incident on 10/23/13 and Resident #13's medical record occurred on February 05-06, 2014. The facility admitted the resident in February 2013. The resident expired in the facility in November 2013.	F 157		

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F 157	Continued From page 5 Diagnoses included insulin dependent diabetes mellitus. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) confirmed the facility staff failed to contact Resident #13's physician regarding the unresponsive incident on 10/23/13. On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedures for physician and family notification. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy manual "disappeared" and they had no policy/procedure for physician or family notification.	F 157	F 164 #1 Resident #6's CNA instructed to complete cares for this resident while maintaining the resident's privacy. Resident #11 moved to a room that shares a bathroom with a dependent resident. Resident #2 and 10 are female residents that share the bathroom.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	#2 All residents have the potential to be affected by lack of privacy while providing cares. All male and female residents that toilet independently and share a bathroom have the potential to be affected. To ensure privacy, male and female residents that toilet independently will not share a bathroom. #3 A new policy titled "Dignity & Privacy" will be implemented. All staff will be educated on the new policy. All nurses and CNA's	

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F 164	Continued From page 6 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to ensure personal privacy during cares for 1 of 2 sampled residents (Resident #6) observed receiving incontinence cares and 1 sampled (Resident #2) and 2 supplemental residents (Resident #10 and #11) who expressed concerns regarding their shared bathroom. Failure to ensure privacy during cares is an infringement on the residents' rights and may lead to a loss of dignity. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for ensuring privacy during cares. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared approximately six months ago" and they had no policy/procedure ensuring privacy during cares. - Observation during the initial tour, on 02/03/14 at 8:20 a.m., showed four residents shared the	F 164	F 164 continued educated on ensuring privacy while providing personal cares to residents. All staff educated on importance of maintaining and assuring privacy while residents use shared bathroom and that bathrooms will not be shared by male and female residents that toilet independently. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Dignity & Privacy" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 164	Continued From page 7 same bathroom (two men, Resident #6 and #11, and two women, Resident #2 and #10). - Review of Resident #2's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 11/29/13, identified Resident #2 was cognitively intact. During an interview on 02/03/14 at 1:30 p.m., when asked if she had any concerns sharing a bathroom with men, Resident #2 stated, "Yeah, you open the door and there is someone sitting in there, a man. They're sitting in there with their pants off. It's not fun. It's unpleasant. It works both ways. They've walked in on me. There's no privacy." - Review of Resident #11's medical record occurred on February 5-6, 2014. The quarterly MDS, dated 12/27/13, identified Resident #11 had moderately impaired cognitive skills. During an interview on 02/04/14 at 8:57 a. m., when asked if he had any concerns sharing a bathroom with women, Resident #11 stated, "It's kinda tricky. You don't know if anybody's in there. If I don't hear em, I don't think anyone is in there." He confirmed he has walked in on them, and they have likewise walked in on him. He reported, "It's uncomfortable, but it's bound to happen." - Review of Resident #10's medical record occurred on February 5-6, 2014. The quarterly MDS, identified Resident #10 had moderately impaired cognitive skills. During an interview on 02/04/14 at 9:05 a.m., when asked if she had any concerns sharing a bathroom with men, Resident #10 stated, "I don't	F 164		

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F 164	Continued From page 8 like a man in here. He walks in on me at times. It's embarrassing when you're sitting there and he walks in. It's embarrassing to see him too. I suppose he don't feel good about it either. Sometimes he locks it so we can't get in. I walk over to use [a resident residing across the hall]'s bathroom." - Review of Resident #6's medical record occurred on February 5-6, 2014. The quarterly MDS, dated 01/07/14, identified the resident had severely impaired cognition and required extensive to total assistance for all ADLs. Observation on 02/05/13 at 1:50 p.m. showed two certified nursing assistants (CNAs) (#6 and #14) assisting Resident #6 into bed. As the CNA's gloved and checked Resident #6's brief, Resident #11 exited the bathroom and walked across the room to the sink located approximately three feet from Resident #6's bed. Resident #11 then washed/dried his hands and preceded to watch as the CNAs provided Resident #6's incontinence cares. The CNAs (#6 and #14) failed to ensure Resident #11 had exited the room prior to assisting Resident #6 with personal cares. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) stated the staff and residents are currently "trying to lock the bathroom doors." They confirmed they expect staff to ensure privacy during cares; "not expose a resident in front of another resident."	F 164	F 226 #1 Resident #13 is no longer in the facility. #2 All residents have the potential to be affected by failure to follow reporting requirements for allegations of abuse. #3 Implementation of policy titled "Abuse & Neglect". All staff educated on "Abuse & Neglect" policy. All staff educated on abuse and neglect reporting requirements, including reporting the incident to the Health Department within 24 hours. Administration re-educated on the seven components of abuse, including screening, training, prevention, identification, investigation, & reporting.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226	#4 On or before April 7, 2014.	

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F 226	Continued From page 9 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of State Agency (SA) files, review of facility policy and procedure, and staff interview, the facility failed to develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and misappropriation of resident property and failed to report and fully investigate 1 of 1 allegation of resident abuse (Resident #13) to the SA within 24 hours. Failure to develop policies and procedures limited the facility staff's ability to implement the seven components of screening, training, prevention, identification, investigation, and reporting. This failure may have contributed to the delay in reporting and the limited investigation of the allegation regarding Resident #13. Findings include: The Centers for Medicare and Medicaid Services (CMS) and SA have defined the reporting requirement of allegations as "immediately" "not exceeding 24 hours." - Review of the facility policy and procedure, Abuse Prevention Program, occurred on February 05-06, 2014. This document, dated 01/16/14, stated "Policy Interpretation and Implementation . . . 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse	F 226	F 226 continued #5 Director of Nursing or designee will monitor compliance with policy titled "Abuse & Neglect" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 226	Continued From page 10 prevention program provides policies and procedures that govern, as a minimum: a. Protocols for conducting employment background checks; b. Mandated staff training/orientation programs . . .; c. Identification of occurrences and patterns of potential mistreatment/abuse; d. The protection of residents during abuse investigations; e. The development of investigative protocols governing resident abuse . . .; f. Timely and thorough investigations of all reports and allegations of abuse; g. The reporting and filing of accurate documents relative to incidents of abuse; h. An ongoing review and analysis of abuse incidents; and i. The implementation of changes to prevent future occurrences of abuse." On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policies/procedures for abuse and neglect. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated the facility's policy manual "disappeared" approximately six months ago. The staff reported the facility purchased policy/procedures for abuse and neglect from a vendor. The facility lacked abuse and neglect policies and procedures specific to the facility and its residents. - Review of the SA files prior to the survey identified the facility reported an incident to the SA on 10/25/13 which occurred on 10/23/13. The incident was described as "Nurse was inappropriate with [a] resident." During interview, on 02/05/14 at 1:35 p.m., an administrative	F 226		

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F 226	Continued From page 11 nursing staff member (#2) reported the incident involved Resident #13. Review of the facility's investigation file revealed the incident occurred at approximately "8:15 to 8:30 a.m." on 10/23/13. The initial report to the facility administration is undated. The facility investigated the incident on 10/24/13 and reported the incident and results of the investigation to the SA on 10/25/13. It is unknown if the initial report was made on 10/23/13 or 10/24/13. Failure to develop and implement policies and procedures clearly outlining the requirements for facility staff to immediately report incidents of suspected abuse or neglect to the administrator; and, requirements for the facility to report allegations of suspected abuse or neglect to the SA within 24 hours, placed Resident #13 and all facility residents at risk of abuse and neglect.	F 226	F 241 #1 Resident #6 is offered small bites while being assisted with eating, is allowed to swallow previous bite before being offered another bite, food on face is removed with a napkin, cueing is provided while eating, and pureed foods are not mixed together. Resident #6's family member (including members of the Richardton Abby Religious Orders) that assists with feeding has been educated on offering small bites, allowing resident to swallow previous bite before offering another bite, removing food from face with a napkin only, cueing resident while eating, and not mixing pureed foods together. Resident #1 provided cueing and close supervision while eating so as to assist resident in maintaining dignity. Resident #1 dressed in personal clothing. #2 Each resident that requires feeding assistance has the potential	
F 241 SS=D	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, record review, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity of 2 of 3 sampled residents (Resident #1 and #6) dependent on staff for assistance with dining and dressing. Failure to ensure dignity in the dining	F 241		

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	355122	A. BUILDING _____ B. WING _____	02/06/2014

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F 241	Continued From page 12 room and to ensure residents are dressed appropriately does not recognize the individuality of each resident or enhance their quality of life. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for treating residents in a dignified manner. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared approximately six months ago" and they had no policy/procedure fpr treating residents in a dignified manner. - Resident #6's medical record, reviewed on February 5-6, 2014, identified diagnoses of Alzheimer's dementia, lack of coordination, and weakness. The quarterly Minimum Data Set (MDS), dated 01/07/14, identified the resident had severely impaired cognition and required extensive to total assistance for all ADLs. The current care plan stated, ". . . Problem: Resident is limited in ability to maintain grooming/personal hygiene . . . Approaches: . . . Assist as needed with hand over hand cueing . . ." Dining room observations showed the following: * 02/03/14 at 12:40 p.m., a visitor fed Resident #6 heaping teaspoon after heaping teaspoon of pureed food and/or swallow after swallow of thin liquids from a glass prior to ensuring the resident had swallowed the previous bite. Resident #6 drooled onto his chin and/or clothing protector seven times. Using the spoon, the visitor scraped the saliva/food from the resident's face, mixed it	F 241	F 241 continued to be affected by this deficient practice. There are no other residents in the facility that do not have personal clothing. #3 Implementation of policy titled "Dignity & Privacy". All nursing staff educated on policy. Implementation of policy titled "Nutrition & Hydration". All staff educated on policy. All nursing staff educated on providing cueing and close supervision to residents while eating in an effort to assist resident in maintaining dignity. All nursing staff educated on dressing resident in personal clothing unless resident refuses or there are other extenuating circumstances. #4 On or before April 7, 2014.	

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F 241	Continued From page 13 into the food remaining on his plate, and continued to feed him. * 02/04/14 at 8:12 a.m., a Certified Nursing Assistant (CNA) (#10) fed Resident #6 heaping teaspoon after heaping teaspoon of pureed food without ensuring the resident had swallowed. Resident #6 drooled onto his chin and/or clothing protector two times. Using the spoon, the CNA (#10) scraped the saliva/food from the resident's face, and continued to feed him. * 02/04/14 at 12:28 p.m. and 02/05/14 at 12:28 p.m., the same visitor fed Resident #6 heaping teaspoon after heaping teaspoon of pureed food without ensuring the resident had swallowed. Resident #6 drooled onto his chin four times. Using the spoon, the visitor scraped the saliva/food from the resident's face, mixed it into the food remaining on his plate, and continued to feed him. * 02/05/14 at 8:10 a.m., a CNA (#11) assisted Resident #6 with his meal. The CNA held a bowl in front of the resident, and asked him if he wanted his "eggs and toast." The CNA (#11) fed Resident #6 mixed pureed food items (eggs and toast) from the bowl. During interview, on 02/05/14 at approximately 11:00 a.m., a dietary management staff member (#) reported she was uncertain if Resident #6's pureed eggs and toast are routinely mixed. On 02/06/14 at 8:30 a.m. this staff member (#) reported facility staff should not combine Resident #6's pureed eggs and toast. - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and dysphagia. The quarterly MDS, dated 01/14/14, identified the resident had moderately impaired	F 241	F 241 continued #5 Director of Nursing or designee will monitor compliance with policies titled "Dignity & Privacy" and "Nutrition & Hydration" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 241	Continued From page 14 cognition, required limited assistance for eating, and on a mechanically altered diet. The "Speech Therapy Plan of Treatment for Dysphagia," dated 01/31/14, identified, ". . . Supervision for all Meals/Snacks. . . ." Dining room observations showed the following: * On 02/04/14 at 8:08 a.m., Resident #1 fed himself breakfast. He dropped meat from his fork onto his clothing protector, picked the meat up with his fingers, and ate it. The unidentified CNA, sitting across the table from Resident #1, failed to provide cuing and/or remove the food item from his protector. * On 02/05/14 at 8:00 a.m., Resident #1 fed himself breakfast. He dropped eggs from his fork onto the table, scraped the eggs up with his fork, and ate them. The unidentified CNA, sitting across the table from Resident #1, failed to provide cuing and/or remove the eggs from the table. * On 02/05/14 at 12:28 p.m., Resident #1 fed himself lunch. He held a bowl up to his mouth and ate from the bowl (without using silverware). He dropped food items onto his clothing protector three times, picked the items up with his fingers, and ate them. The unidentified CNA, sitting across the table from Resident #1, failed to provide cuing and/or remove the food items from his protector. Observations on all days of survey showed Resident #1 dressed in a hospital gown and brief; regardless of the time of day or location. The current care plan utilized by direct care staff failed to address Resident #1's lack of personal clothing and/or preference (if any) to wear	F 241		

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F 241	Continued From page 15 hospital gowns. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) reported the visitor had been allowed to feed Resident #6 without receiving any training. The staff members (#2 and #4) also reported requesting and failing to receive any clothing from Resident #1's family. (Resident #1 was admitted to the facility in August of 2012; 16 months prior to the interview.) They confirmed 1) dietary and nursing staff should not serve pureed food items that have been mixed together, 2) staff are taught to use napkins to wipe saliva/food from residents' faces, 3) staff should cue/discourage residents from eating directly out of a bowl and/or off of a clothing protector or table, and 4) staff should dress residents in their personal clothing unless otherwise care planned.	F 241	F 246 #1 Resident #3 foot support placed under resident's feet. OT consultation ordered for wheelchair positioning. OT recommendations implemented. OT consult ordered for Resident #2 for wheelchair positioning. Resident offered alternative dining room placement, but declined to be moved. Resident #12 is no longer in facility.	
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, resident interview, and staff interview, the facility failed to provide reasonable accommodations of individual needs and preferences for 2 of 7 sampled residents (Resident #2 and #3) and 1	F 246	#2 All residents have the potential to be affected with inappropriate positioning and table height. #3 Implementation of policy titled "Wheelchair Positioning & Transporting". All nursing staff educated on the policy. Staff educated on proper foot support while in wheelchair and foot support	

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F 246	Continued From page 16 supplemental resident (Resident #12) seated in wheelchairs at dining room tables. Failure to provide appropriate table heights (Resident #2 and #12); appropriate height arm rests and trunk support (Resident #2 and #12); and, failure to provide foot support in the wheelchair (Resident #3) has potential to cause these residents to decline in their abilities to remain independent and may contribute to pressure sores. (Refer to F314) Findings include: - Review of Resident #3's medical record occurred on February 03-06, 2014. The facility admitted the resident in May 2009. The significant change Minimum Data Set (MDS), dated 12/29/13, identified Resident #3 required total assistance of two or more persons for bed mobility, impaired range of motion in both lower extremities, and one Stage II pressure ulcer. Resident #3's Therapy Progress Reports, stated the following: *10/30/13, Physical Therapy (PT) - "Consult orders received re: LE [lower extremity] tone . . . Tone has increased significantly since prior to hospital stay in all 4 extremities . . ." *01/24/14, ". . . OT [Occupational Therapy] did recommend placing built up foot squares for foot pedals if res.'s LE [lower extremities] are not raised as in @ [at] meal times. Nursing agreed. . . ." Resident #3's current care plan, dated 12/18/13, stated "Problem, ADL [Activities of Daily Living] Functional/Rehabilitation Potential. Mobility impaired related to cognitive impairments and poor balance. . . . Approach . . . PT [Physical	F 246	F 246 continued provided. Staff educated on proper table height while eating, maintaining appropriate armrest height and trunk support while in wheelchair. Nursing staff educated on the importance of following OT recommendations for positioning. #4 On or before April 7, 2014. #5 Director of Nursing or designee will monitor compliance with policy titled "Wheelchair Positioning & Transporting" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 246	Continued From page 17 Therapy]/OT evaluations for transfering [sic] safety as needed and with any significant change. Follow PT/OT recommendations. . . ." Observation on February 03-06, 2014, showed facility staff assisted Resident #3 from his bed to the geriatric wheelchair and positioned him with his knees flexed. The resident's feet were approximately three inches from the wheelchair foot pedals. This placed Resident #3's feet in a position with the toes pointed down potentially shortening the heel cords and causing tightness at the ankle joints. Sitting with the feet unsupported may also increase the resident's sliding forward in the chair, resulting in shear force on the buttocks and potential recurrent pressure ulcer issues on the resident's buttocks. (Refer to F314.) During these observations, facility staff failed to attempt or offer any type of foot support for Resident #3. During interview, on 02/05/14 at 4:15 p.m., two administrative staff members (#2) and (#4) agreed facility staff should have provided foot support for Resident #3. - Observation in the facility dining room during the noon meal on 02/03/14, the breakfast and noon meals on 02/04/14 and 02/05/14, and breakfast meal on 02/06/14, showed Resident #12 seated in a wheelchair with bolsters on each wheelchair armrest at the dining room table. The dining room table was at the resident's mid-chest level; the wheelchair arm rests were at the table height, and did not allow the resident to be positioned close to the table. Resident #12 was seated at arm's length and at chest height from her meal items. She accessed her meal items independently and ate approximately half of her	F 246		

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F 246	Continued From page 18 meals. Resident #12 placed her elbows on the wheelchair arm rests which placed her arms away from her body at approximately 60 degrees. The heights of the arm rests and width of the seat did not allow the resident to rest her forearms on the arm rests and keep her arms at her sides. During interview on 02/06/14 at 8:00 a.m., Resident #12 was asked if her arms became tired or sore after being positioned away from her body on the wheelchair armrests and she responded "Get sore." During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) reported the facility did not offer Resident #12 alternative wheelchair or table positioning. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 11/29/13, identified Resident #2 as cognitively intact, and required set-up assist for eating and extensive assistance for all other Activities of Daily Living (ADLs). The current care plan stated, ". . . Problem: Resident requires a therapeutic diet . . . Approaches: Eats meals in dining room with set-up assist." The dietary progress notes, dated 01/23/14, identified ". . . Resident has significant wt [weight] loss in 1 month [and] 6 months related to Lasix [a diuretic medication]. . . . Resident did request small portions . . . Avg [average] oral intake . . . B [breakfast] 83%, D [dinner] 67%, S [supper] 74% . . ."	F 246		

