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 _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHARDTON HEALTH CENTER INC	8885 HIGHWAY 10 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 January 31, 2017 and completed on February 2, 2017, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		3/9/17

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

Electronically Signed | 03/01/2017

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEYS COMPLETED ON 03/03/16, 04/01/15, AND 02/06/14. Based on record review and staff interview, the facility failed to ensure timely notification of the physician for 1 of 9 sampled residents (Resident #8) who experienced a significant event. Failure to notify the residents' physician of a choking incident limited the physician from providing appropriate care and may result in adverse consequences, affecting the resident's quality of life. Findings included:	F 157	F Tag 157 - 483.10(g)(14) Notification of Changes 1. We cannot notify the physician/provider in a timely manner related to the amount of time that has lapsed since the significant event. 2. All residents have the potential for the physician/provider not to be notified of a significant event. 3. All nurses including newly hired and agency nurses will be educated related to timely notification of physician/provider concerning significant events. Nurses will	

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F 157	Continued From page 2 Review of Resident #8's medical record occurred on 02/02/17. Diagnoses included dementia with behavioral disturbances. Resident #8's progress notes identified on 11/15/16 at 12:30 p.m., the resident choked on her food and was "still moving air but airway was restricted by food. I coached her through coughing and relaxing and food bolus of meat came out. She recovered well and voiced that this scared her. Small amount of vomit came with food bolus. . . ." The note lacked evidence facility staff notified Resident #8's medical provider (physician or nurse practitioner) of the choking incident. During interview on 02/02/17 at 2:15 p.m., an administrative staff member (#1) confirmed the medical record lacked evidence the nursing staff notified the physician of this event.	F 157	sign off on the educational materials as read and understanding the requirements of the regulation to avoid deficient practice. All education for nursing staff was completed on February 24th. Yes, education completed before compliance date of March 9th 2017. 4. The DON or designee will monitor compliance of notification of the physician/provider in a timely manner of any significant event. QA started 2.3.2017 and monitoring will be completed as each significant event occurs for ninety (90) days. If any concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue for an additional ninety (90) days to ensure deficient practice has been corrected. The clinical interdisciplinary team will meet weekly and review compliance monitoring to review any concerns noted to ensure the deficient practice has been corrected. The DON or designee will submit a report of the QA monitoring and review to the QAPI committee at each scheduled monthly meeting for further action, if necessary. QAPI committee will continue to review compliance at each scheduled monthly meeting for six (6) months and then randomly review for three (3) months to ensure substantial compliance continues. 5. Date of completion for deficiency correction is March 9,2017.	

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F 164 SS=E	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) 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. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative	F 164		3/9/17

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F 164	Continued From page 4 proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure confidentiality of medical records in 1 of 1 occupational therapy (OT)/physical therapy (PT) room and 1 of 1 restorative therapy (RT) room. Failure to secure medical records is a violation of the residents' privacy. Findings include: Review of facility policy titled "Confidentiality of Information" occurred on 02/01/17. This policy, revised December 2006, stated, ". . . The facility will safeguard all resident records . . . to protect the confidentiality of the information. . . . Access to resident medical records will be limited to the staff and consultants providing services to the resident. . . ." During an interview on the morning of 01/31/17, when asked if the therapy records are computerized or handwritten, a Certified Nursing Assistant/Restorative Aide (CNA/RT) (#16) indicated RT staff store a binder containing "charting" [handwritten progress notes] on each resident currently receiving RT services in the top left drawer of the desk in the RT room. She further indicated OT/PT staff store another binder containing the "minutes" of service received by each resident currently receiving OT/PT services	F 164	F Tag 164 - 483.10; 483.70 Personal Privacy/Confidentiality of Records 1. Corrective action of securing medical records was implemented by installing self-closing/locking doors on one occupational therapy (OT)/physical therapy (PT) room and one restorative therapy (RT) room as of February 3, 2017. 2. All residents have the potential for medical records to not be secured. 3. All employees including contracted PT/OT/ST employees will be educated related to privacy and confidentiality of medical records. All employees, including contracted therapy employees, will sign off on education materials as read and understanding the requirements of the regulation to avoid deficient practice. Education was completed on 2.24.17. 4. The DON or designee will monitor compliance of securing medical records, starting on 2.3.17, of one occupational therapy (OT)/physical therapy (PT) room and one restorative therapy (RT) room by checking for locked doors three (3) times	

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F 164	Continued From page 5 in the top right drawer of the desk in the OT/PT room. When asked if the facility locks the doors to the OT/PT and RT rooms when staff are not present, the CNA/RT (#16) reported the doors remain "unlocked in the evenings and over night." Observations immediately following the interview, on the morning or 01/31/17, showed the binder containing RT notes on top of the desk in the RT room. Observations on 02/01/17 at 7:27 a.m. and approximately 7:50 a.m., showed the doors to the OT/PT and RT rooms unlocked. Two OT reports were found lying face-up on the desk in the OT/PT room. During an interview on 02/01/17 at approximately 8:00 a.m., an administrative nurse (#1) and administrative maintenance staff member (#15) indicated they were unaware the doors to the OT/PT and RT rooms remained unlocked and anyone who entered either of those rooms could access the therapy records.	F 164	per day every day for fourteen (14) consecutive days, then monitor one (1) time per day for fourteen consecutive days, then monitor three (3) times per week for two (2) weeks, then monitor randomly for four (4) weeks. If concerns are identified immediate corrective action will be implemented. If no concerns are noted, then random monitoring will continue for a minimum of ten (10) times for two (2) more months to ensure deficient practice is corrected. The clinical interdisciplinary team will meet weekly to review compliance monitoring to ensure deficiency is corrected. The DON or designee will submit a report of QA monitoring and review to the QAPI committee at each scheduled monthly meeting for further action, if necessary. QAPI committee will continue to review compliance at each scheduled monthly meeting for six (6) months and then randomly review monthly to ensure substantial compliance continues. 5. Date of completion for deficiency correction is March 9, 2017.	
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 203		3/9/17

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F 203	Continued From page 6 facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or	F 203		

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F 203	Continued From page 7 (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 203		

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F 203	Continued From page 8 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to notify the resident and/or resident's family/legal representative, in writing, of a transfer, including the destination and the reason for the transfer, and the resident's right to appeal the action for 2 of 2 sampled residents (Residents #4 and #10) transferred to the hospital after November 28, 2016. Failure to provide a notice of transfer or discharge does not allow the resident to make an informed choice regarding their rights. Findings include:	F 203	F Tag 203 - 483.15 Notice Requirements Before Transfer/Discharge 1. We cannot retroactively notify, in writing, Resident #4 or her representative of transfer to hospital. We cannot notify Resident #10 or her representative of transfer to the hospital as the resident no longer resides in our facility. 2. All residents and their representatives have the potential not to be notified, in	

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F 203	Continued From page 9 Review of facility "Transfer/Discharge Policy" occurred on 02/02/17. The policy, dated 11/16, stated: "1. Nursing is to initiate and complete Transfer or Discharge Information on Notice of Transfer or Discharge form. - including discharge location, date and reason. 2. Business office manager or designee is to complete the Right to Appeal, Right of Representation and Persons Notified in Writing information sections of Notice of Transfer or Discharge form. - including a copy sent to the Office of the State Long-Term Care Ombudsman." - Review of Resident #4's medical record occurred on all days of survey. An emergent transfer to the emergency room occurred on 01/15/17 which resulted in admission to the hospital on 01/15/17. The medical record lacked evidence the facility provided the resident or the resident's representative a written notice of transfer or discharge. - Review of Resident #10's medical record occurred on 02/01/17. The record included a "NOTICE OF TRANSFER FOR HOSPITALIZATION" which lacked information on who the facility provided the notice. The facility left page 2 of the form blank which included the "Persons Notified in Writing." The form identified the persons to notify as "(Resident), (Resident Representative) and (Facility Representative Who Completed Form.	F 203	writing, of a transfer to the hospital. 3. All nurses including newly hired and agency nurses will be educated related to the requirements of written notification to residents and/or their representative of a transfer to the hospital. Nurses will sign off on the education materials as being read and understanding the requirements of the regulation to avoid deficient practice. Education was completed on 2.24.17. 4. The Business Office Manager or designee will monitor compliance, starting on 2.3.17, of notification in writing to the resident and/or representative at the time of each transfer to the hospital for ninety (90) days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, random compliance monitoring will continue for an additional ninety (90) days to ensure deficient practice is corrected. The clinical interdisciplinary team will meet weekly and review compliance monitoring to review any concerns to ensure the deficient practice has been corrected. The Business Office Manager will submit a report of the QA monitoring to the QAPI committee at each scheduled monthly meeting for six (6) months and then randomly for three (3) to ensure substantial compliance continues and for further action, if necessary. 5. Date of completion for correction of deficiency is March 9, 2017.	

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F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(3) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy, and staff interview, the facility failed to provide a bed-hold notice upon transfer for 3 of 3 sampled	F 205	F Tag 205 483.15 Notice of Bed-Hold Policy Before/Upon Transfer	3/9/17

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F 205	Continued From page 11 residents (Resident #3, #4, and #10) transferred for hospitalization. Failure to provide a transferred resident the option of a complete bed hold notice does not allow the resident to make an informed choice regarding their rights. Findings include: Review of the facility policy titled "BED HOLD" occurred on 02/02/17. The policy, undated, stated: "Hospitalization - When transferred to an acute care hospital, the facility will keep a * Medicaid resident's bed available for 15 days. . . . * A Private pay resident's bed will be held as long as resident/responsible party agrees to pay for the bed hold. . . . Therapeutic Leave . . . Residents must notify the Facility prior to therapeutic leave whether they desire to have the bed held. . . . For Private Pay or Medicare A stay residents In case of an emergency transfer to an acute care hospital, the facility will contact the primary contact person . . . * You may choose to have the residents bed held and will be responsible for the charges . . . * Within 24 hours of notification of Transfer, you must let the Facility know that you do NOT want the bed held. If no response is given, the bed will be held for the number of days allotted to those on Medicaid and the responsible party will be charged for these days. . . ." Review of the facility's "BED HOLD SIGNATURE FORM" occurred on 02/02/17. The resident, family member, or legal representative was asked to specify:	F 205	1. A bed hold notice with the choice to specify the duration of the bed hold cannot be issued for Resident #3 as the resident has returned from the hospital. A bed hold notice with the choice to specify the duration of the bed hold cannot be issued for Resident #4 as the resident has returned from the hospital. A bed hold notice with the choice to specify the duration of the bed hold cannot be issued for Resident #10 as the resident no longer resides in our facility. 2. All residents have the potential to not be provided a bed hold notice with the choice to specify the duration of the bed hold. 3. All nurses including newly hired nurses, agency nurses, Business Office Manager and designee will be educated/reeducated related to providing a resident and/or representative a bed hold notice with the choice to specify the duration of the bed hold. All nurses, Business Office Manager and designee will sign off on educational material as being read and understanding the importance of compliance with regulations to ensure deficient practice is corrected. Education was completed on 2.24.17. 4. The Business Office Manager or designee will monitor compliance of bed holds being offered to residents and/or representatives with the choice to specify the duration of the bed hold for each occurrence of bed hold eligibility for ninety	

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F 205	Continued From page 12 * "I request to have the bed held" or "I do not wish to have my bed held" * "Reason for Bed Hold" as either "Hospitalization" or "Therapeutic Leave" * "Date of Hospitalization" or "start and return Date(s) of Therapeutic Leave" * "Person(s) Notified" including the "Signature of the Resident or Family Member/Legal Representative and Date" and the "Signature of Staff personnel completing this form and Date." The form lacked the option of the resident or resident representative to specify the number of days for the bed hold. - Review of Resident #3's medical record occurred on all days of survey. Hospitalization to an acute care hospital occurred on 05/25/16. The form provided for the bed hold notice lacked the choice for the resident or the resident's representative to specify the duration of the bed-hold. - Review of Resident #4's medical record occurred on all days of survey. Hospitalization to an acute care hospital occurred on 01/15/17. The form provided for the bed hold notice lacked the choice for the resident or the resident's representative to specify the duration of the bed-hold. - Review of Resident #10's medical record occurred on 02/01/17. Hospitalization occurred on 01/05/17. The form provided for the bed hold notice lacked the choice for the resident or the resident's representative to specify the duration of the bed-hold. During an interview on 02/02/17 at 2:00 p.m., an	F 205	(90) days to ensure deficient practice is corrected. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue for an additional ninety (90) days to ensure deficient practice is corrected. The clinical interdisciplinary team will meet weekly and review compliance monitoring to review any concerns to ensure the deficient practice is corrected. The Business Office Manager or designee will submit a report of the QA monitoring to the QAPI committee at each scheduled monthly meeting for six (6) months and then randomly for three (3) months to ensure substantial compliance continues and for further action, if necessary.QA will be completed in nine (9) months. 5. Date of completion for correction of deficiency is March 9, 2017.	

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F 205	Continued From page 13 administrative nurse (#1) stated the facility does not provide bed hold notices for residents on Medicaid (medical assistance), as it is an automatic 15 days.	F 205		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 9 sampled residents (Resident #3) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's improvement limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.13), dated October 2015,	F 274	F Tag 274 - 483.20 Comprehensive Assessment after Significant Change 1. A correction for Resident#3 was made by completing a comprehensive assessment for a significant improvement with an ARD date of 2.17.2017 within the allotted time frame for MDSs. 2. All residents have the potential for a comprehensive assessment for a significant improvement not to be completed. 3. The MDS Coordinator and the interdisciplinary MDS team will be	3/9/17

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F 274	Continued From page 14 page 2-20 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-23 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . [such as] increase in the number of areas where behavioral symptoms are coded as being present and/or frequency of a symptom increases . . . Any decline in an ADL [activity of daily living] physical functioning area where a resident is newly coded as Extensive assistance . . ." Review of Resident #3's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated 06/06/16, identified the resident needed extensive assistance with bed mobility, transfers, locomotion on and off the unit; and that ambulating in the room and corridor did not occur. The quarterly MDS, dated 08/30/16, identified the resident independent with bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, eating, toileting and personal hygiene. During an interview on 02/02/17 at 11:35 a.m., an administrative staff member (#1) agreed the facility should have completed a significant change MDS for the improvement.	F 274	educated related to significant improvements and need for a comprehensive assessment to be completed. The MDS Coordinator and the interdisciplinary MDS team will sign off on the educational material as read and understanding of the RAI manual related to significant improvements and comprehensive assessments. Education completed on 2.24.17. 4. The MDS Coordinator and the interdisciplinary MDS team will meet weekly to review all residents for a significant improvement for twelve (12) weeks. The DON or designee will monitor compliance of completion of comprehensive assessments related to significant improvements, starting 2.3.17, for ninety (90) days. If concerns are identified, immediate corrective action will be implemented. If no concerns are noted, random compliance monitoring will continue for an additional twelve (12) weeks to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of the QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for correction of deficiency is March 9, 2017.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		3/9/17

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F 278	Continued From page 15 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON	F 278	F Tag 278 - 483.20 Assessment Accuracy/Coordination/Certified	

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F 278	Continued From page 16 04/01/15 AND 03/03/16. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to accurately complete the toileting section of the Minimum Data Set (MDS) for 1 of 9 sampled residents (Resident #1). Failure to code portions of the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, stated the following: * Section H0300 (Urinary Continence), page H-7, stated, "URINARY INCONTINENCE the involuntary loss of urine. CONTINENCE Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting." The Coding Instructions, located on page H-8, stated the following: "Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids. Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g. is on chronic dialysis with no urine output) for the entire 7 days." Review of Resident #1's medical record occurred	F 278	1. The correction for Resident #1 is a modification of a Quarterly MDS Assessment with an ARD date of 11.13.16 and completed within the time frame for MDSs. The modification was completed and accepted on 2.16.17 2. All residents have the potential for urinary status of the MDS to be coded incorrectly. 3. All members of the MDS interdisciplinary team will be educated related to coding of the toileting section of the MDS. The interdisciplinary MDS tam will sign off on the education materials as read and being understood related to the RAI specifications. The MDS interdisciplinary team will review the most current MDS for all residents with indwelling catheter and make modifications, if necessary, to reflect accurate coding related to urinary status. Education was completed on 2.24.17. 4. The MDS Coordinator or designee will monitor compliance of accurate coding of urinary status, starting on 2.3.17, for all residents with indwelling catheters for ninety (90) days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, then compliance monitoring will continue for an additional ninety (90) days to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at each	