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F 246	Continued From page 19 Observations on 02/03/14 at 12:40 a.m., 02/04/14 at 8:02 a.m. and 12:28 p.m., 02/05/14 at 12:28 p.m., and 02/06/14 at 8:00 a.m., showed Resident #2 sitting in a low wheelchair at the dining room table, leaning to the left at an approproximate 70 degree angle. The height of the arm rest and width of the seat did not allow the resident to rest her left forearm on the arm rest. Resident #2 fed herself following tray set-up. She leaned forward to access the items on her plate, with her right forearm on the table and her right shoulder elevated. Observation showed the table at the level of her upper chest. During the noon meal on 02/03/14, Resident #2 attempted to open a spice packet using her right hand and teeth. After several tries, she dropped the packet onto her potatoes. During an interview on the morning of 02/06/14, an administrative nursing staff member (#3) confirmed the facility staff failed to offer Resident #2 alternative wheelchair/table positioning.	F 246	F 248 #1 Activity staff will interview resident and/or residents representative for residents #1, 3, 4, and 6 regarding current and past activity preferences and will develop a care plan based on their individual interests and needs. #2 Activity staff will interview all residents and/or resident's representative regarding current and past activity preferences and will develop a care plan based on their individual interests and needs.	
F 248 SS=E	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, family interview, and staff interview, the facility failed to provide ongoing programs of meaningful activities designed to meet the interests and the physical,	F 248	#3 All staff will be educated on the importance of providing activities that meet individualized preferences and needs. A policy titled "Activities" will be implemented and all staff will be educated on the new policy. #4 On or before April 7, 2014	

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F 248	Continued From page 20 mental, and psychosocial well-being of 4 of 7 sampled residents (Resident #1, #3, #4, and #6). Failure to provide activities that meet the resident's individual needs and interests, including one-to-one and bedside activities, limited the residents' abilities to reach their highest practicable levels of physical, mental, and psychosocial well-being and may result in lowered self-esteem and feelings of isolation. Findings include: - Review of Resident #3's medical record occurred on February 03-06, 2014. The facility admitted the resident in May 2009. The resident's significant change Minimum Data Set (MDS), dated 12/29/13, identified he sometimes understood others and made himself understood by others, demonstrated inattention, demonstrated mild depression, demonstrated physical and verbal behaviors four to six days during the seven day assessment period, showed worsening behaviors, and required total assistance of one person for locomotion off his unit. Resident #3's Activities Progress Notes, dated 04/02/13, 06/28/13, and 09/30/13 identified the resident enjoyed ". . . news, reminisce, game groups, socials, and entertainment . . ." and on 06/28/13 stated ". . . Resident spends his leisure time in the front living room watching TV, looking outside and napping. . . ." During interview, on 02/03/14 at 1:40 p.m., Resident #3's family member (#1) reported the resident "likes to visit." Resident #3's Activities Care Area Assessment	F 248	F 248 continued #5 Activity Director or designee will monitor compliance with policy titled "Activities" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 248	Continued From page 21 (CAA), dated 01/10/14, failed to identify Resident #3's preferences identified in the Progress Notes and identified by the family member. Resident #3's current care plan, dated 12/18/13, regarding Activities, failed to include Approaches or Interventions identified in the Progress Notes and identified by the family member (Refer to F280). Review of Resident #3's Activities Attendance records for the period October 2013 to January 2014 identified the following: *October 2013 - Visitor: 5 days; TV: 15 days; Snack: 5 days; Socialize: 11 days; Activity (non-specific): 1 day. *November 2013 - TV: 7 days; Snack: 6 days; Socialize: 5 days. *December 2013 - TV: 8 days; Snack: 3 days; Socialize: 1 day. *January 2014 - One-to-One: 9 times in 8 days; Ice cream social: 1 time; Reading/Devotions: 1 time; Music entertainment: 1 time; Film/Movie: 1 time; Education/Intellectual: 1 time; Parties: 3 times; Current Events: 2 times; Social Hour, TV (General and Independent Activity), Coffee, Music - daily, Monday through Friday during the	F 248		

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F 248	Continued From page 22 month. Resident #3's Activities Attendance records for this period showed he did not have any activities participation on 67 of 123 days (54%). Observation identified the following: *02/03/14, 12:55 p.m. to 2:20 p.m. - Resident #3 seated in a geriatric wheelchair in the nurse's station lounge visiting with family members. 2:20 p.m. to 4:45 p.m. - Resident #3 remained seated in a geriatric wheelchair in the nurse's station lounge with the television on. Facility staff members provided the resident a candy bar at 2:45 p.m., repositioned his wheelchair to look out the window at 2:55 p.m., and reclined his wheelchair at 3:40 p.m. *02/04/14, 8:40 a.m. to 9:25 a.m. - Resident #3 seated in a geriatric wheelchair in the nurse's station lounge, the TV on. 9:25 a.m. to 11:00 a.m. - Facility staff assisted Resident #3 to bed. 1:05 p.m. to 2:40 p.m. - Resident #3 seated in a geriatric wheelchair in the nurse's station lounge and TV on. 2:40 p.m. to 4:45 p.m. - Facility staff assisted Resident #3 to bed. *02/05/14, 1:10 p.m. to 2:40 p.m. - Resident #3 seated in a geriatric wheelchair in the nurse's station lounge, the TV on. During random observations and the observations previously identified facility staff failed to offer activities, including one-to-one and scheduled group activities. Resident #3 did not attend any scheduled activities during these observations. - Resident #1's medical record, reviewed on all days of survey. The quarterly MDS, dated	F 248		

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(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 248	Continued From page 23 01/14/14, identified the resident had moderately impaired cognition and required extensive-to-total assistance for all Activities of Daily Living (ADLs), except eating. The admission MDS, dated 04/22/13, showed the resident enjoyed listening to the news and/or music, participating in religious services, and being outdoors. The initial activity assessment, dated 09/04/12, identified Resident #1 as interested in "listening to country music, Fox news, and the History channel." Past interests included "bowling, fishing, and playing checkers and dominos." The current care plan stated, ". . . Problem: Resident unable to attend activities regularly d/t [due to] disease process . . . Approaches: Offer to bring materials such as; newspaper, magazines, books or DVD's, Talk about family, past job as a Professor and family vacations, Will encourage resident to get out of bed and sit in wheelchair, go to dining room for activity, wheel around facility or go outside, Will offer to turn TV [television] on to appropriate programming for resident . . ." The Activity Progress Note, dated 01/14/14, identified, ". . . Resident spends most of his time in bed. He is up in his chair for all three meals. Resident is [sic] a one-to-one program and sensory [sic] d/t his yelling out which is disruptive to other residents. Writer visits Resident 2 x [times] week for sensory and one-to-one programming. Resident is in dining room for meals so he can have contact with his peers. . . ." Review of activity participation logs for November 1, 2013 - February 6, 2014 showed the following: * November 1-30, 2013: Bingo, Coloring, and Salon: 1 day	F 248		

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	355122	A. BUILDING _____ B. WING _____	02/06/2014

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F 248	Continued From page 24 Aromatherapy and Reading/Devotions: 2 days Special/Holiday/Parties/Meals: 3 days Friendly Conversation and Sensory Stimulation: 4 days Coffee/Snack: 11 days Family/Friend Visit: 12 days Music/CDs, Social Hour, TV/Day Area/Activity, and TV/Radio/Room/Sun Area: 20 days The log showed no activity participation on 10 of 30 days. * December 1-31, 2013: Meal with Family and School Visit: 1 day Special/Holiday/Parties/Meals: 2 days Friendly Conversation and Sensory Stimulation: 5 days Family/Friend Visits: 7 days Music/Entertainment: 12 days Music/CDs, Social Hour, TV/Day Area/Activity and TV/Radio/Room/Sun Area: 22 days The log showed no activity participation on 9 of 31 days. * January 1-31, 2013: Current Events, Educational/Intellectual, Film/Movie, and Reading/Devotions: 1 day Music/Entertainment: 2 days Sensory Stimulation: 4 days Friendly Conversation and Special/Holiday/Parties/Meals: 6 days Family/Friend Visits: 7 days Music/CDs, Social Hour, TV/Day Area/Activity, and TV/Radio/Room/Sun Area: 23 days The log showed no activity participation on 8 of 31 days. * February 1-6, 2014: Friendly Conversation and Reading/Devotions: 1 day	F 248		

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F 248	Continued From page 25 Social Hour and TV/Radio/Room/Sun Area: 2 days The log showed no activity participation on 4 of 6 days. During an interview on 02/05/14 at 12:15 p.m., when asked for an explanation of the facility's activity participation logs, an activity staff member (#1) gave the following descriptions: * Coffee/Snack: "Snack pass, sometimes we have coffee in her [sic] room." * Current Events: "Newspaper, reading 30 minutes in the dining room." * Education/Intellectual: "Lady who comes in, was a teacher." * Family/Friend Visit: "Any company." * Film/Movie: "A DVD." * Friendly Conversation: "One-on-ones, I will go into their room, spend 15-20 minutes or more." * Music: "In room . . . during their meals I'll put a CD in." * Music Entertainment: "People that come in." * Reading/Devotional: "Magazines, books, in room one-on-one" * Social Hour: "Anytime they're together, lunch, ice cream, together at a table." * Special/Holiday/Parties/Meals: "Ice cream with sing-a-long, something special." * TV/Day Area/Activity and TV/Radio/Room/Sun Area: "In room or lounge area." * Outdoor walking: "They go outdoors." Observations showed the following: * 02/03/14 at 11:50 a.m., 02/04/14 at 11:50 a.m., and 02/05/14 at 10:50 a.m., 1:00 p.m., and 2:05 p.m., Resident #1 lying in bed, with eyes closed. * 02/03/14 at 12:34 p.m. and 1:04 p.m., Resident #1 reclining in his Broda chair [reclining chair] in his room, with eyes closed and tv on.	F 248		

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F 248	Continued From page 26 * 02/03/14 at 1:50 p.m. and 3:25 p.m., 02/04/14 at 8:40 a.m. and 9:15 a.m., Resident #1 reclining in his Broda chair in his room, with tv on. * 02/04/14 at 1:50 p.m., Resident #1 lying in bed, with tv on. Observations during survey showed staff failed to provide meaningful and individualized activities specific to Resident #1's physical and/or cognitive abilities. Other than meals, Resident #1 laid in his bed in silence with his eyes closed or in his bed/Broda chair with the television on in the background. - Resident #6's medical record, reviewed on February 5-6, 2014. The quarterly MDS, dated 01/07/14, identified the resident had severely impaired cognition and required extensive-to-total assistance for all ADLs. The annual MDS, dated 07/07/13, identified Resident #6 had participated in religious activities. The initial activity assessment, dated October 2012, identified Resident #6 as interested in "exercising, listening to gospel, old time, piano, or polka music, and attending parties." Past interested included "going to mass and rosary, listening to the birds, classical music, or public radio, participating in discussions, playing bingo and dice, and reading the bible and newspapers." The assessment further identified, "Resident likes to wheel up/down hallway. Resident likes volunteer dog. Volunteer reads from 'Partners in Prayer' out loud to resident. [Priest] visits resident 1-2 x day . . . Resident received communion in his room when he doesn't attend mass." The current care plan stated, ". . . Problem: Due to declining cognitive abilities resident no longer	F 248		

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F 248	Continued From page 27 attending most activities . . . Approaches: Adjust the intensity, frequency, and/or duration of activities to accommodate the resident's energy level and tolerance, Assess resident for health issues that could result in reduced activity participation . . . Encourage resident to become involved with activities, Adapt to resident's current abilities, Offer opportunities to interact with others through activities such as shared dining, afternoon refreshments, monthly birthday parties, Vary the physical environment when possible. (Place where he can move or leave when he chooses.)" The Activity Progress Note, dated 01/07/14, identified, "Resident will attend social activities and entertainment activities. Resident prefers to stay in bed most of the day napping d/t resident diagnosis of Alzheimer's and dementia. . . . [Priest] visits Resident 1-2 x daily . . ." Review of activity participation logs for November 1, 2013 - February 6, 2014 showed the following: * November 1-30, 2013: Special/Holiday/Parties/Meals: 4 days Reading/Devotions: 7 days Coffee/Snack: 11 days Family/Friend Visit, Music/CDs, Pastoral Visit/Communion, Social Hour, TV/Day Area/Activity, TV/Radio/Room/Sun Area, and Walks/Propelling W/C [Wheelchair]: 20 days The log showed no activity participation on 10 of 30 days. * December 1-31, 2013: School Visits: 1 day Special/Holiday/Parties/Meals: 2 days Reading/Devotions: 8 days Music/Entertainment and Pet Birds: 12 days Family/Friend Visit, Pastoral	F 248		

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F 248	Continued From page 28 Visit/Communion, Social Hour, TV/Day Area/Activity TV/Radio/Room/Sun Area, and Walks/Propelling W/C: 22 days The log showed no activity participation on 9 of 31 days. * January 1-31, 2013: Film/Movie and Music/Entertainment: 1 day Educational/Intellectual: 2 days Special/Holiday/Parties/Meals: 6 days Reading/Devotions: 9 days Meal with Family and TV/Radio/Room/Sun Area: 12 days Birds, Family/Friend Visit, Music, Pastoral Visit/Communion, Social Hour, TV/Day Area/Activity, and Walks/Propelling W/C: 22 days The log showed no activity participation on 8 of 31 days. * February 1-6, 2014: Friendly Conversation and Reading/Devotions: 1 day Family/Friend Visit, Pastoral Visit/Communion, Social Hour, and TV/Day Area/Activity: 2 days The log showed no activity participation on 4 of 6 days. During the interview on 02/05/14 at 12:15 p.m., when asked for additional information regarding Pet Birds, the activity staff member (#1) also stated, "They [residents] talk to them." Observations showed the following: * 02/05/14 at 10:50 a.m., 1:50 p.m., and 2:05 p.m., Resident #1 lying in bed. * On all days of survey, a priest visited with Resident #1 following his noon meal. Observations during survey showed staff failed to	F 248		

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F 248	Continued From page 29 provide meaningful and individualized activities specific to Resident #6's physical and/or cognitive abilities. Other than the priest visiting, Resident #6 laid in his bed in silence. - During the initial tour of the facility, on the morning of 02/03/14, facility staff identified Resident #4 is out of bed for only 45 minutes twice a day due to recent skin flap surgery to her sacrum. Resident #4's medical record, reviewed on all days of survey, identified an admission Minimum Data Set (MDS), dated 01/16/14, which indicated the resident was cognitively intact and had a depression severity score of 5 (mild depression). An interview with Resident #4 occurred on 02/04/14 at 10:02 a.m. When asked about the activities offered, the resident stated staff have not provided any in-room activities for her other than reading magazines and watching TV. The resident stated, "I'm not much for TV." Review of Resident #4's Activity Profile Assessment indicated the resident was interested in listening to music, church, cooking, baking, knitting, crocheting, embroidery, newspapers, magazines, and news and variety programs on TV. Review of the resident's current care plan, dated 01/09/14, failed to identify an activity plan for Resident #4. Review of Resident #4's activity participation logs identified the following: *January 9 - February 5, 2014: No weekend activities Clinic/Doctor: 1 day Social Hour: 15 days	F 248		

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F 248	Continued From page 30 Friendly conversation: 4 days TV/radio/room/sun area: 19 days Family/friend visit: 9 days Cards/games/puzzles: 6 days Salon: 1 day The resident's Record of One-to-One Activities identified staff provided three One-to-One visits in January and one One-to-One visit in February 2014. During an interview on 02/05/14 at 3:00 p.m. with an activity staff member (#1) and an administrative staff member (#4) the activity staff member (#1) stated the facility does not provide weekend activities. On the morning of 02/06/14, the survey team requested the policy/procedure for activities. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy manual "disappeared" and they had no policy/procedure for activities.	F 248	F 280 #1 Resident #s 1, 2, 3, 4, 5, 6, & 9 reviewed and revised. Resident #1 care plan revised to include activity preferences of country western music and religious activities and updated with dining recommendations including current diet order, proper positioning during meals and the need for supervision while dining. Care plan revised to include fall prevention/positioning with wedges while in bed, Broda chair secondary to positioning needs, and potential for dehydration and the need to offer fluids. Resident 2's care plan revised to address restorative therapy needs and the need for a gait belt to be used during transfers. Resident #6 care plan revised to reflect resident activity preferences, and the fact that the priest (considered family member) may visit daily, resident feeding needs and the fact that he is fed by a family member. Resident #9's care plan revised to identify how staff will	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		

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F 280	Continued From page 31 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/31/13. Based on observation, record review, family interview, resident and staff interviews, the facility failed to review and revise the resident's plan of care for 6 of 7 sampled residents (Resident #1, #2, #3, #4, #5 and #6), 1 supplemental resident (Resident #9), and 1 resident discharged from the facility (Resident #8). Failure to review and revise the plan of care limited the facility's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Parkinson's disease, Alzheimer's dementia with behavioral disturbance, dyskinesia (involuntary muscle movements), and dysphagia. The quarterly Minimum Data Set (MDS), dated 01/14/14, identified the resident had moderately impaired cognition and required extensive-to-total assistance for all Activities of Daily Living (ADLs), except eating; required limited assistance for eating and a mechanically altered diet. The	F 280	F 280 continued ensure his timely return to the building when he goes outside to smoke, and how he will obtain assistance should he need it while outside smoking. Resident # 4's care plan reviewed and updated to reflect that he can be up for meals, added contact isolation, need for assistance with transfers and resident activity preferences. Resident #5's care plan reviewed and updated to reflect restorative therapy program. Resident #8 is no longer in facility. Resident #3's care plan reviewed and updated to reflect personal activity preferences as well as pressure ulcer prevention approaches such as trial (and continued use if appropriate) of Broda chair with feet supported, use of pressure relieving cushion and use of non-skid pad in chair seat to decrease sliding. #2 All residents have the potential to be affected. All care plans will be reviewed to accurately reflect the	