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F 278	Continued From page 17 on all days of survey. Diagnoses included benign prostatic hyperplasia (BPH), urinary retention, and indwelling foley catheter. Resident #1's current care plan stated, "Problem . . . Problem Start Date 07/11/15 Indwelling foley catheter d/t [due to] impaired urinary elimination S/T [secondary to] BPH. . . ." The quarterly MDS, dated 11/13/16, indicated urinary continence, always incontinent. The significant change MDS, dated 05/17/16, indicated urinary continence, occasionally incontinent. The MDSs, failed to identify Resident #1's urinary status as a "9" due to the presence of an indwelling catheter. During an interview on 02/01/17 at 1:00 p.m., an administrative staff nurse (#13) confirmed the following: * "Resident #1 has had a foley catheter for well over one year now." * "The MDS dated 05/17/16 was not completed by me." * "The MDS dated 11/13/16 was coded a 3 (indicates always incontinent) because Resident #1 had the catheter and I was trying to justify why he had it."	F 278	weekly meeting to ensure the deficient practice is corrected. The MDS Coordinator or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting to ensure substantial compliance is continued. 5. Date of completion for deficiency correction is March 9, 2017.	
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	F 280		3/9/17

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F 280	Continued From page 18 including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 280		

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F 280	Continued From page 19 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 03/03/16 AND 02/06/14. Based on observation, facility policy, record	F 280	F Tag 280 - 483.10 Right to Participate Planning Care-Revise Care Plan 1. Correction, addition, deletion, revision of Resident #1's care plan will be made to	

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F 280	Continued From page 20 review, and staff interview, the facility failed to review and revise the comprehensive care plans for 6 of 9 sampled residents (Residents #1, #2, #3, #4, #5 and #6). Failure to review and revise the residents' care plans limits communication of resident care needs between staff and does not ensure continuity of care for each resident. Findings include: The facility policy titled "Using the Care Plan" occurred on 02/02/17. This policy, undated, stated, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation . . . CNA's [certified nursing assistants] are responsible for reporting to the Charge nurse any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. . . . Changes in the resident's condition must be reported to the MDS [Minimum Data Set] Assessment Coordinator so that a review of the resident's assessment and care plan can be made. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included aspiration pneumonia, Barrette's esophagus (irritated tissue of the esophagus due to back up of food from stomach), stroke with right sided hemiplegia (weakness), weight loss, urinary retention, Foley catheter, Benign Prostatic Hypertrophy (BPH), Cerebral Vascular Accident (CVA), and history of stage two pressure ulcer to left heel. The quarterly	F 280	include, but not limited to identifying the frequency of changing of the catheter, recommendations for nutritional status, oxygen use, clarification of transferring resident and current therapy orders before or on March 3, 2017. Correction, addition, deletion, revision of Resident #2's care plan will be made to include, but not limited to non-pharmacological measures for uncontrolled anxiety before or on March 3, 2017. Correction, addition, deletion, revision of Resident #3's care plan will be made to include, but not limited to reflection of the resident's current condition and needs before or on March 3, 2017. Correction, addition, deletion, revision of Resident #4's care plan will be made to include, but not limited to placing a call light within reach, therapy orders, pain medications and recommendations by speech therapy before or on March 3, 2017. Correction, addition, deletion, revision of Resident #5's care plan will be made to reflect the resident's current condition and needs on February 28, 2017. Correction, addition, deletion, revision of Resident #6's care plan will be made to include, but not limited to identifying custom routine, specific approaches, identify how often to check and change	

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F 280	Continued From page 21 Minimum Data Set (MDS), dated 11/13/16, identified moderately impaired cognition and extensive assistance of one to two needed with activities of daily living (ADLs). The physician order report, dated 09/07/16, stated, "Using aseptic and sterile technique . . . change Foley every 30 days . . ." Resident #1's current care plan stated: * "Problem . . . Indwelling Foley catheter d/t [due to] impaired urinary elimination S/T [secondary to] BPH. . . . Approach . . . administer medications as ordered. Assess urinary output. Report to nurse if odor or blood noted in urine. Provide assistance for toileting if he allows. Close door/curtain for privacy. Report sign/symptoms of UTI [urinary tract infection] . . ." The care plan failed to identify the frequency of changing the catheter. During an interview, on 02/01/17 at 3:00 p.m., a speech pathologist (#3) confirmed Resident #1 should be sitting in an upward position at 90 degrees during all meals and anytime he is eating and/or drinking fluids. Resident #1 should be using a spoon to drink out of a cup and should not be drinking directly from the cup or with a straw. Resident needs supervision and cues during all meals and fluids especially if he is coughing or forgetting what he needs to do." The Speech Language Pathologist Examination, dated 10/28/16, identified: * "The resident trialed the following liquids/foods: Honey thickened liquids . . . by cup; Resident displayed a delayed cough and throat clear after the swallow. Resident also displayed a gugurly	F 280	the resident and reflect the resident's current condition and needs before or on March 3, 2017. 2. All residents have the potential for comprehensive care plans not to be corrected, reviewed or revised. 3. The interdisciplinary MDS team will be educated related to reviewing, revising, updating, correcting and resolving comprehensive care plans. The interdisciplinary MDS team will sign off on education materials as being read and understanding the importance regulations related to care plans. Education was completed on 2.24.17. 4. The MDS Coordinator and the interdisciplinary MDS team will monitor reviewing and revising of care plans as an ongoing process. The MDS coordinator will be responsible for ensuring care plans are up to date and current. All residents care plans will be reviewed and revised, as appropriate, by the MDS Coordinator and the interdisciplinary MDS team before or on March 8, 2017. The clinical and MDS interdisciplinary teams will review three (3) random care plans for reflection of resident's current condition and needs in a weekly team meeting for eight (8) weeks. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, random reviews by the clinical and MDS teams will continue on a weekly basis for an additional twelve (12) weeks to ensure	

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F 280	Continued From page 22 [sic] voice and slight coughing after the swallow . . ." * "Pudding thickened iquid [sic] by spoon . . . Resident tolerates this consistency with no outward s/s [signs and symptoms] of aspiration. . . ." * "Recommendations: Res. [resident] appropriate for a pureed diet, with pudding thickened liquids by spoon. Cues: Remain upward in sitting position for 30 minutes following each meal . . ." * "Recommend resident to seek referral for a Swallowing Video fluoroscopy in Radiology . . . to help determine the most appropriate liquids & consistencies." The Video Fluoroscopic Swallow Study results and recommendations, dated 11/11/16, identified: * "All liquids via cup . . . Upright 90 degrees . . . Remain upright after meals 60 minutes . . . Level of Supervision with meals . . . Assist, Standby . . ." * " . . . results indicated pt [patient] presents with moderate to severe pharyngeal dysphagia [swallowing difficulty] . . ." * "Problem . . . Nutritional Status . . . Altered Nutritional Status R/T [related to] post CVA and Impaired Swallowing and Significant Weight Loss. . . . Per ST [speech pathologist] Recommendations: . . . is to continue current swallow cues/recommendations independently. . . . Remain upright in a sitting position for 30 minutes following each meal . . ." The care plan failed to identify the most up to date recommendations regarding Resident #1's nutritional status. The current physician order report, dated	F 280	the deficient practice is corrected. The MDS Coordinator or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. QA monitoring began on 2.3.17 5. Date of completion for correction of deficiency is March 9, 2017.	

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F 280	Continued From page 23 01/31/17, stated, "Oxygen on at HS 1-2 lpm [liters per minute] to keep sats [saturation levels of oxygen] greater than 90%. Take off in AM [morning] if sats are greater than 90% . . ." * "Problem . . . ADL [activities of daily living] Functional/Rehabilitation Potential . . . Approach . . . Oxygen therapy at HS [bedtime] and PRN [as needed] . . ." The facility failed to update the care plan. The care plan did not identify the most up to date doctor's order regarding oxygen use for Resident #1." During an interview, on 02/01/17 at 5:15 p.m., an administrative staff (#1) confirmed Resident #1 is no longer receiving PT or OT services and the care plan states "Use appropriate pressure support devices in W/C and bed as indicated" but should state "pressure reducing" instead. This indicates a pressure relieving mattress and cushion on wheel chair. The care plan lacked specific devices to utilize to prevent pressure ulcers and lacked current therapy orders. Observation on 01/31/17 at 12:55 p.m. showed two CNAs (#4 and #5) transferring Resident #1 from the wheelchair to the bed. The staff utilized a gait belt for the transfer. Both CNAs (#4 and #5) assisted Resident #1 to a standing position then pivot using the gait belt and lowered him onto his bed. * "Problem . . . Pressure Ulcer . . . is at risk for pressure ulcers R/T decrease mobility and need for assist with all transfers. . . . Approach . . . PT/OT [physical therapy/occupational therapy] skilled therapy as ordered . . . Use appropriate pressure support devices in W/C [wheel chair]	F 280		

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F 280	Continued From page 24 and bed as indicated. . . ." *Problem . . . ADL Functional/Rehabilitation (start date 11/18/16) . . . Approach . . . needs the use of a stand up lift for transfers, however bed to chair can utilize stand-pivot transfers. . . ." * Problem . . . ADL Functional/Rehabilitation (start date 04/26/15) . . . Approach . . . Transfer with stand up lift with all transfers. The care plan identified the same problem areas (ADL Function/Rehabilitation) twice with conflicting information. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included intracerebral hemorrhage, dementia, depression, and right-sided weakness. The quarterly MDS, dated 01/05/17, identified moderately impaired cognition, supervision of one for meals, independent with transfers, bed mobility and dressing, and occasional mild pain. Resident #4's current care plan stated: * "Problem . . . Falls Resident is at risk for falls d/t recent loss of physical ability, loss of neuromuscular function . . . stroke affecting R [right] side . . . Approach . . . Implement exercise program . . . Increase staff supervision . . . based on resident need . . . place fall mat by bed and keep bed in lowest position . . . Provide individualized toileting interventions . . ." The current care plan did not identify the need for staff to place a call light within reach to help prevent falls. During an interview on 02/01/17 at 3:00 p.m., a speech pathologist (#3) confirmed Resident #4 is	F 280		

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presently receiving speech therapy two times a week to help improve her swallowing difficulty.

During an interview on 02/01/17 at 5:15 p.m., an administrative staff (#1) confirmed Resident #4 is presently receiving physical and occupational therapy.

The current physician order report, dated 01/31/17, identifies "Speech/Swallow evaluation complete. Recommend skilled ST [speech therapy] services 2x/week for 12 weeks to target dysphagia & speech."

The SLP (speech language pathologist) initial Examination, dated 01/24/17, identified "Recommend resident receive skilled ST services 2x/week for 12 weeks to target dysphagia & speech."

* "Problem ADL Functional/Rehabilitation Potential . . . Approach . . . Allow resident to make as many choices as possible . . . Bed mobility is extensive. Resident also needs total assistance with toileting/dressing/grooming/ and personal hygiene . . ." The care plan failed to identify Resident #4 is presently receiving physical therapy, occupational therapy, and receiving speech therapy.

The current physician order report, dated 01/31/17, identified "acetaminophen [Tylenol] 500 mg 2 tablets 1000 mg [milligrams] every six hours for chronic pain." There is no current physician order for the Hydrocodone listed on the care plan.

* "Problem . . . Pain Resident has complaints of

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chronic pain R/T neuralgia. Pain site(s): L [left] hand. . . . Approach . . . Administer medications: Tylenol 325 mg 2 tabs PRN [as needed] q6H [every 6 hours], Hydrocodone 5-325 mg PRN q4H. . . ." The facility failed to update the care plan to identify current medications available to for pain.

The SLP Initial Examination, dated 01/24/17, stated, " . . . Recommendations: . . . nectar thickened liquids by cup. . . ."

The current Physician Order Report, dated 01/31/17, stated, "Resident to have AM, PM and HS [at bedtime] snack Three Times A Day; 10:00, 14:00 [2:00 p.m.], 20:00 [8:00 p.m.]. Res. requires 1:1 [one on one] feeding/assistance during all meals."

* "Problem . . . Nutritional Status . . . Potential for Altered Nutritional Status . . . stroke . . . Approach . . . Diet: Pureed diet, ground meat/gravy with nectar thick liquids . . . Assistance with meals . . . Encourage oral intake of food and fluids . . . Monitor and record oral intake of flood/fluids. . . Monitor weights taken . . . Obtain dietary consult. Obtain food preferences . . . Snacks offered between meals . . . Supplement per dietary recommendations . . ." The facility failed to up date the care plan to identify current physician orders regarding snacks/frequency time and feeding assistance during meals and recommendations made by the speech pathologist.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease, dementia, anxiety,

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weakness, constipation, and history of urinary tract infections (UTI). The annual MDS, dated 10/01/16, identified extensive assistance of one to two persons for all ADL's, frequently incontinent of urine and occasionally incontinent of stool.

During an interview on 02/01/17 at 5:15 p.m., an administrative staff (#1) confirmed Resident #6's care plan intervention/approach regarding urinary incontinence "provide privacy and normal area for voiding" is not appropriate and staff need to update the care plan; Resident #6 can occasionally answer yes or no questions but not sure if able to request the use for the bathroom; and staff should check and change this resident every two hours.

Resident #6's current care plan stated:
* "Problem . . . Psychosocial Well Being . . . Approach . . . Offer individualized care based on customary routine. Use appropriate socially acceptable language during conversation . . ." The care plan did not identify the resident's "customary routine".

* "Problem . . . Urinary Incontinence . . . Approach . . . Observe for S/SX of UTI . . . Provide privacy and normal area for voiding . . . Report areas of skin redness or breakdown . . . Will be assisted with incontinent product and pericare as needed by staff." The current care plan lacked resident specific approaches and failed to identify how often staff need to check and change the resident.

During an interview on 02/02/17 at 1:30 p.m., an administrative staff (#1) stated, "when one of our

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staff members went to training the 'normalized toileting' verbiage is what they used, so she carried it back to our facility and put it in our care plans."

During an interview on 02/01/17 at 5:15 p.m., an administrative staff (#1) stated, "I'm not sure what 'normalized toileting' means. The resident should be toileted every two hours."

* Problem . . . Falls . . . Risk for falls related to impulsiveness secondary to Alzheimer's diagnosis. . . . . Approach . . . Nursing will anticipate resident's need for toileting and will apply normalized toileting Once a Day; 08:00 . . ."

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses included an event with encephalopathy secondary to sepsis secondary to a UTI in May 2016. A decline in condition occurred at that time.

Current physician's orders included an order dated 06/01/16 to use a "Hoyer lift with toileting sling as necessary due to resident's increased confusion." Orders, initial order date 02/22/15, included an order for an "AIMS" [Abnormal Involuntary Movement Scale] on admission and continuing on specific days/months (unclear). The record showed the resident not on any antipsychotic medications throughout the year 2016 to current.

The current care plan includes:
* "[Resident] requires limited to extensive assist with ADLs" with an approach, initial entry date 02/25/05, "Nursing staff to assist with mobility and ambulation as per directed by PT [physical

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F 280	Continued From page 29 therapy] and OT [occupational therapy]; Skilled PT and OT services at this time." * "Urinary incontinence" with an approach, dated 02/25/15, of "Provide assistance for toileting as needed." * Falls" with an approach, dated 02/25/15, "Provide toileting assistance as needed." Resident #3's progress notes stated: * 06/01/16 at 6:19 p.m.: "Written order received from physical therapist for Hoyer lift [full body lift] with toileting sling as necessary due to residents increased confusion." * 06/17/16 at 4:48 p.m.: ". . . Per therapy, nursing staff may ambulate to and from meals with fww [front wheeled walker] as tolerated. . . . " During interview on 02/01/17 at 9:20 a.m., an administrative staff member (#1) stated Resident #3 no longer receives PT and OT services; regarding the physician's order, dated 06/01/16, the staff member stated if nursing staff would notice a change in the resident's condition they could use the Hoyer to assist her; and if a CNA thinks a resident requires more assistance the CNA should let the nurse know and the nurse will let PT/OT know. The staff member stated currently Resident #3 is totally independent. The facility failed ensure an up-to-date care plan (as well as physician's order) to reflect the resident's current condition and needs. The process of expecting direct care staff to provide cares based on an assessment by PT/OT personnel and not given concise direction, placed the resident at risk for inadequate cares. - Review of Resident #2's medical record	F 280		

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F 280	Continued From page 30 occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. A provider note, dated 12/15/16, identified the resident with uncontrolled anxiety, and the provider ordered an anti-anxiety medication with an order to "Monitor closely as with [increase] risk for falls." The care plan identified the following problems: *"Psychotropic Drug Use" with approaches of "Assess/record effectiveness . . . Monitor resident's mood and response to medication, Pharmacy consultant review." The care plan lacked evidence the facility identified a problem with behaviors including uncontrolled anxiety; and failed to put non-pharmacological measures in place. - Review of Resident #5's medical record occurred on all days of survey. The record showed a decline in the resident's urinary and bowel function occurred after admission. The current care plan failed to identify this problem and implement resident specific measures.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff	F 281	F Tag 281 - 483.2 Services Provided Meet Professional Standards	3/9/17