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F 280	Continued From page 32 admission MDS, dated 04/22/13, showed the resident identified listening to music, participating in religious services, and being outdoors as being important to him. Observations on all days of survey showed Resident #1 dressed in a hospital gown and brief; regardless of the time of day or resident's location. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) reported requesting and failing to receive any clothing from Resident #1's family. The current care plan utilized by direct care staff failed to address Resident #1's lack of personal clothing and/or preference (if any) to wear hospital gowns. The initial activity assessment, dated 09/04/12, identified Resident #1 as interested in "listening to country music." The current care plan stated, ". . . Problem: Resident unable to attend activities regularly . . . Approaches: Offer to bring materials such as; newspaper, magazines, books or DVD's, Talk about family, past job as a Professor and family vacations, Will encourage resident to get out of bed and sit in wheelchair, go to dining room for activity, wheel around facility or go outside, Will offer to turn tv on to appropriate programming for resident . . ." The current care plan utilized by direct care staff failed to identify the activities that were important to Resident #1; listening to country music and participating in religious services.	F 280	F 280 continued resident's current status, preferences and needs. #3 Implementation of policy titled "Care Planning". All direct care staff including nursing staff, social service staff, dietary and activity staff will be educated on the policy. #4 On or before April 7, 2014. #5 Director of Nursing or designee will monitor compliance with policy titled "Care Planning" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 280	Continued From page 33 The physician's order, dated 04/16/13, identified, ". . . Liquids: Honey Thickened with ice chips for quality of life . . . Diet: Pureed . . ." The "Speech Therapy Plan of Treatment for Dysphagia," dated 01/31/14, identified, ". . . may upgrade liquids to nectar thick, however diet needs to be pureed foods. . . . Upright [Position], 90 Degree Hip Flexion, Upright, 30 Minutes After Meal . . . Supervision for all Meals/Snacks. . . ." The current care plan stated, ". . . Problem: Resident is at nutritional risk d/t [due to] impaired swallowing . . . Approaches: . . . If meat is not tender needs to be ground. Thin liquids up for 30 minutes after meals . . . Avoid foods that are difficult to swallow . . . Monitor and report difficulties swallowing, Monitor for signs and symptoms of aspiration pneumonia . . ." The current care plan utilized by direct care staff failed to address Resident #1's recommended diet (pureed diet with nectar thick liquids), proper positioning during meals, and need for supervision. The nurse's note, dated 11/15/13 at 3:00 p.m., identified, ". . . Wedges in place today between bed [and] wall for cushion . . . Has wedge for positioning from side to side. . . ." Observations showed the following: * 02/04/14 at 9:15 a.m., two CNAs (#10 and #11) transferred Resident #1 into bed, placed a wedge between the Resident #1's bed and the wall. * 02/04/14 at 1:50 p.m., two CNAs (#6 and #10) transferred Resident #1 into bed, placed a wedge behind his back, and a wedge between the	F 280		

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F 280	Continued From page 34 residents bed and the wall. The current care plan utilized by direct care staff failed to address the use of wedges to assist with positioning/prevent futher falls. Observation on all days of survey showed Resident #1 utilizing a Broda [reclining] chair. The current care plan utilized by direct care staff failed to address Resident #1's use of a Broda chair. Observations on 02/04/14 at 9:15 a.m., 11:50 a.m., and 1:50 p.m., showed the CNAs assisting Resident #1 failed to offer him fluids while providing cares. Although the current care plan utilized by direct care staff addressed Resident #1's nutritional risk, it failed to address his risk of dehydration secondary to requiring extensive to total assistance for cares and catheter placement. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included bone/cartilage disorder, osteoarthrosis, muscle weakness, and history of falls. The quarterly MDS, dated 11/29/13, identified Resident #2 was cognitively intact and required extensive assistance for all ADLs except eating. The MDS further showed Restorative Nursing services were not being provided at the time of the assessment. The "Therapy Discharge Notice," dated 11/20/13, identified, ". . . Continue with assistive ambulation as tolerated, LE [lower extremity] seated ex [exercises]: marching, hip slides, kicks."	F 280		

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F 280	Continued From page 35 The physician order, dated 11/26/13, stated, ". . . continue with restorative to maintain current level of function." The "Staff Instruction Sheet," dated 11/26/13, identified, ". . . Please walk to bathroom [with] assist [and] FWW [front wheeled walker], Please walk to meals [with] assist as far as able [with] w/c [wheelchair] following, Supervise LE [and] UE [upper extremity] exercises daily: seated marching, leg kicks, knee pull-aparts, arm lifts. . . ." The current care plan utilized by direct care staff failed to address Resident #2's restorative therapy needs. The "ADL Function and Falls Care Area Assessment (CAA)," dated 07/31/13, identified, "[Resident #2] requires limited assistance for . . . transfers . . . [Resident #2] also requires supervision for walking in room, walking in corridor, toilet use . . . She is not steady and only able to stabilize with staff assistance for balance during transition and walking . . ." Observations showed the following: * On 02/03/14 at 1:50 p.m., a CNA (#9) placed a gait belt around Resident #2's waist as the resident ambulated towards her bed. * On 02/04/14 at 11:58 a.m., a CNA (#6) placed a gait belt around Resident #2's waist, and assisted her down the hallway. * On 02/04/14 at 1:15 p.m., a CNA (#10) held onto the back of Resident #2's pants as she walked into the bathroom, and from the bathroom to her recliner.	F 280		

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F 280	Continued From page 36 The current care plan utilized by direct care staff failed to address Resident #2's need for staff assistance and utilization of a gaitbelt when transferring and/or walking. - Resident #6's medical record, reviewed on February 5-6, 2014, identified diagnoses of Alzheimer's dementia with behavioral disturbance, lack of coordination, and weakness. The annual MDS, dated 07/07/13, identified Resident #6 had participated in religious activities. The quarterly MDS, dated 01/07/14, identified the resident had severely impaired cognition and required extensive-to-total assistance for all ADLs. The initial activity assessment, dated October 2012, identified Resident #6 as interested in "exercising, listening to gospel, old time, piano, or polka music, and attending parties." The assessment further identified, "Resident likes to wheel up/down hallway. Resident likes volunteer dog. Volunteer reads from 'Partners in Prayer' out loud to resident. [Priest] visits resident 1-2 x day . . ." The current care plan stated, ". . . Problem: . . . resident no longer attending most activities . . . Approaches: Adjust the intensity, frequency, and/or duration of activities to accommodate the resident's energy level and tolerance, Assess resident for health issues that could result in reduced activity participation . . . Encourage resident to become involved with activities, Adapt to resident's current abilities, Offer opportunities to interact with others through activities such as shared dining, afternoon refreshments, monthly birthday parties, Vary the physical environment when possible."	F 280		

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F 280	Continued From page 37 Observation on all days of survey showed a priest visited with Resident #6 following his noon meal. The current care plan utilized by direct care staff failed to identify the activities that were important to Resident #6 (exercising, listening to gospel, old time, piano, or polka music, wheeling up/down the hallways, and interacting with the volunteer dog), and address his daily visits from the priest. The Nutrition CAA, dated 07/07/13, identified, ". . . Receives a Pureed diet, divided plate provided for self feeding. Need extensive or total assist with meals. . . ." On February 3-5, 2014, observations in the dining room showed a visitor feeding Resident #6. The current care plan stated, ". . . Problem: Resident is limited in ability to maintain grooming/personal hygiene . . . Approaches: . . . Need set up and cueing with meals. Assist as needed with hand over hand cueing or dining assistance . . . Problem: Resident requires a mechanically altered diet . . . Approaches: . . . pureed, divided plate promote self feeding, Encourage oral intake of foods and fluids, Monitor acceptance of mechanical altered diet . . . Set up assistance and assist of one for meals . . ." The current care plan utilized by direct care staff failed to identify the level of feeding assistance Resident #6 required, and failed to identify Resident #6 was eligible to be assisted by a visitor. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses	F 280		

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F 280	Continued From page 38 included muscle spasms and/or weakness, neuropathy, and history of tobacco use. The annual MDS, dated 01/19/14, identified Resident #9 as cognitively intact and requiring supervision whenever he moved to/returned from off-unit locations. Resident #9's current care plan stated, ". . . Problem: Resident at risk for injury d/t [due to] smoking . . . Approaches: . . . Educate resident to wear proper attire . . ." Observations on all days of survey showed Resident #9 sitting on his walker, smoking alone, next to the ashtray located on the sidewalk near the main entrance to the facility. He was wearing a hooded sweatshirt, pajama bottoms, bedroom slippers, and (on four of eight occassions) an unzipped coat. It was snowing on 2 of 4 days of survey, and the local radio and television stations indicated temperatures ranged from minus 4-6 degrees Farenheit. During interview on 02/05/14 at 9:02 a.m., when asked how he would acquire staff assistance if something happened after he left the facility, he stated, "I have a time limit, then they [staff] come and check on me." During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) reported staff are not required to check on Resident #9 while he is smoking. The current care plan utilized by direct care staff failed to identify how staff were to ensure Resident #9 returned to the building in a timely manner, and failed to identify how Resident #9 would acquire staff assistance if something	F 280		

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F 280	Continued From page 39 happened after he left the facility. - During the initial tour of the facility, on the morning of 02/03/14, observation identified a sign outside Resident #4's room directing visitors to check with a nurse before entering the room. A licensed nurse (#5) stated Resident #4 was in "Contact Isolation" due to an antibiotic resistant urinary tract infection (UTI). The nurse (#5) also identified Resident #4 is out of bed for only 45 minutes twice a day due to recent skin flap surgery to her sacrum. A nurse's note, dated 01/24/14 at 2:00 p.m. stated, ". . . Occupational Therapist seen today. Told nurse 'resident is able to be up in chair for 45 min [minutes] two times a day now.' Resident spoke to nurse 'I would like to be able to get up for meals' . . ." Resident #4's current care plan, dated 01/09/14, included a problem: "Impaired skin integrity R/T [related to] new gluteal ulcer flap repair." Approaches to the problem included: ". . . May be up for meals no more thatn [sic] 30 minutes at a time . . ." Staff failed to update the care plan regarding number of minutes Resident #4 could be up for meals and failed to develop a care plan regarding the contact isolation, assistance with transfers, and the resident's activities. - Resident #5's medical record, reviewed on all days of survey, identified a therapy "Staff Instruction Sheet," dated 12/26/13. The sheet stated, "Please assist [Resident #5] with completing her exercises daily, copy of her program is in her room along with the weights &	F 280		

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F 280	Continued From page 40 [and] a copy is also in her chart under therapy tab. . . ." The record failed to identify a care plan developed regarding Resident #5's restorative program. - Resident #8's closed medical record, reviewed on February 5-6, 2014, identified diagnoses including steroid dependence secondary to polymyalgia rheumatica, congestive heart failure, renal insufficiency, benign prostatic hypertrophy with [urine] retention. Quarterly MDSs, dated 06/14/13 and 09/14/13 identified the resident had a urinary tract infection in the past 30 days.	F 280		
	Review of physician's/practioner's documentation revealed the following: * 09/04/13: ". . . He states he has not been feeling well for about a week. Nursing staff states he is down about eleven pounds since last week. He states he is really nauseated. He just has a generalized aching sensation to her [sic] stomach. . . .He is on fluid restrictions, is given a 1500 fluid allowance, but he is not drinking even close to that amount . . . It appears that he is somewhat dehydrated. . . . Insomnia. Nursing staff are to change his order to scheduled dose of melatonin at h.s. [hour of sleep]. . . " * 09/17/13: ". . . The patient will need a every 8 hours straight cath [catheterization] for urine if he makes less than 80 mL [milliliters]. He has a history of urinary retention. . . . Instructions include daily weights. If weight increases more than three pounds in 1 day or 5 pounds in 1 week the patient is instructed to call [physician's name] Hold Coreg and lisinopril [medications to control blood pressure] for systolic blood pressure less than 100 . . . ." Resident #8's care plan, dated 07/30/13, lacked			

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F 280	Continued From page 41 updates/revisions identifying interventions for the resident's urinary tract infections, nausea and abdominal discomfort, risk for dehydration, insomnia, need for monitoring of urine output and possible need for catheterization, monitoring of weights and reporting changes to the physician, and holding the medications if his systolic blood pressure was less than 100. On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the care planning process. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared" approximately six months ago and they had no policy/procedure regarding care planning. The facility's failure to update and revise care plans with changes in the resident's condition inhibited staff's ability to provide continuity of care placed residents at risk for inconsistent care. - Review of Resident #3's medical record occurred on February 3-6, 2014. The facility admitted the resident in May 2009. Current diagnoses included dementia, a history of pressure sores, and a current Stage II pressure sore. The significant change MDS, dated 12/29/13, identified physical and verbal behaviors occurred four to six days during the seven day assessment period, the resident required total assistance of two or more persons for bed mobility, and had one Stage II pressure ulcer. Resident #3's Activities Progress Notes, dated 04/02/13, 06/28/13, and 09/30/13 identified the resident enjoyed ". . . news, reminisce, game groups, socials, and entertainment . . ."	F 280		

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F 280	Continued From page 42 During interview, on 02/03/14 at 1:40 p.m., Resident #3's family member (#1) reported the resident "likes to visit." Resident #3's Occupational Therapy (OT) Progress Reports stated the following: *01/24/14 - "OT consult for w/c positioning. Nursing requested trial use of blue geri [geriatric] [wheel] chair instead of current [brand name multi-position] [wheel] chair, as res. has been noted to have [decreased] positioning & safety in [brand name multi-position] [wheel] chair. Staff reports res. has been . . . 'sliding out' when sitting upright for meals. O.T. agrees to trial use of blue geri chair . . . LE [lower extremities] is [sic] fully supported by one large lg [leg] rest in the geri chair. O.T. did recommend placing built up foot squares for foot pedals if res.'s LE are not raised . . . Nursing agreed. O.T. also recommended cont. [continued] use of res.'s current w/c cushion in geri chair to [decrease] potential for skin breakdown. . . ." *01/31/14 - "O.T. consult: Res. observed in blue geri chair & appeared in comfortable position. . . . O.T. also recommended using [brand name non-skid pad] under res.'s bottom to [decrease] potential for sliding down in chair. . . ." Resident #3's current care plan lacked approaches or interventions regarding activities of interest to him identified in the Progress Notes and by the family member; and lacked pressure sore prevention approaches or interventions as recommended by the occupational therapist.	F 280	F 281 #1 The facility will complete investigations of the episodes of entrapment for resident #1. #2 All residents with side rails in place have the potential to be affected. All side rails on resident beds in the facility have been removed. #3 Implementation of policy titled "Incident Reporting" & policy titled "Incident Nurse's Notes Guidelines". All staff will be educated on the policy titled "Incident Reporting". Nurses will be educated on the policy titled "Incident Nurse's Notes Guidelines". #4 On or before April 7, 2014	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 43 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to investigate and complete incident reports on two occasions for 1 of 1 sampled resident (Resident #1) who experienced four incidents of side rail entrapment. Failure to complete an incident report, including a description of the incident and the investigation of the precipitating factors, how the incident could have been prevented, whether equipment should have been adjusted, and/or any other interventions the facility attempted in order to prevent a reoccurrance, has the potential to result in additional incident's of entrapment, injury, and/or death. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for writing incident reports. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared approximately six months ago" and they had no policy/procedure regarding writing incident reports. Kozier & ERB's "Fundamentals of Nursing Concepts, Process, and Practice," 9th Edition, 2012, page 75 stated, ". . . An incident report . . . is an agency record of an accident or unusual occurrence. . . . The report should be completed as soon as possible . . . The purpose of the report form is to alert the risk manager to the event. The	F 281	F 281 continued #5 Director of Nursing or designee will monitor compliance with policies titled "Incident Reporting" and "Incident Nurse's Notes Guidelines" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 281	Continued From page 44 person who identifies that the incident occurred should complete the incident report. . . . Incident reports are often reviewed by an agency risk management committee, which decides whether to investigate the incident further. Nurses may be required to answer such questions as what they believe precipitated the accident, how it could have been prevented, and whether any equipent should be adjusted. . . ." Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and dyskinesia (involuntary muscle movements). The quarterly Minimum Data Set (MDS), dated 01/14/14, identified the resident had moderately impaired cognition and required total assistance for bed mobility and transfers. The nurse's note identified the following: * On 10/21/13 at 3:40 p.m., "Resident fell out of bed at this time. (L) knee was stuck between bed rail [and] mattress. Bruising noted to inside leg, red marks to inner [and] outer leg. Resident stated, 'I'm in pain, my leg hurts.' Will continue to monitor." The facility failed to complete an incident report following the entrapment episode. * On 11/14/13 at 5:00 p.m., "Resident found on floor by CNA [Certified Nursing Assistant] with neck caught in the arm rail, resident was having hard time breathing [and] wasn't able to talk. Assessment done at this time [and] nothing appears out of normal. Will monitor." The facility failed to complete an incident report following the entrapment episode. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) confirmed they were aware of Resident #1's	F 281		

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F 281	Continued From page 45 episodes of side rail entrapment, and were aware staff failed to complete incident reports on 10/21/13 and 11/14/13.	F 281	F 309 1. #1 Resident #8 is no longer in the facility. #2 All residents with a change in condition have the potential to be affected by this deficient practice.	
F 309 SS=G	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.	F 309		
	This REQUIREMENT is not met as evidenced by: 1. Based on record review and staff interview, the facility failed to provide the necessary care and services for 1 of 1 discharged resident (Resident #8) who required hospitalization. Failure to assess the resident's condition and to promptly notify the physician resulted in the resident's admission to the intensive care unit (ICU) with digoxin (medication for heart failure) toxicity and sepsis (infection in the bloodstream). Findings include: Resident #8's closed medical record, reviewed on February 5 - 6, 2014, identified diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease, and atrial fibrillation. A quarterly Minimum Data Set (MDS), dated 09/14/13, identified the resident with a Brief Interview for Mental Status score of 15, indicating the resident cognitively intact.		#3 Implementation of new policy titled "Assessment of Resident & Notification of Physician and Responsible Party Regarding Resident Change in Condition". All nurses will be educated on the policy. Nurses educated on the importance of prompt physician notification and completing an appropriate resident assessment including vital signs with a change in the resident's condition #4 On or before April 7, 2014.	

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F 309	Continued From page 46 The record identified Resident #8 was admitted to a hospital ICU on 09/06/13 with chronic cardiomyopathy, CHF, chronic renal failure stage III, acute uncontrolled atrial flutter, and acute respiratory failure secondary to pulmonary edema. The record showed he returned to the facility on 09/10/13 and his medication regimen included digoxin 0.25 milligrams daily, which he also received prior to that admission. Resident #8's nurse's notes identified the following: * 09/14/13 at 7:10 a.m.: ". . . Res [resident] cont [continues] to c/o [complain of] 'feeling weak & [and] tired.'. . ." * 09/14/13 at 8:00 p.m.: "Resident spent shift resting in bed . . . Resident c/o decreased appetite and upset stomach which he said he had been dealing with 'for about 10 days.' . . ." *09/15/13 at 6:10 a.m.: "Wanting to go to hospital. Says 'they will give me IV's [intravenous] to help.' Had emesis of lg [large] amt [amount] light green bile. Enc [encouraged] to eat et [and] try to get moving. Did agree to take Mylanta." The record lacked evidence facility staff informed the physician of Resident #8's complaints and lacked evidence staff assessed the resident's condition or obtained vital signs for 18 hours. Nurse's Notes on 09/16/13 identified: *12:40 a.m.: "Resident had small bright yellow/lime green colored emesis at this time. . . . Resident was cool & clammy & also pale. Productive cough noted of yellow/green sputum. Resident stated, 'I want to go to the hospital, someone has to figure out what's wrong [with] me.' Resident reassured that appropriate actions would be taken in the AM [morning] when	F 309	F 309 continued #5 Director of Nursing or designee will monitor compliance with policy titled "Assessment of Resident & Notification of Physician and Responsible Party Regarding Resident Change in Condition" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting. 2. #1 Residents #1, 3, & 6 positioned at a 90 degree angle while being fed, are given the prescribed diet consistency, and offered small bites at a reasonable rate of feeding. Resident #6's visitor (considered a family member) trained on feeding someone with dysphagia.	