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F 281	Continued From page 31 interview, the facility staff failed to provide services to meet professional standards of practice for 1 of 1 sampled residents (Resident #7) observed during medication administration through a gastric tube (G-tube). Findings include: Review of the facility policy titled "Administering Medications through an Enteral Tube" occurred on 02/02/17. This policy, revised December 2012, stated, "Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medication through an enteral tube. . . . Steps in the Procedure . . . If administering more than one medication, flush with 5 mL [millimeters] (or prescribed amount) warm sterile water between medications. . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th ed., Pearson Education Inc., New Jersey, page 780, stated, " . . . Administering Medications by Nasogastric or Gastrostomy Tube . . . If you are giving several medications, administer each one separately and flush with at least 15 to 30 mL . . . of tap water between each medication. . . ." Review of Resident #7's medical record occurred on 02/02/17. Medical diagnoses included dysphagia (difficulty swallowing). The quarterly Minimum Data Set (MDS), dated 01/02/17, identified nutrition via feeding tube. The current care plan identified the following, ". . . Problem Impaired swallowing R/T [related to] dysphagia . . . Approach Administer medications: crush via peg tube. . . . Diet: NPO [nothing by mouth]."	F 281	1. A correction on Resident #7 related to failing to administer water flushes between each of the medications administered via a gastric tube cannot be made after all of the medications have been administered. 2. All residents with a gastric tube have the potential for water flushes not to be administered after each medication. 3. All nurses, including newly hired and agency nurses will be educated related to flushing with water after each medication administered through a gastric tube. All nurses will sign off on education material as read and being understood. Education completed on 2.24.17. 4. The DON or designee will monitor compliance, starting 2.3.17, by observing nurses flushing after each medication administered via a gastric. Monitoring compliance of flushing with water after each medication administered via a gastric tube will be completed at a minimum of once daily for two (2) weeks, three (3) times weekly for three (3) weeks and then randomly for a minimum of ten (10) times during the next sixty (60) days. If any concerns are noted, immediate corrective actions will be implemented. In no concerns are noted, then random observations will be conducted for an additional thirty (30) days to ensure the deficient practice is corrected. The clinical interdisciplinary team will review	

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F 281	Continued From page 32 On 02/01/17 at 11:20 a.m., observation showed a staff nurse (#2) administered each of Resident #7's medications separately via a gastric tube. The nurse failed to administer water flushes between each of the seven medications. During an interview on 02/01/17 at 2:10 p.m., an administrative staff member(#1) confirmed staff should flush with sterile water between each medication administered.	F 281	compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting, for further action, if necessary. 5. Date of completion for correcting deficiency is March 9, 2017.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and	F 309		3/9/17

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F 309	Continued From page 33 preferences. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEYS COMPLETED ON 03/03/16, 04/01/15, 02/06/14 AND 01/31/13. URINARY TRACT INFECTION AND SEPSIS 1. Based on record review and review of facility policy, the facility failed to provide care and services to manage a urinary tract infection (UTI) for 1 of 7 sampled residents (Resident #3) with a history of UTIs and 1 closed record (Resident #10) with a history of UTIs caused by a multi-drug resistant organism (MDRO). This resulted in Resident #3's hospitalization due to inappropriate treatment of a bacterial UTI with progression to encephalopathy, secondary to sepsis (infection in the blood stream), and secondary to a UTI, and a decline in Resident #3's overall well-being, and resulted in delayed treatment of Resident #10's UTI. Findings include: Review of facility policy "Urinary Tract Infections/Bacteriuria - Clinical Protocol" occurred on 02/02/17. The policy, dated 02/14, stated: "Assessment and Recognition . . . The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI. . . . Cause Identification 1. The physician will help nursing staff interpret the significance of signs, symptoms, and lab test results. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses	F 309	F Tag 309 - 483.24 Provide Care/Services for Highest Well Being URINARY TRACT INFECTION 1. A correction for Resident #3 related to follow up and appropriate treatment for a UTI cannot not be made after the treatment was completed in May 2016. A correction for Resident #10 cannot be made as the resident does not reside in the facility. 2. All residents have the potential for not having follow up and appropriate treatment. 3. All nurses, newly hired and agency staff will be educated on urinary tract infections and the importance of following up on appropriate treatment. All policies, procedures and clinical assessments will be reviewed and revised, as appropriate to ensure compliance with regulations. All nurses, newly hired and agency staff will be educated related to changes in policies, procedures and clinical assessments. All nurses will sign off on educational materials as being read and understood related to follow up and appropriate treatment of urinary tract infections. Education was completed on 2.24.17. 4. The DON or designee will monitor	

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F 309	Continued From page 34 included depression with dementia, kidney failure, and history of UTIs. An admission Minimum Data Set (MDS), dated 02/16/16, identified Resident #3 as cognitively intact, and either independent or requiring limited assistance of one person with all activities of daily living (ADLs) except bathing. A significant change MDS, dated 06/06/16, identified Resident #3 had moderate cognitive impairment, and required extensive assist of one person for bed mobility, transfers, locomotion on and off the unit, dressing, toileting, personal hygiene, bathing, and walking in the room and corridor did not occur. A quarterly MDS, dated 08/30/16, identified the resident returned to a status of cognitively intact, and independent or limited assistance with all ADLs, except dressing and bathing. Progress notes identified the resident taken to an acute care hospital on 05/08/16 and returned on 05/09/16, diagnosed with a UTI, and orders for Ciprofloxacin (Cipro) (an antibiotic), for nine days. The "Instructions for after Discharge" identified follow up with the resident's primary care physician within one week, and the hospital "Lab Test Awaiting Results" included urine cultures. The final culture report, dated 05/10/16, identified the organism of Escherichia coli (E coli), greater than 100,000 colony forming units/milliter. (E coli is a common organism found in patients with UTIs). The culture identified the organism resistant to Cipro. The record showed the nurse practitioner (FNP) "saw resident for follow up visit; post hospital admission" on 05/12/16. The primary care	F 309	compliance, starting on 2.3.17, of implemented policies, procedures and clinical assessments for urinary tract infections at each occurrence times eight (8) weeks, then randomly for an additional sixty (60) days to ensure deficient practice is corrected. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue for an additional thirty (30) days to ensure substantial compliance. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for deficiency correction is March 9, 2017. BEHAVIOR MANAGEMENT 1. A correction for Resident #2 related to behavior assessment was completed on February 27, 2017. 2. All residents diagnosed with dementia and organic brain disease have the potential for behavioral symptoms not to be managed. 3. Social Services Designee and all nursing staff, including nurses and CNAs will be educated on the facility's	

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F 309	Continued From page 35 physician saw the resident on 05/17/16, and no new orders given. Nursing staff administered the last dose of Cipro on the morning of 05/18/16. On 05/19/16, the FNP ordered a follow-up urinalysis (UA) for 05/20/16. Nursing staff obtained the UA on 05/20/16 via a clean catch sample and sent it to the clinic. The progress notes stated the FNP reviewed the UA results and "Will send for UC [urine culture] as it appears infection has not resolved." The final urine culture, dated 05/22/16, showed the organism isolated as "sensitive" (verses resistant) to Macrobid, and resistant to Cipro. On 05/23/16 at 1:16 p.m., the FNP ordered Macrobid for 10 days and the resident continued to have no symptoms of urgency noted. Nursing staff gave the first dose of an antibiotic on the evening of 05/23/16. Progress notes identified: * 05/24/16 at 5:42 p.m., "Resident alert, oriented, presentes [sic] with nausea, shaking, 1 small emesis and complaints of stomach upset. Temp. [temperature] 99.1, P [pulse] - 91, R [respirations] - 24; b/p [blood pressure] - 171/77 . . . This was a significant change from earlier in the afternoon when her temp. was 97.5 and b/p - 152/84 after lunch." The physician gave orders to transfer the resident to the emergency room [ER] at 5:46 p.m. The facility sent the resident by ambulance. * 05/24/16 at 11:54 p.m., ". . . Lab results from last UA faxed to [hospital]. That last UA final culture report, dated 05/22/16, showed Escherichia coli bacteria, greater than 100,00 colony forming units/ml [milliliter]. The final urine culture, from the previous UA collected on 05/08/16, showed the same organism, and also resistant to Cipro. * 05/25/16 at 2:18 a.m., "[hospital] called and	F 309	behavioral management program, including, but not limited to policies and procedures implemented, as appropriate for compliance with regulations. All staff included in training will sign off on educational material as read and understood. Social Services Designee will be reeducated related to implementing and monitoring behavioral management. Education was completed on 2.24.17. 4. The Social Services Designee or designee will monitor compliance, starting 2.3.17, of implemented behavioral management program according to policies and procedures daily times four (4) weeks, then three (3) times weekly for four (4) weeks, then weekly for (2) weeks, then randomly monitor for the next sixty (60) days to ensure deficient practice is corrected. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, Social Services Designee will randomly monitor compliance for an additional ninety (90) days to ensure deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring weekly to ensure deficient practice is corrected. The Social Services Designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for deficiency correction is March 9, 2017.	