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F 309	Continued From page 47 clinic/hospital was open. Resident acknowledged waiting til [sic] morning. . . ." * 7:10 a.m.: "Res c/o still [not] feeling well & c/o [not] being able to keep even H2O [water] down. Res took PO [oral] meds [medications] as ordered." * 8:40 a.m.: "Will cont [continue] to monitor. Res c/o nausea & refusing to eat. Stated '. . . I still think I need to see the Dr. [doctor].' Encouraged res to try & eat something to help [decrease] nausea. Refused at this time." * 10:15 a.m.: "Message left for clinic to call back." This message to the clinic occurred approximately 28 hours after the resident initially voiced multiple complaints and requests to go to the hospital. The record identified a nurse practitioner saw Resident #8 on 09/16/13 at 2:00 p.m. and ordered medication for nausea but the medical record lacked evidence staff assessed the resident's condition or obtained vital signs for another 18 hours. Nurses notes on 09/17/13 identified: * 8:00 a.m.: "VS [vital signs] BP [blood pressure] 88/50, P [pulse] 61 . . . Resident stated that 'I want to go to the hospital. I think they'll be able to figure out what's wrong [with] me.' [physician's name] notified about request & stated, 'I'm coming over this afternoon & I'll make appointment time to see him.'" * 12 noon: "Resident's pulse was 44 when taken radially, apically was 38 & when machine was used 40. Manual BP was taken 82/48 machine read 101/47. [Physician's name] called & ordered resident to be transferred via ambulance to [hospital name] ER [emergency room]. [Physician's name] ordered 4LO2 [4 liters oxygen] & IV [with] lactated ringers [an IV solution] be	F 309	F 309 continued #2 All residents with dysphagia have the potential to be affected by this deficient practice. #3 Implementation of a new policy titled "Nutrition & Hydration". All nursing staff will be educated on new policy. Implementation of new policy titled "Dignity & Privacy". All nursing staff will be educated on new policy. All staff educated on signs and symptoms associated with aspiration while eating, importance of proper positioning of the dysphagia resident to assist in the prevention of aspiration while eating, serving & offering the correct consistency of foods, feeding rate & portion size. All staff educated on the importance of following the residents prescribed diet texture, to include not feeding prohibited items including snack items. Nurses educated on the need to train family members feeding someone with dysphagia.	

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	355122	A. BUILDING _____ B. WING _____	02/06/2014

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F 309	Continued From page 48 started before transport. . . ." * 7:00 p.m.: "Called [Hospital name] @ [at] this time, admitted to ICU . . ." A nurse's note, dated 09/19/13 at 1:40 p.m. stated, "[Hospital name] called for an update. Stated resident is still in the ICU still on a dopamine [medication to treat shock] drip [IV]. No change in resident condition . . ." A physician's progress note, dated 09/23/13, stated, "[Resident #8] is back from the hospital after an episode of sepsis and digitalis toxicity. . . ." An interview occurred with two administrative nurses (#2 and #3) on the morning of 02/06/14. When asked to provide any pertinent notes or vital signs from September 15-17, 2013, the staff members provided no additional information. The facility's failure to assess the resident's condition and promptly notify the physician of Resident #8's repeated requests to "go to the hospital" contributed to delayed diagnosis of the digoxin toxicity and sepsis which resulted in the resident's admission to the ICU. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/31/13. 2. 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 possible during meals for 3 of 3 sampled residents (Resident #1, #3, and #6) observed or with a history of signs/symptoms of aspiration. Failure to ensure residents were positioned	F 309	F 309 continued #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policies titled "Nutrition & Hydration" and "Dignity & Privacy" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting. 3. #1 Resident #13 is no longer in the facility. #2 All residents with diabetes have the potential to be impacted.	

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F 309	Continued From page 49 properly, provided the correct consistency foods, fed bite-sized portions at a slow rate, and to ensure individuals feeding the residents were properly trained in dysphagia, resulted in Resident #1 and #6 aspirating and placed Resident #3 at risk of aspirating. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedures for dysphagia and feeding dependent residents. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy manual "disappeared" and they had no policy/procedures for dysphagia and feeding dependent residents. Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 47, 125, 128, 137 and the educational handouts identified, ". . . Any patient who . . . has been diagnosed with a neurological disorder may be at risk for aspiration. . . . Signs of oral phase dysphagia include losing food or liquid out the front of the mouth [Observed with Resident #6 on February 3-4, 2013 while being fed] . . . Signs of pharyngeal dysphagia are coughing or choking during a meal [Observed with Resident #1 on 02/03/14 and with Resident #6 on February 3-6, 2013 while being fed] . . . For patients with mechanical problems in the oral phase . . . thickened liquids and pureed foods are often the easiest to swallow. . . . Generally, avoid foods that fall or break apart in the mouth . . . This precaution helps prevent small pieces of food from entering the airway. During the oral intake of . . . foods and/or liquids, it is optimal for a patient	F 309	F 309 continued #3 Implementation of policy titled "Diabetes Management". All nurses will be educated on the new policy. All nurses educated on the necessity of completing an appropriate resident assessment including vital signs when the resident experiences a change in condition. #4 On or before April 7, 2014. #5 Director of Nursing or designee will monitor compliance with policy titled "Diabetes Management" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 309	Continued From page 50 to be seated at a 90 degree angle . . . 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 [Observed Resident #1 in a reclined position on 02/03/14] . . . Controlling the bolus [bite] size is important . . . As long as the bolus size is controlled to a small amount . . . the bolus can rest in the valleculae and pyriforms [parts of the throat] without aspiration during a delayed swallowing response [Observed staff and visitors presenting heaping teaspoons of food to Resident #6 on February 3-5, 2013].	F 309		
	- Resident #6's medical record, reviewed on February 5-6, 2014, identified diagnoses of Alzheimer's dementia, lack of coordination, and weakness. The quarterly MDS, dated 01/07/14, identified the resident had severely impaired cognition and required extensive-to-total assistance for all ADLs. The Nutrition Care Area Assessment (CAA), dated 07/07/13, identified, ". . . Receives a Pureed diet, divided plate provided for self feeding. Need extensive or total assist with meals. Eats all meals in dining room. . . ." During an interview on the morning of 02/06/14, an administrative nursing staff member (#3) reported the facility failed to assess Resident #6's swallow safety. The current care plan stated, ". . . Problem: Resident is limited in ability to maintain grooming/personal hygiene R/T [related to] decline in physical status secondary to advancing Alzheimer's Dementia . . . Approaches: . . . Need set up and cueing with meals. Assist as needed			

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F 309	Continued From page 51 with hand over hand cueing or dining assistance . . . Problem: Resident requires a mechanically altered diet . . . Approaches: . . . pureed, divided plate promote self feeding, Encourage oral intake of foods and fluids, Monitor acceptance of mechanical altered diet . . . Set up assistance and assist of one for meals . . ." The physician's order, dated 05/20/13, identified, ". . . Diet: Pureed . . ." The nurse's notes identified the following: * 06/18/13 at 12:30 p.m., "CNA [Certified Nursing Assistant] called me to D/R [dining room] stating res [resident] had a swallow of milk [and] began to cough [and] 'choke' Res teary eyed [and] not actively choking now but coughing up clear thick phlegm. . . ." * 07/07/13 at 9:00 p.m., ". . . Occasionally spits out pieces of pills. . . ." * 07/21/13 at 12:30 p.m., "Res had 2 bites of meal [and] CNA states was fine, but coughed [and] started coughing up thick clear phlegm. I attended Res [and] [sic] continued to cough up lg [large] amt [amounts] of clear thick phlegm, oral cavity cleaned out of clear phlegm [and] only very scant amt of pureed food particles from teeth. . . ." The dietary progress note, dated 01/14/14, identified, ". . . LRD [Licensed, Registered Dietitian] observed noon meal. Resident was fed by [visitor]. Resident ate quite well - no problems chewing or swallowing. . . ." Dining room observations showed the following: * 02/03/14 at 12:40 p.m., a visitor fed Resident #6 heaping teaspoon after heaping teaspoon of pureed food prior to ensuring the resident had	F 309		

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F 309	Continued From page 52 swallowed the previous bite. On two occasions, Resident #6 leaned away from the spoon when it touched his bottom lip (an indication Resident #6 was not prepared for the next bite of food). The visitor also presented and Resident #6 consumed swallow after swallow of thin liquids from a glass. On one occasion, Resident #6 turned his head away from the glass when it touched his bottom lip (an indication Resident #6 was not prepared for the next swallow of liquid). Resident #6 drooled (an indication Resident #6 did not swallow his secretions) twice, throat cleared twice, and coughed/choked (an indication Resident #6 had poor vocal fold closure and secretions had entered his airway) four times; once so hard he sprayed food across his place setting and onto the visitor. * 02/04/14 at 8:12 a.m., a CNA (#10) fed and Resident #6 consumed heaping teaspoon after heaping teaspoon of pureed food without ensuring the resident had swallowed. At times, Resident #6 could be seen chewing the previous bite of food when the CNA (#10) fed him the next spoonful. On one occasion, Resident #6 leaned away from the spoon when it touched his bottom lip. Resident #6 drooled twice, throat cleared once, and on five occasions coughed/choked immediately following the consumption of thin liquids from a glass; once so hard he sprayed food onto the CNA. * 02/04/14 at 12:28 p.m., the visitor fed and Resident #6 consumed heaping teaspoon after heaping teaspoon of pureed food without ensuring the resident had swallowed. At times, Resident #6 could be seen still chewing the previous bite of food when the visitor fed him the next spoonful. Resident #6 throat cleared twice and coughed five times. While feeding Resident #6, the visitor stated, "[Resident #6] lost seven	F 309		

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F 309	Continued From page 53 teeth with his bridge, so he chews on one side of his mouth." * 02/05/14 at 8:00 a.m., a CNA (#6) provided [hand-over-hand] guided assistance as Resident #6 attempted to feed himself. The resident ate heaping teaspoons of pureed food. On one occasion Resident #6 coughed on the pureed food, and on the other occasion he immediately coughed following the consumption of thin liquids. * 02/05/14 at 12:28 p.m., the visitor fed and Resident #6 consumed heaping teaspoon after heaping teaspoon of pureed foods without ensuring the resident had swallowed. Resident #6 throat cleared twice and coughed twice following the consumption of thin liquids from a glass. On one occasion, the visitor was seen putting food in Resident #6's mouth while he was coughing. * 02/06/14 at 8:10 a.m., a CNA (#11) fed breakfast to Resident #6. Resident #6 coughed twice following the consumption of thin liquids from a glass. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) reported direct care staff had received training on dysphagia and/or aspiration. They further reported the visitor had been allowed to feed Resident #6 without receiving this same training. - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and dysphagia. The quarterly MDS, dated 01/14/14, identified the resident had moderately impaired cognition, required limited assistance for eating, and had a mechanically altered diet. The current care plan stated, ". . . Problem: Resident is at nutritional risk d/t [due to] impaired	F 309		

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F 309	Continued From page 54 swallowing . . . Approaches: . . . If meat is not tender needs to be ground. Thin liquids up for 30 minutes after meals . . . Avoid foods that are difficult to swallow . . . Monitor and report difficulties swallowing, Monitor for signs and symptoms of aspiration pneumonia . . . cough . . ." The physician's order, dated 04/16/13, identified, ". . . Liquids: Honey Thickened with ice chips for quality of life . . . Diet: Pureed . . ." The "Speech Therapy Plan of Treatment for Dysphagia," dated 01/31/14, identified, ". . . He has been tolerating pureed foods and honey liquids well and they would like to upgrade his diet if possible. Swallow eval [evaluation] complete may upgrade liquids to nectar thick, however diet needs to be pureed foods. . . . Upright [Position], 90 Degree Hip Flexion, Upright, 30 Minutes After Meal . . . Supervision for all Meals/Snacks. . . ." Observation on 02/03/14 at 1:50 p.m., showed two CNAs (#8 and #9) obtained Resident #1's room tray from the nourishment center, warmed the food, entered the resident's room, and provided tray set-up. The resident sat in his Broda [reclining] chair, which was reclined at a 45 degree angle, and fed himself. Resident #1 coughed (an indication Resident #1 had poor vocal fold closure and secretions had entered his airway) three times during the meal. The CNAs failed to position Resident #1 as close to 90 degrees as possible prior to/during his meal (placing Resident #1 at an increased risk of premature loss of food/liquid over the back of his tongue). The facility failed to 1) position Resident #1 as	F 309		

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F 309	Continued From page 55 close to 90 degrees as possible prior to allowing him to eat, 2) control the size of the bolus [bite], offering [flat] teaspoon sized bites of food to Resident #6, 3) offer food to Resident #6 using a slow rate of presentation, 4) recognize Resident #1 and #6's signs/symptoms of dysphagia and/or aspiration (drooling, throat clearing, and/or coughing/choking) 5) assess Resident #6's swallow safety, 6) ensure Resident #6 had no complicated feeding problems and was eligible to be assisted by a visitor, and 7) properly train all individuals allowed to feed residents in the dining room. Failure to implement the above interventions resulted in the residents continuing to aspirate during meals. - Review of Resident #3's medical record occurred on February 03-06, 2014. The facility admitted the resident in May 2009. Current diagnoses included dementia and dysphagia. The significant change MDS, dated 12/29/13, identified the resident sometimes understood others and made himself understood by others, required extensive assistance of one person for eating, had no swallowing problems, and received a mechanically altered diet. The quarterly MDS, dated 10/04/13, identified difficulty with swallowing. Resident #3's Nutrition CAA, dated 12/29/13, stated ". . . Receives mechanical soft diet with pureed meats/gravy . . . Divided plate with meals to aide in self feeding is assist of one with meals. . . ." The resident's current care plan, dated 12/18/13, stated "Problem, Nutritional Risk . . . Approach, Regular mechanical soft diet with pureed meats. . . ." Resident #3's Nurse's Notes stated the following:	F 309		

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F 309	Continued From page 56 *10/02/13, 12:00 a.m. - ". . . Unable to administer HS [bedtime] meds d/t lethargy and inability to open mouth and swallow. . . . no cough noted. . . ." *10/03/13, 10:30 a.m. - ". . . Resident remains lethargic at times. . . ." *10/04/13, 10:30 a.m. - ". . . Res. took AM [morning] meds slowly. Note res. double swallows but [without] cough." 3:00 p.m. - "Orders received for diet [change] to regular diet mechanical soft. *10/07/13, 10:30 a.m. - "Resident is pocketing food and has trouble swallowing food and has cough noted [with] med administration [with] 3 attempts at swallowing. . . ." *10/10/13, 1:30 p.m. - ". . . Diet [change] to pureed meats, mechanical soft. . . ." The Nurse's Notes through 02/02/14 and Dietary Progress Notes through 01/14/14 lacked any indication Resident #3 demonstrated problems with swallowing after the diet change on 10/10/13. Resident #3's medical record lacked evidence of a swallow evaluation. Observation on 02/03/14 at 2:45 p.m. showed Resident #3 seated upright in a wheelchair in the nurse's station lounge. A CNA (#15) approached the resident and held a candy bar for him to eat. The CNA held the candy bar by the wrapper as Resident #3 bit pieces off the candy bar. Resident #3 did not demonstrate coughing or difficulty swallowing. Following this observation the CNA (#15) identified the candy bar as "Milky Way". Observation on 02/05/14 at 9:55 a.m. showed Resident #3 supine in bed with the head of his bed elevated approximately 30 degrees. A number of small chocolate candies were present	F 309		

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F 309	Continued From page 57 on the floor of the room. A CNA (#6) reported she dropped the candies on the floor and had just finished feeding the resident some of the candies, identified as "M & Ms". Failure to provide chocolate snacks in a pureed or mechanical soft texture placed Resident #3 at risk for aspiration. Providing the M & Ms while partially reclined in bed further increased the risk of aspiration. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) agreed facility staff should offer Resident #3 snacks that are pureed or mechanically soft in texture. 3. Based on record review, review of State Agency (SA) files, and staff interview, the facility failed to provide the necessary care and services regarding monitoring of blood glucose levels and providing the appropriate interventions for 1 of 1 supplemental resident (Resident #13) who became unresponsive in the dining room after receiving insulin. Failure to assess the cause of Resident #13's unresponsiveness, the resident's blood glucose level at the time of the unresponsiveness and later in the day, and failure to assess the resident's response to the oral intake during the unresponsive episode limited the physician's ability to determine if other treatment measures were indicated and delayed medical treatment. (Refer to F157.) Findings include: Review of the SA files prior to the survey identified the facility reported an incident occurred on 10/23/13 described as "Nurse was	F 309		

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F 309	Continued From page 58 inappropriate with [a] resident." During interview, on 02/05/14 at 1:35 p.m., an administrative nursing staff member (#2) reported the incident involved Resident #13. Review of the facility investigation file showed a certified nursing assistant (CNA) (A) submitted a confidential allegation to the facility regarding a licensed nurse (B) aggressively slapping Resident #13 and providing oral fluids to drink while the resident was unresponsive or had limited response. The allegation stated ". . . I was trying to feed [Resident #13] her breakfast but she was too out of it . . . [Licensed nurse (B)] also tried to wake her up as well. . . . [Licensed nurse (B)] said 'She needs to eat her food or at least drink her milk because I just gave [her] 20 units of insulin and I don't want her blood sugar to drop.' . . . she then grabbed the cup of milk and put it to her face and tried to get her to drink it . . . She put it up to her lips and started to dump it slowly. I had to clean up milk off her chin . . . [Resident #13] finally opened her eyes for a few seconds and closed them after taking a quick drink. . . ." The facility's investigation file included interviews with a second CNA (C) and the licensed nurse (B) which confirmed Resident #13 was unresponsive and had received her insulin. Review of Resident #13's closed medical record occurred on February 05-06, 2014. The facility admitted the resident in February 2013 and the resident expired on 11/07/13. The resident's diagnoses included diabetes mellitus. Resident #13's physician orders, dated 10/21/13, included: *Regular ADA diet, initiated 05/20/13, ". . . Give her whatever she wants due to no further tx.	F 309		