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F 309	Continued From page 36 stated waiting for CT results to see if anything there . . ." At 6:36 a.m., the hospital informed the facility the hospital admitted the resident with a diagnosis of UTI. The hospital discharged the resident back to the facility on 05/30/16 with diagnoses including urinary tract bacterial infection, acute encephalopathy, and sepsis. Orders included an antibiotic, Augmentin, for five days for treating the UTI. On that day and the two days following, nursing staff identified the resident as "extremely confused," having hallucinations, not making sense at times, unable to feed herself, requiring total to extensive assist with all cares, and at times, with jerky and spasmodic movements, and hard to arouse. Medicare progress notes written on 06/02/16, 06/03/16, and 06/04/16 identified the resident admitted to hospital for acute encephalopathy secondary to "sepsis secondary to UTI." Failure to ensure follow-up and appropriate treatment occurred for a UTI identified from Resident #3's overnight hospital stay on May 08-09, 2016 resulted in facility failure to treat Resident #3's UTI with a medication to which the identified organism was sensitive. This progressed to a second hospitalization due to sepsis from an untreated UTI, as well as acute encephalopathy. This resulted in a decline in the resident's ADL status, changes in cognitive status, and an overall deterioration of health. - Review of Resident #10's medical record occurred on 02/01/17. Diagnoses included depression, diabetes, and history of UTIs caused	F 309	ASPIRATION PRECAUTIONS 1. A correction for Resident #1 was implemented on February 3, 2017 related to supervised, cues and positioning appropriately at all meals and snack time to reduce risk of aspiration. 2. All residents have the potential to be at risk for aspiration. 3. All staff will be educated related to aspiration precautions. Food and Nutrition Services staff, nurses and CNAs will be educated related to residents with specific recommendations and needs to reduce risk of aspiration. All staff will sign off on appropriate educational materials as read and understood. Education was completed on 2.24.17. 4. The Food and Nutrition Services Manager or designee will monitor compliance, starting 2.3.17, of supervision cues and positioning of resident during meals and snack times. Compliance monitoring will be daily at all meals and snack times for four (4) weeks, then four (4) days weekly at all meals and snack times for three (3) weeks, then two (2) days weekly at all meals and snack times, then randomly three (3) times weekly for thirty days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, then random compliance monitoring will be conducted for an additional thirty (30)	

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F 309	Continued From page 37 by multi-drug resistant organisms (MDRO). A significant change MDS, dated 10/30/16, identified Resident #10 had short/long term memory problems, moderately impaired daily decision-making/reasoning skills, and required extensive assist of one person for toileting and personal hygiene. The progress note, dated 10/18/16 at 12:15 a.m., identified, "UA [urinary analysis] [was] collected per doctors order 0015 [12:15 a.m.]" The "Urine Culture," dated 10/21/16 at 12:02 p.m., identified, ". . . Organism of Escherichia coli, > [greater than] 100,000 colony forming units/milliliter. Extended Spectrum Beta-Lactamase (ESBL) producing organism. Attention: Antiobiotic Resistant Alert. CDC [Centers of Disease Control] Recommends Contact Isolation. . . ." The panel further identified the organism was susceptible to Nitrofurantoin. Progress notes identified the following: * 10/24/16 at 1:24 p.m., "Final Urine culture reviewed by [nurse practitioner]. Written order to start resident on 100 mg [milligrams] of Nitrofurantoin BID [twice daily] x [times] 10 days. Recheck urine in 12 days. . . ." There was no indication in the record the facility attempted to obtain Resident #10's lab results prior to 10/24/16. * 10/24/16 at 2:16 p.m., "First dose of Macrobid given at 1400 [2:00 p.m.] d/t [due/to] ESBL in urine. Isolation precautions are in place and being followed; resident was moved to private room and staff have been educated." * 10/26/16 - 11/02/16, "Resident remains on Macrobid antibiotic therapy for treatment of ESBL	F 309	days to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The Food and Nutrition Services Manager will submit a report of QA monitoring to the QAPI committee at each monthly scheduled meeting for further action, if necessary. 5. Date of completion for correction of deficiency is March 9, 2017. PRESSURE ULCERS 1. Correction for Resident #1 related to floating heels was completed on February 3, 2017. 2. All residents have the potential to be at risk for pressure ulcers if heels are not floated. 3. All nurses, newly hired and agency staff and CNAs will be educated related to the potential risk of pressure ulcers if heels are not floated. All nursing staff will sign off on educational materials as being read and understood. Education completed on 2.24.17. 4. The DON or designee will monitor compliance, starting 2.3.17, of Resident #1, related to floated heel or heels while in bed. Compliance monitoring will be three (3) times daily for four (4) weeks, then four (4) days weekly for three (3)	

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F 309	Continued From page 38 infection present in urine; no signs/symptoms of reaction noted . . . Contact isolation precautions are in place and being followed. . . ." * 11/02/16 at 10:12 a.m., ". . . repeat UA obtained at 1000 [10:00 a.m.] and sent to clinic for evaluation" . . . and at 3:43 p.m., "UA results received from clinic and noted to have a moderate amount of leukocytes present; NP wrote: please culture . . ." * 11/04/16 at 10:27 a.m., "At this time per [employee] in microbiology at the lab . . . 'there is not any ESBL organism growing . . .' [Employee] indicated lab results will be [sic] follow procedure for documented notification'" . . . and at 10:30 a.m., "Resident has been cleared to remove isolation precautions . . . resident to be moved back to prior room arrangements . . ." The facility failed to obtain Resident #10's lab results (information about culture results and/or antibiotic resistance) in a timely fashion. This resulted in delayed treatment of Resident #10's UTI caused by a multi-drug resistant organism and left other resident's (including her roommate), visitors, and staff, at risk of exposure from October 21-24, 2016. BEHAVIOR MANAGEMENT 2. Based on record review, review of facility policy and staff interview, the facility failed to provide care and services to manage behavioral symptoms of dementia for 1 of 7 sampled residents (Resident #2) identified with dementia. Failure to identify and assess behaviors, implement a behavior management plan, and evaluate interventions affects and may negatively impact the resident's quality of life.	F 309	weeks, then two (2) days weekly, then randomly three (3) times weekly for thirty days. Residents #5, #6, #7, and #11 were also monitored starting 2.3.17, for floated heels while in bed following the above monitoring schedule. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, random compliance monitoring will continue for an additional thirty (30) days to ensure deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for correction of deficiency is March 9, 2017.	

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F 309	Continued From page 39 Findings include: Review of the facility "BEHAVIOR SYMPTOM POLICY" occurred on 02/02/17. The undated policy, states, "Richardton Health Center strives to meet all the needs of its residents. When behavior symptoms negatively affect the quality of life of a resident/residents, a team approach is required. . . . the resident's behavior symptoms are assessed. Care planning is developed and implemented to maximize the resident's potential to function in a least restrictive environment. . . . A negative behavior has an impact on the resident's overall quality of life. Behaviors that are a danger to self or others also require immediate assessment and care planning. . . . The first priority is to pursue medical assessment . . . assess the resident for potential unmet needs and identify antecedents. . . . If the resident has dementia and cannot communicate, pain must be considered as a contributor to mood and behavior indicators. . . . this step should be completed prior to initiating any psychotropic medication. . . . The care plan should be updated to address the change in behavior. Target behavior symptoms are identified along with potential/actual antecedents. . . . implement approaches designed to decrease the negative behavior. . . . The CNAs [certified nursing assistants] and/or charge nurses will document the frequency of the behavior, interventions tried and the success of those interventions. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, major depressive disorder, chronic pain syndrome, and	F 309		

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a fracture of the right fibula and fracture of the 9th, 10th and 11th ribs occurring secondary to a fall on 12/17/16. An annual Minimum Data Set (MDS), dated 08/18/16, identified no behaviors. A significant change MDS, dated 12/20/16, identified a change in the resident's behavioral symptoms which included verbal behaviors one to three days per week and rejection of care one to three days per week.