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F 309	Continued From page 59 [treatment] per family request.]" *Accu check (blood glucose check) every Sunday, initiated 04/08/13. *Humalog Mix 75-25 insulin, 100 units/milliliter (ml), 10 units, at 5:00 p.m., daily, initiated 02/01/13. *Humalog Mix 75-25 insulin, 100 units/ml, 20 units at 9:00 a.m. every morning, initiated 02/01/13. Resident #13's Medication Administration Record (MAR) for 10/23/13 showed the facility staff administered the insulin as scheduled in the morning, with no specific time identified. Resident #13's only nurse's notes, from 10/21/13 at 12:30 p.m., and 10/27/13 at 7:00 p.m. lacked information regarding the unresponsive episode on 10/23/13. The nurse's note, dated 10/27/13 at 7:00 p.m., stated ". . . Resident's daughter is also very concerned about the resident & [and] why she's not awake more, hasn't been eating at meals & her excessive thirst. Daughter is also concerned about the resident receiving [sic] insulin & not eating to compensate for the insulin. . . ." Review of a Health care provider (HCP) (#13)'s progress note, dated 10/29/13, stated ". . . met with [Resident #13's family member] and [administrative nursing staff member (#2)] . . . Her [family member] last concern was that of her diabetes. . . . She thinks she is to [sic] a little more lethargic after receiving the insulin dose prior to her meal and she feels that she is probably getting that insulin too early and that it is starting to work before she is actually eating and then her blood sugars are probably dropping and so she is having a hard time eating her meals to	F 309		

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F 309	Continued From page 60 keep that blood sugar were [sic] it should be. . . ." The progress note lacked information regarding the unresponsive episode on 10/23/13. During interview, on 02/06/13 at 9:30 a.m., two administrative staff members (#2) and (#4) reported the facility had no additional information regarding Resident #13's unresponsive episode on 10/23/13. Resident #13's blood glucose level on the morning of 10/23/13 is unknown. Resident #13's vital signs (blood pressure, pulse, respirations, neurological signs) are unknown. The duration of Resident #13's unresponsiveness is unknown. Failure to evaluate Resident #13's status at the time of unresponsiveness on 10/23/13 placed the resident at risk of experiencing a hypoglycemic episode without treatment by non-oral agents. Treatment with oral agents (milk) while unresponsive or with limited response placed the resident at risk of aspiration (choking). Failure to evaluate the resident prevented the physician or HCP from determining and implementing the most appropriate care in a timely manner.	F 309	F 314 #1 Resident #3 pressure ulcer interventions implemented including repositioning, use of pressure relieving cushions, provision of lower extremity support while in wheelchair, and use of non-skid pad in wheelchair seating surface to prevent sliding in chair. Resident #4's care plan revised to include repositioning the resident with a pressure ulcer and dressings applied to ulcer. #2 All residents at risk for pressure ulcers have the potential to be impacted.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	#3 Implementation of policy titled "Skin Care". All nursing staff will be educated on the policy. Nursing staff educated on identification and consistent assessment and documentation of pressure ulcers. All nursing staff educated on the necessity of complying with the ordered wound care to include dressings.	

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F 314	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to ensure 2 of 3 sampled residents with a history of pressure sores and current pressure sores (Resident #3 and #4) received the necessary treatment and services to prevent pressure sores, prevent recurrence of healed pressure sores, promote healing, and prevent infection. Failure to identify pressure sores and implement treatment resulted in delayed healing and surgical debridement of a Stage II pressure sore (Resident #3). Failure to reposition residents (Resident #3 and #4), provide a pressure relieving seat cushion and lower extremity support (Resident #3), and ordered wound dressing (Resident #4) placed these residents at risk of delayed healing of existing pressure sores and recurrence of pressure sores. Findings include: Review of the National Pressure Ulcer Advisory Panel (NPUAP), "Prevention and Treatment of Pressure Ulcers, Quick Reference Guide for Prevention," Washington, D.C., 2009, occurred on 02/06/14. This document, pages 16-21, provides a reference for pressure ulcer care. Review of the facility policy and procedure, "Wound Assessment Parameters and Documentation," occurred on February 05-06, 2013. This undated document, stated "Care of the Wound, A. Goals: 1. Enhance systemic conditions . . . d. decrease stress 2. Protect from trauma, a. mechanical . . . 4. Prevent infection . .	F 314	F 314 continued #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Skin Care" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 314	Continued From page 62 ." The policy and procedure lacked specific information regarding routine skin assessment, identification, measurement, documentation, or measurement of pressure sores and positioning of residents with existing pressure sores. - Review of Resident #3's medical record occurred on February 03-06, 2014. The facility admitted the resident in May 2009. Current diagnoses included congestive heart failure, a current Stage II pressure sore on the left hip, and a history of healed pressure sores on the buttocks and right hip. The significant change Minimum Data Set (MDS), dated 12/29/13, identified the resident sometimes made himself understood and understood others, required total assistance of two or more persons for bed mobility and transfers, had impaired functional limitation in range of motion of both lower extremities, had an indwelling catheter, was always incontinent of bowel, experienced an unprescribed weight loss, and had one Stage II pressure sore. Resident #3's Care Area Assessments (CAAs), dated 12/29/13, stated the following: Pressure Ulcer - ". . . total dependent with bed mobility. . . . always incontinent of stool. . . . at risk for developing a pressure ulcer. He scored a 14 [Moderate Risk] on his Braden Scale. . . . dated 12/28/13. . . . . currently has a stage 2 pressure ulcer. See weekly skin assessment sheet dated 12/26. . . . will care plan." Nutritional - ". . . Weight decreased 1.4% in 1 month and had a significant weight loss in 6 months with 11%. . . . Receives 6 oz. [ounces] Ensure plus [high calorie supplement] TID [three times a day], 4 oz. Arginaid Extra [high protein supplement] BID [two times a day] with 83-95%	F 314		

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F 314	Continued From page 63 acceptance. . . ." Resident #3's current care plan, originated 12/18/13 and updated 01/10/14, stated "Problem, Resident has Stage 2 pressure ulcer to left hip. . . . Approach [updated 01/08/14], Air mattress;" and, "Approach, Avoid postioning resident on a [sic] lesions. . . . Position for comfort with physical support as necessary. . . . Use positioning devices to raise lesion off the support surface: wedge or pillows. . . ." Resident #3's CAAs and care plan failed to identify pressure relief approaches in the wheelchair or positioning approaches. (Refer to F280.) PRESSURE SORE TREATMENT Review of Resident #3's Nurse's Notes identified the following: *10/13/13, 3:15 p.m. - "Res. [Resident] has area to (L) [left] hip center purple in color and non-blanchable [with] outer edges red to dark pink in color and blanchable, measures 6 x [by] 6 cm [centimeters]. Skin intact. Also has red area 2 x 2 cm skin intact to (R) [right] hip. Repositioning res. [every] 1-2 hrs [hours]. Faxed [physician] [with] update and message left for [family member] . . . Will cont. [continue] to monitor." *10/14/13, 10:45 a.m. - "Resident seen by [health care provider (HCP) (#13)], orders to obtain culture of (L) hip blister, then place absorbent pad on. New skin condition noted to (L) knee. Blister is to have [moist occlusive dressing] placed on it per [HCP (#13)] orders. Also place [moist occlusive dressing] to red area on (R) hip. New skin condition noted to (R) buttocks, measuring 11 cm x 2 1/2 cm, [moisture barrier ointment] applied & [and] [HCP (#13)] notified."	F 314		

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F 314	Continued From page 64 *10/29/13, 11:25 a.m. - "Dressing to (L) hip had lg [large] amount of bloody drainage at this time. Ulcer is dark purple/black in color. Condition to (L) hip is getting worse. Entire area measures 11 cm x 10.5 cm, the ulcer measure 6 cm x 6 cm. . . . New blister noted just below previous ulcer, it measures 1 cm x 1 cm. Blister is intact & [clear occlusive] has been applied. . . ." 1:45 p.m. - "[HCP (#13)] came to see resident. New orders are: [debriding ointment] to (L) hip ulcer once daily & PRN [as needed] if soiled. Cleanse [with] NS [normal saline] before applying, cover with 4 x 4 & ABD [gauze dressing]." *11/15/13 - Resident #3 was seen by a dermatologist with instructions to apply [moist occlusive dressing] to the left hip and knee, discontinue the [debriding ointment] to the right hip and "offload" the hips and left knee. *11/21/13 - Left hip wound drainage and culture positive, antibiotic "Levaquin" initiated. *12/09/13 - Resident #3 was seen by HCP (#13) and left hip dressing changed to clean with half strength hydrogen peroxide and normal saline, then apply [antibiotic gel dressing] and [moist occlusive dressing] daily and prn; wound cultured and orders received for antibiotic Bactrim DS one, BID for 10 days. *12/11/13 - HCP (#13) provided referral to surgeon for possible debridement of left hip wound. Appointment scheduled 12/17/13. *12/17/13 - Physician orders for daily wet to dry dressing with normal saline following debridement of left hip pressure ulcer. *12/01/13, 10:35 a.m. - "Dressing [change] was done on pt. [patient's] left hip. Area noted to be hard, draining bright red blood. Area was approx. [approximately] silver dollar size [3.8 cm	F 314		

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F 314	Continued From page 65 diameter] with its center noted to be black in color. . . ." *12/07/13, 10:00 a.m. - " Pt. [Patient's] shower is today, removed old drsg [dressing] (L) hip, had large amt. [amount] of liquid brown-black in color foul smelling drng [drainage]. After shower cleaned area [with] NS, applied [antibiotic gel dressing] et [and] [clear occlusive]. Area appears tennis ball size [6.7 cm diameter], outer edge dark red [with] white center. Does not appear to cause pain while dressing pt. . . ." *12/18/13, 1:35 p.m. - "New orders from HCP (#13) . . . Insert Foley catheter & re-evaluate effectiveness in 1 wk [week]; diagnosis - perineal agitation due to urinary incontinence." Resident #3's Weekly Pressure Ulcer Record identified the resident is to be repositioned every one to three hours and the resident received high protein dietary supplements and multivitamins. The Pressure Ulcer Record identified the following information, including ulcer stages and measurements: *Left hip - Date of Onset - Blank - 10/13/13 - Stage I; Size - 6 x 6 cm; Depth - 0 - 10/13/13 - Stage II; Size - 6 x 6 cm; Depth - Superficial - 10/14/13 - Stage II: Size 6 x 6 cm; Depth - Blank - 10/18/13 - Stage II; Size 7.5 x 6 cm, open area 2.8 x 2 cm; Depth - Blank - 10/24/13 - Stage II; Size 6 x 6 cm; Depth - 0 - 10/29/13 - Stage II; Size 10.5 x 11 cm; Depth - 0 - 10/31/13 - Stage II; Size 5.5 x 6 cm; Depth - Superficial - 11/06/13 - Stage II; Size 9 x 9.5 cm; Depth - Blank - 11/13/13 - No Stage; Size 7.5 x 7.5 cm; Depth - Increased; Progress - Deteriorated - 11/15/13 - No Stage; Size 4.5 x 5.5 cm; Depth -	F 314		

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F 314	Continued From page 66 0.1 cm; Progress - Improved - 12/01/13 - No Stage; Size 5 x 5.5 cm; Depth 0.1 cm; Progress - Deteriorated - 12/03/13 - No Stage; Size 4 x 6 cm; Depth 0.3 cm; Progress - Improved - 12/07/13 - No Stage; Size 4 x 6 cm; Depth 0.3 cm; Progress - Improved - 12/11/13 - No Stage; Size 5 cm x 5 cm; Depth 0.5 cm; Progress - Deteriorated - 12/19/13 - No Stage; Size 5 cm x 5 cm; Depth 1 cm; Progress - Improved (Surgical debridement on 12/17/13.) - 12/26/13 - No Stage; Size 5 x 5.5 cm; Depth 0.5 cm; Progress - Blank *Left hip "blister" - Date of Onset - 10/29/13 - 10/29/13 - Stage I; Size 1 cm x 1 cm; Depth - 0 - 11/13/13 - Healed *Right hip "redness" - Date of Onset - 10/13/13 - 10/13/13 - No Stage; Size 2 cm x 2 cm; Depth - 0; "Appears to be scratches." - 10/18/13 - Healed - 10/29/13 - "blister" - Date of Onset - 10/29/13 - 10/30/13 - No Stage; Size 3.5 cm x 3 cm; Depth - Blank - 11/06/13 - No Stage; Size 4.5 cm x 4.5 cm; Depth - Superficial; Progress - Deteriorated - 11/13/13 - No Stage; Size 3 cm x 3 cm; Depth - Blank; Progress - Blank - 12/01/13 - No Stage; Size 3 cm x 2 cm; Depth - Blank; Progress - Improved - 12/02/13 - No Stage; Size 3 cm x 2 cm; Depth - Blank; Progress - Improved - 12/10/13 - No Stage; Size 3 cm x 2 cm; Depth - Blank; Progress - Blank - 12/19/13 - Healed *Left buttock - Date of Onset - 12/12/13	F 314		

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F 314	Continued From page 67 - 12/12/13 - Stage I; Size 9 cm x 3.5 cm; Depth - 0 Undated - Healed. The Nurse's Notes lacked any further information regarding this area. *Right buttock - Date of Onset - 10/14/13 - 10/14/13 - Stage I; Size 11 cm x 2.5 cm; Depth - Blank; Pressure Relieving Interventions: Place wedge pillow behind back when lying flat. - 10/18/13 - 4 areas "blisters" - No Stages - No Change; Size 6 cm x 2 cm; 6 cm x 1.5 cm; 6 cm x 2 cm; 5 cm x 1.5 cm - 10/24/13 - Stage I; Size 11 cm x 1.5 cm; Depth - 0 - 10/24/13 - 1 "blister"; Size 2 cm x 4 cm; Depth - 0; Progress - Improved - 10/31/13 - Healed (Stage I and "blister") Observation on 02/05/14 at 9:55 a.m., showed a licensed nurse (#5) removed an occlusive dressing and underlying gauze from Resident #3's left hip and revealed an open area approximately 1.0 cm x 0.5 cm and 0.2 cm in depth. The area appeared clean with edges reddened and no odor. The licensed nurse (#5) cleaned the area with gauze saturated with normal saline, applied dry gauze, and an occlusive dressing. Failure to identify Resident #3's pressure areas until the right buttock measured 11 cm x 2.5 cm and the left hip measured 6 cm x 6 cm delayed healing and resulted in surgical debridement of Resident #3's left hip pressure sore. Failure to develop and implement consistent assessment and documentation methods resulted in inconsistent wound measurements and uncertainty regarding healing, and	F 314		

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F 314	Continued From page 68	F 314		

appropriateness of treatment. These issues further delayed healing and may have contributed to additional pressure sores.

PRESSURE SORE PREVENTION
Resident #3's Occupational Therapy (OT) Progress Reports stated the following:
*01/24/14 - "OT consult for w/c positioning. Nursing requested trial use of blue geri [geriatric] [wheel] chair instead of current [brand name multi-position] [wheel] chair, as res. has been noted to have [decreased] positioning & safety in [brand name multi-position] [wheel] chair. Staff reports res. has been . . . 'sliding out' when sitting upright for meals. O.T. agrees to trial use of blue geri chair . . . LE [lower extremities] is [sic] fully supported by one large lg [leg] rest in the geri chair. O.T. did recommend placing built up foot squares for foot pedals if res.'s LE are not raised . . . Nursing agreed. O.T. also recommended cont. [continued] use of res.'s current w/c cushion in geri chair to [decrease] potential for skin breakdown. . . ."
*01/31/14 - "O.T. consult: Res. observed in blue geri chair & appeared in comfortable position. . . . O.T. also recommended using [brand name non-skid pad] under res.'s bottom to [decrease] potential for sliding down in chair. . . ."

Resident #3's Repositioning Log for the period October 2013 through February 05, 2014 identified "Reposition Every 2-3 hours." The Log included the following examples of "Up in Chair":
*October
11 - 10:00 a.m. to 9:00 p.m. (11 hours)
19 - 4:00 p.m. to 9:00 p.m. (5 hours)
25 - 3:00 p.m. to 8:00 p.m. (5 hours)
29 - 3:00 p.m. to 9:00 p.m. (6 hours)
*November

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F 314	Continued From page 69 14 - 4:00 p.m. to 9:00 p.m. (5 hours) 15 - 4:00 p.m. to 9:00 p.m. (5 hours) *December 03 - 4:00 p.m. to 9:00 p.m. (5 hours) 11 - 10:00 a.m. to 3:00 p.m. (5 hours) 23 - 9:00 a.m. to 3:00 p.m. (6 hours) *January 04 to 24 - 4:00 p.m. to 8:00 p.m. (4 hours) *February 03 - 10:00 a.m. to 10:00 p.m. (12 hours) 04 - 4:00 p.m. to 10:00 p.m. (6 hours) 05 - 10:00 a.m. to 8:00 p.m. (10 hours) Observation on February 03-05, 2014 identified Resident #3 seated upright in a geriatric wheelchair with his knees bent and feet approximately three inches from the wheelchair foot rests. The resident's wheelchair lacked a seat cushion and a non-skid pad on all days of observation. This position placed the resident's legs in a dependent position, increased the shear force on his buttocks, and increased the potential for recurrent skin breakdown of his buttocks. Observation identified Resident #3 seated in this position for the following periods: *02/03/14, 12:20 p.m. to 3:42 p.m. (3 hours, 22 minutes) - two CNAs (#15) and (#16) reclined the chair back to approximately 60 degrees upright and elevated the leg rest to a position level with the chair seat. *02/04/14, 7:55 p.m. to 9:25 a.m. (1 hour, 30 minutes) 12:20 p.m. to 2:40 p.m. (2 hours, 20 minutes) *02/05/14, 10:10 a.m. to 2:40 p.m. (4 hours, 30 minutes) The facility identified a concern with Resident #3 sliding forward out of the wheelchair. The O.T. provided recommendations to improve seating	F 314		

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F 314	Continued From page 70 and reduce the potential for skin breakdown related to seating position. Failure to re-position Resident #3 every two to three hours as identified on the Weekly Pressure Ulcer Record and Repositioning Log; and, failure to implement the O.T. recommendations for foot support, seat cushion, and non-skid pad placed him at risk of recurrent pressure sores and may have contributed to delayed healing of Resident #3's pressure sores. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) confirmed the facility lacked policies and procedures for measurement and treatment of pressure sores, agreed facility staff should re-position Resident #3 every two to three hours, and facility staff should follow O.T.'s seating recommendations. Failure to develop and implement Resident #3's care plan regarding pressure sore prevention, monitoring, and treatment placed him at risk of developing avoidable pressure sores. (Refer to F280.) - During the initial tour of the facility, on the morning of 02/03/14, facility staff identified Resident #4 is only out of bed 45 minutes twice a day due to recent skin flap surgery to her sacrum. Resident #4's medical record, reviewed on all days of survey, identified the resident had a gluteal rotation flap and skin graft surgery for a stage 4 decubitus ulcer on her sacrum on 12/12/13. An admission MDS, dated 01/16/14, identified the resident as cognitively intact, had an indwelling catheter, always incontinent of bowel, at risk for pressure ulcers, had a surgical wound,	F 314		