The care plan identified the problem of the use of "Psychotropic Drug Use" with approaches of "Assess/record effectiveness . . . Monitor resident's mood and response to medication, Pharmacy consultant review." The care plan lacked evidence the facility identified a problem of behaviors which would include approaches/interventions.

Current physician's orders identified Venlafaxine Extended release (Effexor, anti-depressant) 300 milligrams (mg) once a day, ordered on 08/05/16.

Resident #2's progress notes identified the resident seen by a psychiatrist. The record identified the two previous visits occurred on 12/01/16 and 01/05/17.

Progress notes included:
* 01/01/17 at 10:46 a.m.: "Resident has removed dressing to right elbow area . . . and this nurse has re-applied . . . resident removes dressing after it is applied. Resident came to nurses station and voiced, 'aren't you going to dress my arm,' I informed resident I have dressed the area x 2 and that she continues to take the dressing off; resident became very vulgar and stated, 'well aren't you just a stupid nurse, why would I take it

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F 309	Continued From page 41 off my arm; this nurse attempted one last time to enter residents room with a CNA accompanying and offered to dress residents arm for the third time and resident kept cursing at me and stating I was stupid, . . . will try to reapproach resident later once she has calmed down." * 12/20/16 at 11:56 a.m.: "Significant change . . . does see [doctor name] of Archway Mental Health via telemd. [telemedicine] . . . did have the behavior of yelling at staff and rejected care 1 day. . . ." * 12/19/16 at 1:09 p.m.: ". . . came to my office . . . very confused . . . stated she must be having a bad dream. I visited with [resident] until she appeared less stressed . . ." * 12/18/16 at 10:39 p.m., "Resident is alert. CNA's reported behaviors yelling and hurling items at staff. Nurse was able to redirect her. She denies pain at this time. . . ." * 12/17/16 at 6:13 p.m.: ". . . At 1644 [4:44 p.m.] resident requested a pain pill and upon this nurse bring resident a PRN Percocet I asked her to rate her pain and she became very vulgar and screamed. . . . refused to take her 1700 [5:00 p.m.] scheduled medications. . . . CNAs report resident being very non-compliant with letting them assist her and is showing excessive behaviors when CNAs explain what they need resident to do she does the complete opposite. Phoned residents son, [name] and notified him . . ." * 12/17/16 at 9:54 a.m.: ". . . [nurse practitioner] gave orders to discontinue [resident's] Fentanyl patch [narcotic pain reliever] and restart Gabapentin. These orders were implemented. Due to son's verbalization via telephone today, order for Lorazepam [anti-anxiety medication] was never started."	F 309		

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F 309	Continued From page 42 * 12/15/16 at 7:15 p.m.: ". . . self propelling down the hallway yelling at staff. Confused about the time of day. Unable to express her needs. Staff offer to assist her back to her room or bring her a snack. The resident refused and continued to yell at staff when they pass by. Resident denies pain at this time. Staff will approach and redirect resident at a later time. . . ." * 12/15/16 at 6:36 p.m.; "Provider [first name] has new orders on pt. [patient] Uncontrolled anxiety; may use lorazepam 0.5 mg [milligram] 1 tab [tablet] [every] 6 hours prn [as needed] monitor closely as will increase risk of falls. . . ." * 12/14/16 at 11:28 a.m.: "[Resident] . . . stated "my son [first name] hasn't been coming home at night, he hasn't been sleeping in his bed. 'and' I am very concerned because he's been running with these boy's . . . [resident] has some confusion about the time of day . . ." * 12/14/16 at midnight: "Resident came to the nurses station crying and yelling about a dead man under her bed. . . . refused to sleep in her room. . . ." The facility failed to take measures to analyze the behaviors exhibited by Resident #2 including tracking and trending for the the specific behavior exhibited including; when the behavior occurred i.e. during a certain time of day/night; whether the behavior occurred in certain locations; whether the behavior was directed toward particular staff/residents; circumstances surrounding the behaviors (what triggered the behavior), and interventions utilized as effective or not. ASPIRATION PRECAUTIONS 3. Based on observation, record review, review of	F 309		

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professional literature, and staff interview the facility failed to provide the care and services necessary to attain the highest degree of safety possible for 1 of 3 sampled residents (Resident #1) identified by the facility as having swallowing problems. Failure to supervise and/or given cues and position Resident #1 properly placed Resident #1 at risk for aspiration.

Findings include:

Nancy B. Swigert, "The Source of Dysphagia: Third Edition", LinguiSystems, Inc. 2007, pages 9 and 125 and educational handouts, identified, ". . . Signs and symptoms of dysphagia . . . drooling . . . coughing/choking . . . During the oral intake of . . . liquids, it is optimal for a patient to be seated at 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . ."

Review of Resident #1's medical record occurred on all days of survey. Diagnoses included history of aspiration pneumonia, Barrette's esophagus (irritated tissue of the esophagus due to back up of food from the stomach), stroke with right sided hemiplegia (weakness), and weight loss. The quarterly Minimum Data Set (MDS), dated 11/13/16, identified moderately impaired cognitive skills, supervision with set up only for meals, weight loss, and mechanically altered therapeutic diet.

The current care plan identified, "Problem . . . Assistance needed for ADL's [activities of daily living] d/t [due to] generalized weakness . . . Approach . . . Supervision and cueing during

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F 309	Continued From page 44 meals . . . Problem . . . Altered Nutritional Status R/T post CVA [cerebral vascular accident] and Impaired Swallowing and Significant Weight Loss. . . . Approach . . . Remain upward in a sitting position for 30 minutes following each meal. . . . discontinue eating/drinking if excessive coughing/vomiting occurs during meals. . . . Take one, small bite/sip at a time. . . . Use the chin tuck strategy to help clear foods/liquids appropriately. . . . Wait 5 seconds between bites/drinks. . . . Assist resident as needed. . . ." The meal cards dated 01/31/17 at 12:25 p.m. and 02/01/17 at 8:15 a.m. identified, ". . . Texture: Puree Liquid Honey . . . Note: Table Cues. Take one, small bite/sip at a time. Use the chin tuck strategy to help clear foods/liquids appropriately. Wait 5 seconds between bites/drinks. . . . Special Utensils: Divided Plate . . ." The Speech Language Pathologist (SLP) Initial Examination dated 10/28/16 identified the following, " . . . Primary Concern/Chief Complaint: Dysphagia . . . Current Functional Limitations: Swallowing: . . . Pureed food & pudding thickened liquids by spoon . . . Assessment/Diagnosis: ST [Speech Therapy] received orders for a swallow evaluation, following episodes of vomiting and coughing on nectar thickened liquids. . . . Recommendations: . . . pudding thickened liquids by spoon. . . . Patient Education: . . . reasons for switching to pudding thickened liquids, due to high risks of aspiration. . . . Rehab Potential: Fair (Past history of aspiration. Swallowing/esophageal difficulties progressing.). . . . The Speech Language Pathologist Report, dated	F 309		

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F 309	Continued From page 45 11/11/16, identified the following, "Therapy Diagnosis, SLP . . . Moderate to severe pharyngeal dysphagia [swallowing difficulty] . . . Onset of Problem, SLP 11/11/14 . . . Precautions in place . . . Aspiration Precautions . . . Difficulty swallowing . . . Respiratory History . . . Pneumonia, recurrent . . . Swallow Study/Video Fluoroscopic Swallow Study . . . Overall Impressions . . . Pt [patient] presents with moderate to severe pharyngeal dysphagia . . . and silent aspiration with nectar thick liquids . . . Pt successfully utilized chin tuck and multiple swallows with max cueing to improve airway protection and clear majority of residue. . . . Swallow Positions . . . Swallow Recommendations . . . Upright 90 degrees . . . Allow extra time to swallow . . . chin tuck . . . upright for meals . . . Remain upright after meals 60 minutes . . ." The progress notes identified the following: * 11/03/16: "Coughing during breakfast . . ." * 11/11/16: "Continues to cough during drinking or during meals . . ." * 11/11/16: "Swallow Evaluation completed today . . ." * 11/25/16: "No straws or cup drinks, staff to continue close supervision during meals . . " * 11/27/16: "Coughing and spitting noted at breakfast and noon meal . . ." Meal observations showed the following: * 01/31/17 at 12:25 p.m.: Resident #1 sat in his wheel chair facing away from other tables towards a window alone unsupervised feeding himself. Frequently coughed and cleared his throat during the meal. * 01/31/17 at 12:40 p.m.: Unidentified staff sat	F 309		

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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 309	Continued From page 46	F 309		

down next to Resident #1. Resident continued to feed himself and cough occasionally. Staff failed to offer cues to Resident #1.
* 02/01/17 at 12:15 p.m.: Resident #1 sat in his wheel chair facing away from other tables towards a window alone unsupervised drinking fluids with a spoon. Resident eating very little.