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F 314	Continued From page 71 pressure reducing devices for the chair and bed, on a turning/repositioning program, and receiving surgical wound care. The MDS also showed Resident #4 required extensive assistance with bed mobility and transfers. Physician's orders, dated 01/10/14 stated, "dry gauze and tape to lower coccyx area daily. Resident #4's current care plan, dated 01/09/14, included a problem: "Impaired skin integrity R/T [related to] new gluteal ulcer flap repair." Approaches to the problem included: ". . . Keep resident off sacral area. May be up for meals no more thatn [sic] 30 minutes at a time. Turn and reposition every 2-3 hours." A nurse's note, dated 01/24/14 at 2:00 p.m. stated, ". . . Occupational Therapist seen today. Told nurse 'resident is able to be up in chair for 45 min [minutes] two times a day now.' Resident spoke to nurse 'I would like to be able to get up for meals' . . ." Observation on 02/03/14 at 12 noon showed the resident in her room seated in a wheel chair. Observation then showed Resident #4 in her wheel chair in the dining room until 1:25 p.m.(one hour and 25 minutes) when two CNAs (#8 and #9) assisted the resident to bed and positioned her on her back. Observation showed the resident remained in bed on her back at 3:23 p.m. On 02/04/14 at 8:51 a.m. two CNAs (#6 and #11) assisted Resident #4 from her wheel chair to her bed and positioned her on her right side. Observation showed sutures intact to the sacral wound with no dressing in place.	F 314		

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F 314	Continued From page 72 On 02/04/14 at 10:00 a.m. a licensed nurse (#5) entered the room and performed a dressing change to the resident's left thigh. The nurse did not apply a dressing to Resident #4's sacral wound. Record review identified staff failed to apply a dressing to Resident #4's sacrum from January 30-February 2, 2014. On 02/04/14 at 11:55 a.m. observation showed Resident #4 in bed resting on her back. Two CNAs (#10 and #11) assisted the resident from her bed to her wheel chair then to the dining room. Resident #4 remained seated in her wheel chair until 1:42 p.m. (one hour and 53 minutes) when two CNAs (#6 and #10) assisted her back to bed and positioned her on her left side. Review of Resident #4's repositioning records from January 11 - February 5, 2014 identified staff positioned the resident on her back up to six times each day. The record also showed eight days in January and three days in February when staff failed to reposition the resident every three hours. Time frames varied from four to 11 hours without repositioning. During an interview on 02/05/14 at 2:45 p.m. an administrative nurse (#2) confirmed Resident #4 should be in the chair no longer than 45 minutes twice a day and agreed the resident's repositioning records showed long time periods without repositioning.	F 314	F 315 #1 Resident #1 & 4's catheter drain spout wiped with alcohol when contaminated & prior to being replaced in spout holder. #2 All residents with catheter drainage bags have the potential to be affected. #3 Implementation of new policy titled "Emptying a Urinary Drainage Bag". All nursing staff will be educated on the new policy. All nursing staff educated on the importance of proper emptying of urinary drainage bag, including appropriate cleansing of the drain spout should it become contaminated.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	#4 On or before April 7, 2014	

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F 315	Continued From page 73 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility procedures, and staff interview, the facility failed to ensure staff followed the correct technique when emptying urinary drainage bags for 2 of 2 sampled residents (Resident #1 and #4) with a history of urinary tract infections (UTIs). Failure to practice correct technique could result in the resident(s) developing a UTI. Findings include: Review of the facility procedure "Emptying a Urinary Drainage Bag" occurred on 02/06/14. The procedure, dated October 2010, stated, ". . . Steps in the Procedure . . . 6. Remove the drain tube from its holder. . . . After the drainage bag has emptied, close the drain. . . . Wipe the drain with an alcohol sponge or swab. . . . Replace the drain tube back into its holder. . . ." - During the initial tour of the facility, on the morning of 02/03/14, observation identified a sign outside Resident #4's room directing visitors to check with a nurse before entering the room. A licensed nurse (#5) stated Resident #4 was in "Contact Isolation" due to an antibiotic resistant UTI.	F 315	F 315 continued #5 Director of Nursing or designee will monitor compliance with new policy titled "Emptying of Urinary Drainage Bag" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 315	Continued From page 74 Resident #4's medical record, reviewed on all days of survey, revealed a urine culture and sensitivity report, dated 01/26/14, which identified two organisms. Organism #1 - Pseudomonas aeruginosa was found sensitive to two of the seven antibiotics tested, and Organism #2 - Enterobacter cloacae complex was found resistant to all eight antibiotics tested. Observation, on 02/04/14 at 1:42 p.m. showed a CNA (#6) assisted Resident #4 to bed, then donned a gown and gloves. The CNA then emptied the resident's urinary drainage bag but failed to cleanse the drain with an alcohol sponge prior to replacing it in the holder. During an interview on 02/05/14 at 2:45 p.m. an administrative nurse (#2) agreed staff should cleanse the drain tube with alcohol prior to replacing it in the holder. - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of incontinence with a history of UTIs. The quarterly MDS, dated 01/14/14, identified the resident had an indwelling catheter and required total assistance for toileting. The urine culture and sensitivity reports, dated 03/26/13, 06/07/13, 06/20/13, and 07/06/13, identified two organisms: Organism #1 -pseudomonas aeruginosa and organism #2 - escherichia coli. A clinic note, dated 07/23/13, identified, "we treated the infection of pseudomonas aeruginosa . . . We rechecked the urine . . . It came back, as still having the infection of pseudomonas aeruginosa. . . ."	F 315		

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F 315	Continued From page 75 The current care plan stated, ". . . Problem: Increased risk of UTI due to catherization . . . Approaches: . . . Change catheter every 2 weeks and PRN [as needed] due to chronic infections . . . Empty drainage bag routinely to prevent pulling on tubing and bladder spasms, Give good catheter care every shift . . . Use sterile asepsis with any catheter procedure." Observations on 02/04/14 at 9:15 a.m. and 11:50 a.m., showed a CNA (#10) donned gloves. The CNA then emptied Resident #1's urinary drainage bag but failed to cleanse the drain with an alcohol sponge prior to replacing it in the holder. During an interview on the morning of 02/06/14, an administrative nursing staff member (#3) confirmed staff should cleanse the drain tube with alcohol prior to replacing it in the holder.	F 315	F 318 #1 Resident #3 is receiving lower extremity range of motion as recommended per therapist. Resident #2's is assisted with ambulation and receives lower extremity exercises per recommendation of therapy. Resident #5 is receiving restorative nursing therapy per "staff instruction sheet".	
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interviews, the facility failed to ensure 3 of 3 sampled residents (Resident #2, #3, and #5) with limited range of	F 318	#2 All residents receiving restorative nursing therapy have the potential to be impacted by this deficiency. #3 Implementation of a policy titled "Restorative Nursing Therapy". All nursing staff will be educated on the policy. Staff educated on the necessity of including the Restorative Nursing plan in the plan of care.	

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F 318	Continued From page 76 motion (ROM) received the restorative therapy programs developed by the facility's consultant therapy staff. Failure to provide restorative therapy services as recommended did not provide the residents the opportunity to maintain their ROM, balance, strength, endurance, and mobility; and placed them at risk of increased pain. Findings include: - Review of Resident #3's medical record occurred on February 03-06, 2014. The facility admitted the resident in May 2009. Current diagnoses included dementia, joint pain, current pressure ulcer, and history of healed pressure ulcers. The resident's significant change Minimum Data Set (MDS), dated 12/29/13, identified he sometimes made himself understood and understood others, required total assistance of two or more persons for bed mobility, demonstrated impaired ROM in both lower extremities, and had a current Stage II pressure ulcer. Resident #3's Nurse's Notes stated the following: *10/30/13, 9:45 a.m. - "Orders from [health care provider (#13)] to have physical therapist see & [and] evaluate resident . . . [physical therapist] has been notified." *10/31/13, 2:00 p.m. - "Consult received from [physical therapist], evaluation has been faxed to provider (#13)." *12/24/13, 9:00 a.m. - ". . . Does have legs contracted @ [at] knees. Attempts to stretch res. [resident's] legs causes res. to yell out." 10:30 a.m. - "P.T. [Physical Therapist] here now to evaluate EZ stand. [Sit to stand transfer device] . . . Res. tight @ knees. Attempts to	F 318	F 318 continued #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Restorative Nursing Therapy" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 318	Continued From page 77 stretch out legs [with] res. stating it hurts. . . ." *12/25/13, 8:00 p.m. - ". . . Hollers out in pain when attempting to straighten legs. . . . Does hit out during peri [perineal] care et [and] hollers due to spreading of knees. . . ." Resident #3's Physical Therapy (PT) Progress Reports stated the following: *10/30/13 - "Consult orders received re: LE [lower extremity] tone . . . Tone has increased significantly since prior to hospital stay [September 20-30, 2013] in all 4 extremities & neck, left LE tone worse than right. Left LE I was able to extend to 70 [degrees] of flexion, right to 25 [degrees]. . . . Attempts of stretching aggravated [Resident #3] . . . med [medication] intervention should be followed by therapy for short term to ensure ROM progression & then daily maintenance ROM & stretch by CNA [certified nursing assistant] staff." *12/24/13 - "PT consult re: transfer . . . Resident also needs to be stretched daily as previously requested. . . ." Resident #3's current care plan, dated 12/18/13, lacked information regarding a ROM program. The medical record lacked additional information regarding a ROM or a restorative therapy program. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) confirmed the facility staff should have been providing lower extremity ROM for Resident #3 as recommended and requested by the physical therapist. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 318		

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F 318	Continued From page 78	F 318		

included hypertension, anemia, bone/cartilage disorder, osteoarthrosis, muscle weakness, and history of falls. The quarterly Minimum Data Set (MDS), dated 11/29/13, identified Resident #2 was cognitively intact and required extensive assistance for all Activities of Daily Living (ADLs) except eating. The MDS further showed Restorative Nursing services were not being provided at the time of the assessment.

The "ADL Function and Falls Care Assessment Areas (CAA)," dated 07/31/13, identified, "[Resident #2] requires limited assistance for . . . transfers . . . [Resident #2] also requires supervision for walking in room, walking in corridor, toilet use . . . She is not steady and [sic] only able to stabilize with staff assistance for balance during transition and walking. . . . Staff and resident believe she is capable of increase independence in ADL function."

The "Physical Therapy Plan of Treatment," dated 11/20/13, identified, ". . . Fall risk . . . Activity Tolerance: Poor . . . Static [Balance]: Fair, Dynamic [Balance]: Poor, Functional Endurance: Poor . . . Deviations: Flexed forward, severe fatigue . . . Summary: Client will benefit from skilled therapy services to [increase] strength [and] activity tolerance [and] restore I [independent] ambulation ability."

The "Therapy Discharge Notice," dated 11/20/13, identified, ". . . discontinued from PT [and] OT . . . Continue with assistive ambulation as tolerated, LE [lower extremity] seated ex [exercises]: marching, hip slides, kicks."

The physician order, dated 11/26/13, also stated, "Discharge PT/OT orders as client does not meet

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F 318	Continued From page 79 skilled criteria, continue with restorative to maintain current level of function." (The physician's order was written on 11/26/13; 3 months prior to the survey.) The "Staff Instruction Sheet," dated 11/26/13, identified, ". . . Please walk to bathroom [with] assist [and] FWW [front wheeled walker], Please walk to meals [with] assist as far as able [with] w/c [wheelchair] following, Supervise LE [and] UE [upper extremity] exercises daily: seated marching, leg kicks, knee pull-aparts, arm lifts. . . ." Observations throughout the survey showed facility staff made only one attempt to assist Resident #2 to the dining room using her FWW. On 02/04/14 at 11:58 a.m., a Certified Nursing Assistant (CNA) (#6) placed a gait belt around Resident #2's waist, held onto the gaitbelt with one hand and resident's wheelchair with the other, and assisted her down the hallway. The resident sat in her wheelchair after walking approximately ten-to-twelve feet, and was transported the rest of the way to the dining room. The staff failed to assist Resident #2 to the dining room three times a day. During an interview on 02/05/14 at 8:55 a.m., Resident #2 stated the facility staff had failed to provide the recommended restorative therapy program. The current care plan failed to address Resident #2's restorative therapy needs. During an interview on 02/05/14 at 12:10 p.m., a Physical Therapy staff member (#12) reported the facility no longer has dedicated staff to carry out	F 318		

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F 318	Continued From page 80 the recommended restorative therapy programs. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) confirmed they were unaware of the 11/26/13 order for Resident #2's restorative therapy program. The facility failed to develop an effective process for communicating Restorative Therapy needs within the facility, and failed to provide Restorative Therapy services to Resident #2 (as recommended by Physical Therapy) which placed her at risk of losing range of motion, balance, strength, endurance, and mobility. - An interview with Resident #5's family member (#2) occurred on 02/04/14 at 10:20 a.m. The family member expressed a concern that the resident was not receiving assistance with her exercise program. Observation of Resident #5's room occurred on 02/04/14 at 12:10 p.m. and showed the resident resting in bed. Two 8 x 11 inches sheets of paper on the bulletin board near the resident's bed (highlighted in bright yellow) stated, "[Resident #5's] Exercises." When asked, Resident #5 stated staff do not assist her to complete the exercises. Resident #5's medical record, reviewed on all days of survey, identified diagnoses including osteoporosis. The Physical Therapy Plan of Treatment, dated 12/13/13, stated, "3. Functional Goals (Short Term) Establish resistive & weight bearing exercise routine to maximize benefits from drug therapy & [and] prevent further bone loss. Outcome (Long Term) Client will be able to	F 318		

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F 318	Continued From page 81 complete daily exercises with assist . . ." A therapy "Staff Instruction Sheet," dated 12/26/13, stated, "Please assist [Resident #5] with completing her exercises daily, copy of her program is in her room along with the weights & [and] a copy is also in her chart under therapy tab. . . ." Record review showed facility staff failed assist Resident #5 to complete her therapy daily, as recommended by the Physical Therapist. The record also identified facility staff failed to develop a nursing care plan regarding Resident #5's restorative program. When interviewed, on 02/04/14 at 3:00 p.m. two administrative staff members (#2 and #4) stated staff do not document restorative therapy done for residents. On 02/05/14 at 8:50 a.m. an administrative nurse (#2) stated she found Resident #5's "Staff Instruction Sheet" on the Certified Nursing Assistants' desk that morning. The nurse stated the Physical Therapist had not written a telephone order for the therapy, so nursing staff were not aware of the recommended program. The nurse (#2) stated the facility does not have dedicated restorative staff, but CNAs do the restorative therapy under the supervision of a licensed nurse. An interview with a Physical Therapist (#12) occurred on 02/05/14 at 12:10 p.m. The therapist stated she does not write telephone orders for restorative therapy. On the morning of 02/06/14, the survey team requested several policies from administrative staff, including restorative therapy. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy	F 318		

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	355122	A. BUILDING _____ B. WING _____	02/06/2014

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F 318	Continued From page 82 manual "disappeared" and they had no policy/procedures regarding restorative therapy.	F 318	F 323	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and staff interview, the facility failed to ensure the environment remained free of accident hazards for 1 of 1 sampled resident (Resident #1) who experienced 4 episodes of entrapment in or between the side rails on his bed. Failure to evaluate the risks associated with side rail use has the potential to result in resident entrapment, injury, and/or death. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for side rail use. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared approximately six months ago" and they had no policy/procedure for side rail use. Resident #1's medical record, reviewed on all days of survey, identified diagnoses of	F 323	1. #1 Investigation completed into episodes of entrapment for Resident #1. Side rails removed from Resident #1's bed. nursing staff educated on the potential for entrapment with side rail use, the necessity of evaluating the risk of side rail use, the importance of following physician orders, and the proper completion of incident reports. Resident #1's nursing staff also educated on the importance of updating the care plan. Side rails removed from Resident #1's bed. #2 All residents with side rails have the potential to be affected by this practice. Side rails removed from all resident beds. #3 Implementation of policy titled "Side Rails". All nursing staff will be educated on policy. Implementation of policy titled "Incident Reporting". All nursing staff educated on the	

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F 323	Continued From page 83 Alzheimer's dementia, Parkinson's disorder, and dyskinesia (involuntary muscle movements). The quarterly Minimum Data Set (MDS), dated 01/14/14, identified the resident had moderately impaired cognition and required total assistance for bed mobility and transfers. The physician's order, implemented on 05/20/13 and discontinued on 08/02/13, identified, "1/4 side rail to Lt [left] side of bed, 1/2 side rail to upper and lower Rt [right] side of bed for mobility and positioning aide." The "Fall Risk and Side Rail Assessment," dated 06/23/13, identified, ". . . Partial Side rail(s) . . . are recommended at this time . . . due to mobility issues [and] positioning. . . ." The nurse's note, dated 08/05/13 at 5:50 a.m., identified, "Res [Resident] found [with] upper body [and] torso off bed [and] safety mat, res legs were still on bed. Has red indented area on lateral (L) [left] calf of leg from getting it caught in bottom rail. . . ." The facility failed to reassess Resident #1's ability to safely use side rails. The incident report, dated 08/05/13, identified, ". . . Description: . . . Res found by CNA [certified nursing assistant] [with] torso [and] upper body on safety mat [and] feet caught in bottom guard rail. Res states 'I crawled out myself' repeatedly. Hoyer lift [with] assist x's [times] 4 use to transfer res back in bed. . . . Injury: . . . No skin tears or other apparent injuries. Denies pain. Red indentation on lateral (L) calf, [no] c/o [complaints of] pain, no open areas. . . . Follow up plan: Monitor res for restlessness [and] movement in bed. Call placed to [Mental Health Clinic]. [Physician] changed resident's meds	F 323	F 323 continued potential risks for entrapment with side rail use and the importance of following physician orders, as well as the proper completion of incident reports. Side rails removed from resident beds. #4 On or before April 7, 2014. #5 Director of Nursing or designee will monitor compliance with policies titled "Side Rails" and "Incident Reporting", weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting. 2. 1 Resident #9 checks with the staff prior to leaving the facility to smoke and staff ensure he is dressed appropriately. A timer is set when	

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F 323	Continued From page 84 [medications]." The facility failed to discontinue the use of the side rails on Resident #1's bed as per the 08/02/13 physician's order; instead increasing his Seroquil. The nurse's note, dated 08/10/13 at 12:30 a.m., identified, "Yelling out - waking others. Found [with] knees bent between side rails. Had turned self over as resident was on (R) side when placed in bed [after] meds at 8:00 p.m." The facility failed to reassess Resident #1's ability to safely use side rails. The incident report, dated 08/09/13, identified, ". . . Description: . . . Alarm was going off when [checked] by CNA [and] was found on floor in [sic]fall mat. . . . Injury: . . . No noted injury [at] this time. . . . Follow up plan: Staff is now trying to use lavender aroma therapy to help calm resident." The report failed to mention the resident was "found with his knees bent between side rails." The facility failed to discontinue the use of the side rails on Resident #1's bed as per the 08/02/13 physician's order. The nurse's note, dated 10/21/13 at 3:40 p.m., identified, "Resident fell out of bed at this time. (L) knee was stuck between bed rail [and] mattress. Bruising noted to inside leg, red marks to inner [and] outer leg. Resident stated, 'I'm in pain, my leg hurts.' Will continue to monitor." The facility failed to discontinue the use of the side rails on Resident #1's bed as per the 08/02/13 physician's order. The facility failed to reassess Resident #1's ability to safely use side rails, and failed to complete an incident report; identifying what they believe precipitated the incident, how it could have been prevented, whether any equipment should have been adjusted, and/or any other	F 323	F 323 continued the resident leaves the facility in order to assure a timely return to the building. The resident is provided with a walkie-talkie to ensure the means to summon help should the need arise while he is outside smoking. Care plan updated to reflect smoking plan. #2 No other residents in the facility smoke. Smoking policy prohibits smoking by residents admitted after April 6, 2014. #3 Implementation of new policy titled "Smoking". All staff will be educated on the policy titled "Smoking". Staff educated on the importance of resident's physician addressing tobacco use, the importance of assuring resident safety while smoking and ensuring the residents ability to acquire staff assistance once resident leaves the facility to smoke. Nurse educated to	

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F 323	Continued From page 85 interventions the facility attempted in order to prevent the incident from reoccurring. The physician's order, implemented 10/21/13 and discontinued on 12/27/13, identified, "Side rails x 2 to bed for mobility, safety, and repositioning, foot side rail is not needed." The facility obtained a new order for the continued use of side rails; with the knowledge Resident #1 experienced three previous incidents of entrapment. The nurse's note, dated 11/14/13 at 5:00 p.m., identified, "Resident found on floor by CNA with neck caught in the arm rail, resident was having hard time breathing [and] wasn't able to talk. Assessment done at this time [and] nothing appears out of normal. Will monitor." The facility also failed to complete an incident report; describing the incident, identifying what they believe precipitated the incident, how it could have been prevented, whether any equipment should have been adjusted, and/or any other interventions the facility attempted in order to prevent the incident from reoccurring. The nurse's note dated 11/15/13 at 3:00 p.m., identified, "Bilat [bilateral] SR [side rails] removed from bed. Wedges in place today between bed [and] wall for cushion - fall mat on other side of bed [and] bed low to floor. Has wedge for positioning from side to side. . . ." Although the nurse's notes indicate the facility removed Resident #1's side rails on 11/15/13, the physician's order to discontinue was dated 12/27/13. The current care plan stated, ". . . Problem: High risk for falls related to cognitive impairment . . . Approaches: . . . Call light within reach, explain	F 323	F 323 continued ensure resident is dressed appropriately for weather, that a timer is set when resident leaves the facility to smoke in order to assure a timely return to the building and to ensure that resident and staff utilize a walkie talkie when resident leaves facility to smoke in order to facilitate resident acquiring staff assistance outside of building. Nurse educated on importance of updating care plan to reflect resident's smoking plan. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Smoking" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the	

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F 323	Continued From page 86 call light, Evaluate causes of falls, Mat at bedside, Resident rolls shoulders off bed and occassionall [sic] legs due to agitation/restlessness. Fall mat next ot [sic] bed. Bed low to floor. Not considered a fall, Bed alarm on and functional." During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) confirmed they were aware of all four of Resident #1's incidents of side rail entrapment. The facility failed to ensure Resident #1 received the care and services necessary to attain the highest degree of safety possible while in bed. They failed to 1) discontinue the use of the side rails on Resident #1's bed as per the 08/02/13 physician's order; instead increasing his Seroquil, 2) document the resident was "found with his knees bent between the side rails" on the 08/09/13 incident report, and 3) complete incident reports on 10/21/13 and 11/14/13; describing the incidents, identifying what they believe precipitated the incidents, how they could have been prevented the incidents, whether any equipment should have been adjusted, and/or any other interventions the facility attempted in order to prevent the incidents from reoccurring. In addition, the facility obtained a new order for the continued use of side rails on 10/21/13; with the knowledge Resident #1 experienced three previous incidents of side rail entrapment on 08/05/13, 08/09/13, and 10/21/13. The facility also failed to obtain a physician's order to discontinue the use of side rails at the time they removed the rails from Resident #1's bed on 11/15/13, and failed to care plan the use of wedges to assist with positioning/prevent futher falls. Failure to evaluate the risks associated with side rail use resulted in Resident #1's multiple	F 323	F 323 continued QA monitoring to the QA committee at each scheduled meeting. 3. 1 Resident #2 & 4 transferred while using a gait belt and avoiding lifting under the arms during the transfer process. Resident #1 transported safely and in such a manner to avoid injury while in a Broda chair or wheelchair. #2 All residents that require assistance with transfers and residents that require Broda chair or wheelchair transportation have the potential to be affected by this deficiency. #3 Implementation of policies titled "Gait Belt Use" and "Wheelchair Positioning & Transporting". All nursing staff will be educated on policy. Nursing staff educated on properly transferring a resident while	

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F 323	Continued From page 87 incidents of entrapment with injuries. 2. Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to ensure safety for 1 of 1 supplemental resident(Resident #9) who was observed smoking outdoors in sub-zero degree weather conditions without supervision. Failure of the facility to ensure safety while residents smoke placed them at risk for possible accidents and/or injury. Findings: Review of the facility policy and procedure, "Smoking Policy," occurred on 02/06/14. This undated document stated, ". . . Smoking receptacles shall be placed at . . . main entrance to the health care facility . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included hypertension, muscle spasms and/or weakness, neuropathy, and history of tobacco use. The annual Minimum Data Set (MDS), dated 01/19/14, identified Resident #9 as cognitively intact and requiring supervision whenever he moved to/returned from off-unit locations. The "Safe Smoking Assessment," dated 04/18/13, stated, "Earlier this year [Resident #9] was smoking in [a] non-designated area [and] putting cigarettes out inappropriately! Currently not doing that anymore." The assessment identified the resident was safe to smoke unsupervised. The assessment further indicated the resident had a physician's order to smoke. Resident #9's current physician's orders failed to	F 323	F 323 continued using a gait belt and avoiding lifting under the arms during the transfer process. All nursing staff educated on the importance of transporting residents safely and in such a manner to avoid injury while in a Broda chair or wheelchair. #4 On or before April 7, 2014. #5 Director of Nursing or designee will monitor compliance with policies titled "Gait Belt Use" and "Wheelchair Positioning & Transporting" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 323	Continued From page 88 address his tobacco use. Resident #9's current care plan stated, ". . . Problem: Resident at risk for injury d/t [due to] smoking . . . Approaches: . . . Educate resident to wear proper attire . . ." The current care plan did not address Resident #4's need for supervision or how he would acquire assistance from staff once he'd left the facility. Observations revealed the following: * On 02/03/14 at 8:00 a.m., Resident #9 sat on his walker, smoking alone, next to the ashtray located on the sidewalk near the main entrance to the facility. He was wearing a hooded sweatshirt, pajama bottoms, and bedroom slippers. The local radio station indicated the temperature was six degrees Farenheit. * On 02/03/14 at 2:40 p.m., Resident #9 sat on his walker, smoking alone, next to the ashtray. He was wearing an unzipped coat over his hooded sweatshirt, pajama bottoms, and bedroom slippers. * On 02/04/14 at 8:20 a.m., Resident #9 requested a cigarette from the nurse, who failed to cue him on proper attire. The resident exited the building, sat on his walker in the snow, smoking alone, next to the ashtray. He was wearing a hooded sweatshirt, pajama bottoms, and bedroom slippers. The local television station indicated the temperature was four degrees Farenheit and observation showed it was snowing outside. * On 02/04/14 at 10:26 a.m. and 12:07 p.m., and on 02/05/14 at 12:00 and 1:20 p.m., Resident #9 sat on his walker in the snow, smoking alone, next to the ashtray. He was wearing an unzipped coat over his hooded sweatshirt, pajama bottoms, and bedroom slippers.	F 323	F 323 continued 4. #1 All chemicals in bathing room placed behind locked doors. Chemical removed from windowsill in the hair care room. #2 All residents with memory loss or wandering behaviors have the potential to be affected by this deficiency. #3 Implementation of policy titled "Chemical Storage". All staff will be educated on the policy. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Chemical Storage" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator.	

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F 323	Continued From page 89 * On 02/06/14 at 7:45 a.m., Resident #9 sat on his walker, smoking alone, next to the ashtray located on the sidewalk near the main entrance to the facility. He was wearing a hooded sweatshirt, pajama bottoms, and bedroom slippers. The local radio station indicated the temperature was minus four degrees Farenheit. During interview on 02/05/14 at 9:02 a.m., when asked what he thought of the designated smoking area, Resident #9 stated, "I have my own seat [walker]." When asked how he is protected from the elements, he stated, "I have a hood on my jacket." When asked how he would acquire staff assistance if something happened after he left the facility, he stated, "I have a time limit, then they [staff] come and check on me." During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #4) stated Resident #9 currently exits the building unsupervised. They reported staff are not required to check on Resident #9 while he is smoking. They further stated the facility has considered installing security cameras, but has not done so at this point in time. The facility failed to ensure Resident #9 received the care and services necessary to attain the highest degree of safety possible while smoking outside the facility. They failed to 1) ensure Resident #9 returned to the building in a timely manner, 2) ensure Resident #9's safety in the designated smoking area; which included protecting him from weather conditions, and 3) identify how Resident #9 would acquire assistance from staff once he'd left the building. THIS IS A REPEAT CITATION FROM THE	F 323	F 323 continued If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting. 5. #1 Resident #3's chair alarm mat in place in wheelchair to minimize risk of falls and injury to resident.. #2 All residents that use chair alarms have the potential to be affected by this deficiency. #3 Implement of policy titled "Falls". All nursing staff will be educated on the new policy. Implementation of new policy titled "Care Planning". All nursing staff will be educated on care planning policy.	

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F 323	Continued From page 90 SURVEY COMPLETED ON 01/13/13. 3. Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 3 of 4 sampled residents (Resident #1, #2, and #4) requiring assistance with transfers. Failure to appropriately utilize gait belts for Resident #2 and #4 has the potential for the residents to experience falls, injuries, and/or pain. Failure to carefully transport Resident #1 in a Broda chair resulted in the resident experiencing pain and could result in an injury. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for transferring and transporting residents. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy manual "disappeared" and they had no policy/procedure for transferring or transporting residents. Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice, 9th edition, Pearson, Boston, Massachusetts, page 1158-1162 stated, "Transferring Clients: Many clients require some assistance in transferring . . . A gait belt provides the greatest safety. A gait belt is a safety device used for moving or transferring a client. . . . Even if a client is able to partially bear weight and cooperative, it still may be safer to transfer a client with the assistance of two nurses. If so, you should position yourselves on both sides of the client . . . Grasp the client's	F 323	F 323 continued Nursing staff educated on the importance of carrying out care planned fall risk approaches, including properly placing chair alarm mat to minimize risk of injury to resident. All nursing staff educated on following the plan of care regarding chair alarm use. #4 On or before April 7, 2014 #5 Director of Nursing will monitor compliance with policies titled "Falls" and "Care Planning" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 323	Continued From page 91 transfer belt with the hand closest to the client, and with the other hand support the client's elbows. . . ." - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and diabetes, neuropathy. The quarterly Minimum Data Set (MDS), dated 01/14/14, identified the resident had moderately impaired cognition and required total assistance for locomotion on the unit. The current care plan utilized by direct care staff failed to address Resident #1's use of a Broda [reclining] chair. On 02/04/14 at 8:40 a.m., a CNA (#11) transported Resident #1 down the hallway to his room using the Broda chair. The CNA (#11) misjudged the distance as she maneuvered Resident #1's chair through the doorway, running into the door, and bumping Resident #1's right foot against the frame. Resident #1's right foot was turned outward and he was wearing a blue heel protector with his toes exposed. Resident #1 grimaced, and stated "Ow" with rising intonation. The CNA (#11) pushed Resident #1 further into his room, parked his chair in front of the television, and placed the bedside table next to him. Resident #1 stated, "My foot hurts," to which the CNA (#11) responded, "Yeah, she'll [the medication nurse] get to that when she passes meds [medications]." The CNA exited the room and walked past the medication nurse on her way back to the dining room, without mentioning the incident. During an interview on 02/06/14 at 10:00 a.m.,	F 323		

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F 323	Continued From page 92 two administrative staff members (#2 and #4) agreed staff should use care when transporting residents. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included hypertension, anemia, bone/cartilage disorder, osteoarthrosis, muscle weakness, and history of falls. The quarterly MDS, dated 11/29/13, identified Resident #2 was cognitively intact and required extensive assistance for transfers and locomotion on the unit. The "ADL Function and Falls Care Assessment Areas (CAA)," dated 07/31/13, identified, "[Resident #2] requires limited assistance for . . . transfers . . . [Resident #2] also requires supervision for walking in room, walking in corridor, toilet use . . . She is not steady and [sic] only able to stabilize with staff assistance for balance during transition and walking . . ." The current care plan utilized by direct care staff failed to address Resident #2's need for limited assistance for transfers and while walking. Observations showed gait belt usage to be inconsistent; on 02/03/14 at 1:50 p.m., a CNA (#9) secured a gait belt around Resident #2's waist as the resident was ambulating towards her bed, on 02/04/14 at 11:58 a.m., a CNA (#6) placed a gait belt around Resident #2's waist prior to assisting her with ambulation, and on 02/04/14 at 1:15 p.m., a CNA (#10) held onto the back of Resident #2's pants as she ambulated into the bathroom, with a gait belt looped around the front of her walker. During an interview on 02/06/14 at 10:00 a.m.,	F 323		

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F 323	Continued From page 93 two administrative staff members (#2 and #4) stated they expected staff to use gait belts when transferring residents. - Review of Resident #4's medical record occurred on all days of survey. An admission MDS, dated 01/16/14, identified the resident required extensive assistance with transfers. Record review failed to identify a care plan regarding transfers for Resident #4. Observation on 02/03/14 at 1:25 p.m. showed two Certified Nursing Assistants (CNAs) (#8 and #9) transferred Resident #4 from her chair to the bed utilizing a gait belt. Observation showed one CNA (#9) held the gait belt and the other CNA (#8) held Resident #4 under her arm during the transfer. On 02/04/14 at 8:51 a.m. two CNAs (#6 and #11) assisted Resident #4 to transfer from her chair to the bed utilizing a gait belt. Both CNAs held the gait belt, but also held the resident under her arms during the transfer. Observation on 02/04/14 at 11:55 a.m. showed two CNAs (#10 and #11) assisted Resident #4 from her bed to the chair utilizing a gait belt. Both CNAs held the gait belt but one CNA (#11) also held the resident by her arm during the transfer. 4. Based on observation and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 1 of 1 resident care unit storing chemicals on 3 of 4 days of survey (February 3-5, 2014). Failure to secure hazardous chemicals placed residents with memory loss and/or wandering behaviors at risk of exposure to those chemicals.	F 323		

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F 323	Continued From page 94 Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedure for chemical storage. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared approximately six months ago" and they had no policy/procedure for chemical storage. On 02/03/14 at 3:25 p.m., 02/04/14 at 9:05 a.m., and 02/05/14 at 8:15 a.m., observations of the environment revealed the following: * On the floor of an unlocked closet in the bathing room: 1 container of Claire Citrus Blast Air Freshener 1 container of Lysol Disinfectant Spray 2 containers of Mastercare Disinfectant Cleaner 3 containers of Hepacide Quat II * On the windowsill of the haircare room: 1 container of Lysol Disinfectant Spray The product labels stated the following: * Claire Citrus Blast Air Freshener: ". . . concentrating and inhaling the product can be harmful or fatal. Prolonged inhalation may be harmful. . . . Harmful if absorbed through the skin . . . skin irritation and dermatitis (rash) . . . prolonged skin contact may cause allergic reactions . . . Contact with eyes may cause irritation. . . ." * Lysol Disinfectant Spray: ". . . Causes moderate eye irritation. Prolonged or repeated skin contact may result in slight to moderate skin irritation. Contains denatured alcohol; ingestion may result in ethanol poisoning . . ."	F 323		

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F 323	Continued From page 95 * Mastercare Disinfectant Cleaner: ". . . corrosive, causes irreversible eye damage and skin burns . . . harmful if absorbed through skin . . . harmful if swallowed. . . ." * Hepacide Quat II: ". . . Causes moderate eye irritation. Harmful if absorbed through the skin. May be harmful if swallowed. Inhalation of product mist may cause respiratory irritation. . . ." During an interview on 02/05/14 at 8:15 a.m., a managerial maintenance staff member (#17) confirmed he expected chemicals to be kept locked and out of reach of the residents. 5. Based on observation, record review, and staff interview, the facility failed to ensure adequate supervision and use of assistance devices to prevent accidents for 1 of 2 sampled residents (Resident #3) with chair alarms. Failure to ensure facility staff applied a chair alarm on the resident's wheelchair to make staff aware the resident may be attempting to rise from the chair placed the resident at increased risk of falls and injuries. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedures for fall prevention. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated their policy manual "disappeared" approximately six months ago and they had no policy/procedures for preventing resident falls. Review of Resident #3's medical record occurred on February 03-06, 2014. Current diagnoses included dementia, and joint pain. The significant change Minimum Data Set (MDS), dated	F 323		

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F 323	Continued From page 96 12/29/13, identified the resident sometimes made himself understood and understood others, demonstrated physical and verbal behaviors four to six days during the seven day assessment period, required total assistance of two persons for transfers, did not ambulate, and experienced one fall with an injury since the previous MDS, dated 10/04/13. Resident #3's Falls Care Area Assessment (CAA), dated 12/29/13, stated ". . . had one fall since prior assessment, which resulted in a skin tear. . . . received an antianxiety medication seven out of the last seven days. . . . has a diagnosis of dementia with behavior disturbance. . . . will care plan." The CAA failed to identify fall prevention measures. Resident #3's current care plan, dated 12/18/13, stated "Problem . . . High risk for falls related to cognitive impairments and immobility and poor balance. . . . Approach . . . Chair & [and] bed alarms as indicated. . . ." Resident #3's Nurse's Notes stated the following: *06/25/13, 7:50 p.m. - "Res. [Resident] tried getting out of his wc [wheelchair] & ended up on his knees on the foot rest. He had his hands on the couch. . . ." *11/05/13, 8:45 p.m. - "Resident was found kneeling on knees in front of w/c at this time. Noted a 1 cm [centimeter] x [by] 2 cm skin tear on left knuckle pinkie [fifth finger]. Area [with] moderate amount of blood noted on floor. No pain noted. . . ." The Nurse's Notes for these falls lacked information regarding the presence of a chair alarm on the resident's wheelchair.	F 323		

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F 323	Continued From page 97 Resident #3's Incident Reports for the above falls stated the following: *06/25/13, 7:50 p.m. - ". . . Alarms . . . No . . . Plan: Double check to make sure chair alarm is on. Make frequent checks. . . ." *11/05/13, 8:45 p.m. - ". . . Alarms . . . No . . . Plan: When resident is in geri [geriatric] [wheel] chair and not eating the chair should be reclined. . . ." Observation on February 03-06, 2014 identified the facility staff transferred Resident #3 to a geriatric wheelchair, at various times, and failed to apply a chair alarm. Observation showed the resident seated in the wheelchair without a chair alarm attended in the dining room and unattended in the lounge. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) confirmed facility staff should have applied an alarm to the geriatric wheelchair when Resident #3 was seated in the chair. Resident #3 had a history of falls and the facility staff failed to use chair alarms in the past. Failure to apply the chair alarm limited the staff's ability to respond to Resident #3's attempts to stand from the chair and placed him at risk of injury.	F 323	F 327 #1 Resident #1, 3, & 6 offered fluids with cares and between meals. #2 All that are dependent on staff to access fluids and those residents with altered fluid consistency have the potential to be affected by this deficiency. #3 Implementation of a policy titled "Nutrition & Hydration". All nursing staff will be educated on the policy. All nursing staff educated to offer fluids to residents during cares and between meals, particularly those residents that are dependent on staff to access fluids and those residents with altered fluid consistency.	
F 327 SS=D	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	F 327	#4 On or before April 7, 2014	

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F 327	Continued From page 98 by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure 3 of 3 sampled residents (Resident #1, #3, and #6) who were dependent on staff to access fluids received fluids during cares. Failure to offer fluids to dependent residents who are at risk of dehydration placed these residents at greater risk of dehydration, pressure sores, and weight loss. Findings include: On the morning of 02/06/14, the survey team requested several policies from administrative staff, including the policy/procedures for providing fluids to residents. On 02/06/14 at 8:40 a.m., two administrative nurses (#2 and #3) stated, approximately six months ago, their policy manual "disappeared" and they had no policy/procedures for dehydration. Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, page 137 and the educational handouts identified, ". . . For patients with mechanical problems in the oral phase . . . thickened liquids . . . are often the easiest to swallow. . . . One of the most difficult challenges when working with patients is getting them to take enough thickened liquids to meet their fluid needs. . . ." - Review of Resident #3's medical record occurred on February 03-06, 2014. Current diagnoses included dementia, dysphagia, history of pressure ulcers, and a current Stage II pressure ulcer. The significant change Minimum Data Set (MDS), dated 12/29/13, identified the resident required extensive assistance of one	F 327	F 327 continued #5 Director of Nursing or designee will monitor compliance with policy titled "Nutrition & Hydration" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 327	Continued From page 99 person for eating, received a mechanically altered diet, experienced a non-prescribed weight loss, demonstrated no difficulty swallowing, and had one Stage II pressure ulcer. The quarterly MDS, dated 10/04/13, identified the resident demonstrated difficulty swallowing and the resident did not receive a mechanically altered diet. Resident #3's Nutrition Care Area Assessment (CAA), dated 12/29/13, stated ". . . Weight decreased 1.4% in 1 month and had a significant weight loss in 6 months with 11%. . . . Average fluid intake 1287 cc [cubic centimeters]/day. Receives mechanical soft diet . . ." Resident #3's Dietary Progress Notes, dated 01/14/14, stated ". . . Est. [Estimated] needs . . . [approximately] 1800-1900 cc/d [day] . . . Assessed needs are offered. . . ." Resident #3's current care plan, dated 12/18/13, stated "Problem, Nutritional Status, Triggered as a nutritional risk . . . Approach . . . Encourage fluid intake as needed."; and, "Problem, Urinary Incontinence, Functional incontinence related to cognitive impairment . . . Approach . . . Offer fluids between meals and HS [bedtime]. . . ." Observation identified the facility staff provided Resident #3 with cares and failed to offer fluids to the resident as follows: *02/03/14, 2:45 p.m. - A certified nursing assistant (CNA) (#15) provided the resident a candy bar. 2:55 p.m. - A licensed nurse (#3) repositioned the resident in his geriatric wheelchair. 3:40 p.m. - A CNA (#15) offered to transfer the resident from his geriatric wheelchair to his bed and the resident declined. Two CNAs (#15) and (#16) repositioned the resident in his geriatric	F 327		

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F 327	Continued From page 100 wheelchair. *02/04/14, 9:25 a.m. to 12:20 p.m. - Resident #3 remained in bed. Facility staff failed to offer fluids to the resident. *02/05/14, 9:00 a.m. to 10:40 a.m. - CNAs (#6) and (#14) transferred the resident from his bed to the shower chair and returned him to his bed. CNA (#6) prepared the resident for his shower. A licensed nurse (#5) completed a dressing change to the resident's Stage II pressure sore. CNAs (#6) and (#14) transferred the resident from his bed to his geriatric wheelchair. Resident #3's Nutrition CAA and Dietary Progress Notes identified the resident's average daily fluid intake is approximately 500 to 600 cc less than his estimated needs. Failure to offer fluids to Resident #3 between meals and during cares placed the resident at risk of dehydration, additional weight loss, and delayed healing of his Stage II pressure sore. - Resident #6's medical record, reviewed on February 5-6, 2014, identified diagnoses of Alzheimer's dementia, cerebral degeneration, lack of coordination, and weakness. The quarterly MDS, dated 01/07/14, identified the resident had severely impaired cognition and required extensive-to-total assistance for all ADLs. The Nutrition CAA, dated 07/07/13, identified, ". . . Need extensive or total assist with meals. . . ." The clinic note, dated 11/05/13, identified, ". . . there is probably some element of dehydrations [sic]. He does not drink a lot of fluids, so I think if we could increase fluid intake that would help . . ." The physician's order, dated 11/05/13, identified,	F 327		

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F 327	Continued From page 101 ". . . Push fluids when awake . . ." The current care plan stated, ". . . Problem: Risk for imbalanced fluid volume (dehydration) R/T [related to] poor food/fluid intake and diuretic medication . . . Approaches: . . . Push fluids when resident is awake. . . . Problem: Resident is limited in ability to maintain grooming/personal hygiene R/T [related to] decline in physical status secondary to advancing Alzheimer's Dementia . . . Approaches: . . . Assist as needed with hand over hand cueing or dining assistance . . . encourage oral intake of . . . fluids . . ." Observations showed the following: * 02/03/14 at 1:50 p.m., after providing toileting cares, two CNAs (#4 and #6) adjusted Resident #6's clothing, repositioned him, washed their hands, lowered his bed, placed a fall mat, and exited his room. The CNAs (#4 and #6) failed to offer Resident #6 fluids while providing cares. - Resident #1's medical record, reviewed on all days of survey, identified diagnoses of Alzheimer's dementia, Parkinson's disorder, and dysphagia. The quarterly MDS, dated 01/14/14, identified the resident had moderately impaired cognition, required limited assistance for eating, and had a mechanically altered diet. The physician's order, dated 04/16/13, identified, ". . . Liquids: Honey Thickened with ice chips for quality of life . . ." The "Speech Therapy Plan of Treatment for Dysphagia," dated 01/31/14, identified, ". . . Swallow eval [evaluation] complete may upgrade liquids to nectar thick . . . Supervision for all Meals/Snacks. . . ."	F 327		

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F 327	Continued From page 102 The current care plan stated, ". . . Problem: Resident is at nutritional risk d/t [due to] impaired swallowing . . . Approaches: . . . Thin liquids up for 30 minutes after meals . . ." Observations showed the following: * 02/04/14 at 9:15 a.m., after transferring Resident #1 into bed, two CNAs (#10 and #11) repositioned him, provided toileting cares, covered him with a blanket, lowered his bed, placed a fall mat, washed/sanitized their hands, and exited his room. The CNAs (#10 and #11) failed to offer Resident #1 fluids while providing cares. * 02/04/14 at 11:50 a.m., after repositioning Resident #1, two CNAs (#6 and #10) transferred him into his Broda [reclining] chair, provided toileting cares, and washed their hands. The CNAs (#6 and #10) failed to offer Resident #1 fluids while providing cares. * 02/04/14 at 1:50 p.m., after transferring Resident #1 into bed, two CNAs (#6 and #10) repositioned him, lowered his bed, placed a fall mat, and exited his room. The CNAs (#6 and #10) failed to offer Resident #1 fluids while providing cares. During an interview on 02/06/14 at 10:00 a.m., two administrative staff members (#2 and #40 agreed staff should offer fluids while providing cares. The observations during survey demonstrated facility staff failed to offer fluids to Resident #1, #3, and #6 while providing cares, placing the residents at an increased risk for dehydration.	F 327	F 356 #1 Staffing information posted at the beginning of each shift. #2 All nurses educated on the requirement to post staffing information at the beginning of each shift. #3 Implementation of a policy titled "Posting of Nurse Staffing". All nurses will be educated on the policy. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Posting of Nurse Staffing" weekly x4 and monthly x2. Results will be immediately communicated to the Director of Nursing or	
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=B	Continued From page 103 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the actual hours worked per shift by registered nurses (RNs), licensed practical nurses (LPNs), and certified nurse aides	F 356	F 356 continued Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	

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	355122	A. BUILDING _____ B. WING _____	02/06/2014

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F 356	Continued From page 104 (CNAs) directly responsible for resident care at the beginning of each shift during 3 of 4 days of survey (February 4-6, 2014). Findings include: Observations on 02/04/13 at 9:05 a.m., on 02/5/14 at 8:15 a.m, and the morning of 02/06/14, showed the posting of staff directly responsible for resident care in a display case near the nurses' station. The posting of staff identified the total number of staff and the actual hours worked for the morning, evening, and night shifts. The facility failed to post staffing information at the beginning of each shift (days, evenings, and nights). During an interview on 02/05/14 at 1:43 p.m., an administrative nurse (#3) reported, "The night nurse fills it [the posting of staff] out off of the schedule. I don't think anyone is updating the posting if changes occur." She confirmed the posting of staff should be completed each day at the beginning of each shift.	F 356	F 441 #1 Glucometer cleaned and hand hygiene performed after nurse obtains Resident #5's finger stick blood glucose level. #2 All residents that require finger stick glucose monitoring have the potential to be affected by this deficiency. Glucometer cleaned after each resident use. Hand hygiene performed by staff after completing finger stick monitoring of resident's glucose level. #3 Implementation of new policy titled "Cleaning of Glucometers". All nurses will be educated on the policy. Implementation of policy titled "Hand Hygiene". All staff will be educated on the policy. All nurses instructed to clean glucometer after each resident, and the importance of completing hand hygiene after finger stick glucose testing.	
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	F 441		

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F 441	Continued From page 105 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 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: Based on observation, record review, review of facility procedures, and staff interview, the facility failed to ensure staff followed appropriate infection control practices during 1 of 1 observation of blood glucose testing (Resident #5). Failure to follow appropriate infection control practices placed residents and staff at risk for acquiring an infection. Findings include:	F 441	F 441 continued #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policies titled "Cleaning of Glucometers" and "Hand Hygiene" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 441	Continued From page 106 Review of the facility procedure "Cleaning Glucometers" occurred on 02/05/14. The procedure, dated 01/05/14, stated, "Glucometer Cleaning Protocol - 1. Take Sani-Cloth Plus with glucometer into resident's room. 2. Take resident's blood sugar, remove gloves. 3. Put on clean gloves. 4. Clean glucometer. 5. Place glucometer on a clean paper towel. 6. Remove gloves and wash your hands. 7. Pick up glucometer and exit room." Review of the facility procedure "Hand Hygiene" occurred on 02/05/14. The procedure, dated 03/26/10, stated, "Hand hygiene is the primary means of preventing the transmission of infection. . . . Hand hygiene is required in these situations: . . . 4. Before and after performing any invasive procedure (e.g. [such as] finger stick blood sampling) . . ." On 02/04/14 at 12:18 p.m. observation showed a licensed nurse (#5) obtained a blood glucose monitor and entered Resident #5's room. The nurse donned gloves, and obtained a blood sample for the glucose monitor via finger stick. After obtaining the results, the nurse (#5) placed the glucose monitor on the resident's bed. Without removing her gloves or cleaning the monitor, the nurse picked up the monitor and left the resident's room. She then entered the medication room, removed her gloves, and without cleaning the monitor, placed it in a tray on the medication room counter. Without performing hand hygiene, the nurse (#5) then left the medication room, walked down the hall, informed a staff member she was going to lunch, and left the unit.	F 441		

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F 441	Continued From page 107 During an interview, on 02/05/14 at 3:00 p.m. an administrative nurse (#2) stated the nurse (#5) should have brought a Sani-Cloth to Resident #5's to clean the glucose monitor in the room. The nurse (#2) stated the nurse (#5) also should have removed her gloves and performed hand hygiene before leaving Resident #5's room.	F 441	F 514 #1 Resident #8 is no longer in the facility. Resident #13 is no longer in the facility.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 1 discharged resident (Resident #8) and 1 of 1 supplemental resident (Resident #13) had a complete medical record. Failure to ensure a complete medical record does not allow staff and/or providers to have access to all information necessary to provide care and treatment for the residents. Findings include:	F 514	#2 Any resident that experiences a change in condition including but not limited to an unresponsive episode has the potential to be affected by this practice. #3 Implementation of policy titled "Assessment of Resident and Notification of Physician and Responsible Party Regarding Resident Change in Condition". All nurses will be educated on the policy. All nurses educated on necessity of completing an assessment including obtaining vital signs, and appropriately documenting residents change in condition, including signs and symptoms displayed by resident, and	

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F 514	Continued From page 108 - Resident #8's closed medical record, reviewed on February 5-6, 2014, identified diagnoses including congestive heart failure, chronic obstructive pulmonary disease (COPD), and atrial fibrillation. The resident's nurse's notes identified the following: * 07/30/14 at 9:00 p.m.: "late entry - Res [resident] stated he feels like his abdomen is larger in size than previous. Requesting to have weight checked in AM [morning]. The nurse's notes lacked evidence staff obtained the weight and lacked any further assessment, vital signs, or documentation of any kind for the next seven days. *08/06/13 at 9:00 p.m.: "Resident transferred via ambulance to [hospital name] @ 2046 [8:46 p.m.] per [physician's name] order, also ordered 4L02 [4 liters oxygen] to be administered. VS [vital signs] 127/62 [blood pressure], 95.6 [temperature]; 92% [oxygen saturation], 95 HR [heart rate]. Resident was cool, clamy [sic], weak & [and] shaking, which got progressivly [sic] worse. Heart sounds were faint & not easily audible due to lung sounds being loud crackles & wheezes. (L) [left] lobe was raspy & crackles were present on inspiratory & expiratory. (R) [right] lobe was less audible. Resident's family has been notified." * 08/07/13 at 12:45 a.m.: "[Hospital name] admitted resident due to 'pneumonitis & COPD exacerbation' per ER [emergency room] nurse. . . ." The record lacked evidence of vital signs, assessments, signs and symptom displayed by the resident, or interventions implemented by staff in the hours/days just prior to his hospital	F 514	F 514 continued interventions implemented, for any change in resident condition including, but not limited to an unresponsive episode. #4 On or before April 7, 2014 #5 Director of Nursing or designee will monitor compliance with policy titled "Assessment of Resident and Notification of Physician and Responsible Party Regarding Resident Change in Condition" weekly x4 and monthly x11. Results will be immediately communicated to the Director of Nursing or Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the QA monitoring to the QA committee at each scheduled meeting.	

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F 514	Continued From page 109 admission. A practitioner's progress note, dated 09/04/13, stated, ". . . He states he has not been feeling well for about a week. Nursing staff states he is down about eleven pounds since last week. He states he is really nauseated. He just has a generalized aching sensation to her [sic] stomach. . . . He is on fluid restrictions, is given a 1500 fluid allowance, but he is not drinking even close to that amount . . . Does complain of generalized abdominal pain. denies any bloating. does complain of some nausea. He states he also has been vomiting, but nursing staff has not witnessed any episodes. . . . It appears that he is somewhat dehydrated. . . ." Resident #8's nurse's notes identified the following: * 09/05/03 at 1:20 a.m.: "Resident had a large brown emesis and large loose, liquid stool at this time. T [temperature] - 96.6. Denies pain. Resident has refused all meals since yesterday 09/04/13. HOB [head of bed] [elevated] @ [at] 30 [degrees] and emesis basin at bedside. Will continue to monitor." The record lacked evidence staff assessed the resident or performed any further monitoring for the next 34 hours. * 09/06/13 at 10:00 a.m.: "Patient over at clinic & they state they need to send him to [hospital name] ER. . . ." The record lacked evidence of assessments by staff and/or any signs/symptoms displayed by the resident in the hours just prior his appointment at the clinic and his admission to the hospital. Information provided by an administrative nurse (#3) identified the resident's diagnosis on admission to the hospital was acute renal failure.	F 514		

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F 514	Continued From page 110 During an interview on the morning of 02/06/14, administrative staff members (#2 and #3) were asked to provide any additional information available regarding the above hospital admissions. The staff members provided no further information. - Review of Resident #13's closed medical record occurred on February 05-06, 2014. The resident experienced an unresponsive apparent hypoglycemic episode in the facility dining room on 10/23/13. (Refer to F309, Base 3.) Resident #3's medical record included Nurse's Notes, from 10/21/13 to 10/27/13. These Nurse's Notes and the remainder of the medical record lacked information regarding this episode. During interview, on 02/06/14 at 9:30 a.m., two administrative staff members (#2) and (#4) confirmed the facility staff failed to document Resident #13's unresponsive episode in the medical record.	F 514		