Random observations showed the following:
* 01/31/17 at 8:45 a.m.: During initial tour, showed a mug with a lid and a straw in the cover placed on bedside table in Resident #1's room.
* 01/31/17 at 12:55 a.m.: Two Certified Nurse Assistants (CNAs) (#4 and #5) transferred Resident #1 with transfer from his wheel chair to the bed. The CNA (#4) offered Resident #1 fluids while holding a mug with a lid on it and straw in the cover. The resident accepted, drank from the straw twice, coughed and cleared his throat after each sip. The staff failed to offer cues to Resident #1 while he drank fluids. Both CNAs (#4 and #5) assisted Resident #1 to a laying position with head of bed at 30 degrees.
* 01/31/17 at 3:00 p.m.: Two CNAs (#4 and #6) repositioned Resident #1 onto his left side in his bed and raised the head of the bed to thirty degrees. The CNA (#4) offered Resident #1 fluids holding a mug with a lid on it and a straw. Resident #1 then stated "no, I just had some".
* 01/31/17 at 4:15 p.m.: Resident #1 heard from hallway coughing with the door of his room half way closed. Observation showed Resident laying in bed with head of bed at 45 degrees holding a clear glass of yellow thickened liquid and taking sips from the glass. Resident #1 coughed and cleared throat after each drink taken and until glass was empty. Facility staff failed to supervise, offer cues, and elevate the head of the bed to a

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F 309	Continued From page 47 90 degree angle during fluid intake. Observation showed a mug with a lid on it and a straw on top of the bedside table accessible to Resident #1 and a white glass bowl on the bedside table with a small amount of clear liquid and spoon in it. * 02/01/17 at 11:30 a.m.: A mug with a lid and a straw placed on the bedside table in Resident #1's room accessible to the resident. * 02/01/17 at 4:13 p.m.: A mug with a lid on it and a straw placed on the bedside table in Resident #1's room accessible to the resident. During a telephone interview on 02/01/17 at 3:00 p.m., a speech pathologist (#3) stated, "Resident #1 had a video swallow completed in November 2016 and it confirmed the resident has a moderate to severe pharyngeal dysphagia. This resident should be upright at 90 degrees for eating and drinking anything." The speech pathologist (#3) confirmed Resident #1 should drink nectar honey thickened liquids with a spoon out of a cup and if the resident is not at 90 degrees in his room and especially unsupervised he shouldn't receive snacks in his room. Staff must provide supervision and should not cue him to use a straw to drink liquids. During an interview on 02/02/17 at 1:30 p.m., an administrative staff (#1) confirmed Resident #1 has had swallowing problems since he was admitted to the nursing home two years ago. Staff failed to position Resident #1's head of the bed to an approximate 90 degree angle and provide supervision and/or cues when offering liquids and during meals. PRESSURE ULCERS	F 309		

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F 309	Continued From page 48 4. Based on observation, record review, and staff interview, the facility failed to constantly implement pressure-relieving interventions for 1 of 1 sampled resident (Resident #1) identified with a history of pressure ulcers. Failure to float resident's heels as ordered may result in development of avoidable, facility-acquired pressure ulcers. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included peripheral vascular disease (PVD), cerebral vascular accident (CVA), and history of a stage two pressure ulcer on left heel. The quarterly Minimum Data Set (MDS), dated 11/13/16, identified moderately impaired cognition, extensive assistance required for Activities of Daily Living (ADLs), and risk for pressure ulcers. The current care plan stated, ". . . Problem . . . Assistance needed for ADL's d/t [due to] generalized weakness . . . Extensive assistance with bed mobility heels are floated on pillows while in bed . . . Problem . . . Category: Pressure Ulcer: . . . at risk for pressure ulcers R/T [related to] decrease mobility and need for assist with all transfers. . . . Approach . . . Elevate off load bilateral heels off of bed. . . ." Observations showed the following: * 01/31/17 at 12:55 p.m.: Resident #1 laying in bed with his heels directly on the mattress. * 01/31/17 at 2:00 p.m.: Resident #1 laying in bed with a pillow tucked under his knees and his heels directly on the mattress.	F 309		

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F 309	Continued From page 49 * 01/31/17 at 3:00 p.m.: Two Certified Nurse Assistants (#4 and #6) repositioned Resident #1 partially onto his left side with a pillow tucked under his knees and his heels directly on the mattress. * 01/31/17 at 4:15 p.m.: Resident #1 sitting up at 45 degrees with a pillow tucked under his knees and his heels directly on the mattress. * 02/01/17 at 10:30 a.m.: Resident #1 laying in bed with two pillows tucked under his knees and his heels directly on the mattress. * 02/01/17 at 11:30 a.m.: Resident #1 laying in bed with two pillows tucked under his knees and his heels directly on the mattress. During an interview on 02/01/17 at 5:15 p.m., an administrative staff (#1) confirmed staff should ensure Resident #1 heels are off the mattress when lying in bed.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		3/9/17

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F 315	Continued From page 50 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 2 of 2 sampled residents observed incontinent of bowel and/or bladder (Resident #5 and #6) received appropriate services to restore bladder/bowel continence to the extent possible. Failure to complete an accurate, thorough assessment of all residents having urinary/bowel incontinence limits the facility's ability to implement appropriate, individualized interventions that address the incontinence. Findings include: On 02/02/17 at 2:00 p.m., an administrative staff member (#1) stated the facility does not do bladder assessments, rather use the information	F 315	F Tag 315 - 483.25 No Catheter, Prevent UTI, Restore Bladder 1. A correction for Resident #5 related to an assessment of urinary/bowel incontinence will be completed before or on March 3, 2017. 2. All residents have the potential not to have an assessment of urinary/bowel incontinence completed. 3. Incontinent assessments, polices and procedures will be reviewed and revised, as appropriate. All nurses and CNAs will be educated related to incontinence. All nurses, including newly hired and agency	

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F 315	Continued From page 51 from a "Clinical Admission Documentation" as the assessment. - Review of Resident #5's medical record occurred on all days of survey. Admission diagnoses included vascular dementia, a fractured neck which occurred at home prior to admission (and use of a C-collar to maintain stability), and an anxiety disorder. An admission Minimum Data Set (MDS), dated 11/18/16, identified moderate hearing impairment without hearing aids; severe cognitive impairment; extensive assistance with transfers, toileting, and personal hygiene; and occasional urinary and bowel incontinence. For this comprehensive assessment, the care area assessment (CAA) for urinary incontinence identified the resident with urinary urgency and needed assistance with toileting as the resident unable to perform activities of daily living (ADLs). The "Admission -- Clinical Admission Documentation," completed on 11/11/16, indicated the resident severely impaired in decision making; occasionally incontinent of urine "2 + times/week, incontinent, but not daily;" and "complete control" of bowel. A progress note, dated 11/12/16, identified "continent of bowel and bladder. Wears pull ups for protection during periods of stress incontinent [sic]. A progress note dated 11/21/16, stated, ". . . Continent of bowel/bladder; requires extensive assistance with toileting. Requires extensive assistance with ADLs. Transfers with extensive assistance of 2 into her wheelchair propelled by staff. . . ."	F 315	staff will be educated related to revised policies and procedures for incontinence assessments. Incontinence assessments will be completed on all residents with incontinence before March 9, 2017. Education was completed on 2.24.17. 4. The DON or designee will monitor compliance, starting 2.3.17, of urinary/bowel incontinence assessment and services provided to restore continence, if possible, according to policy established for six (6) months. QA monitoring will occur on admission, quarterly assessment upon MDS schedule, and any significant change in status. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue for an additional three (3) months to ensure deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for correction of deficient practice is March 9, 2017.	

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F 315	Continued From page 52 The care plan identified the following problems and approaches: * "Resident has a memory/recall problem R/T [related to] vascular dementia diagnoses" with approaches of "Engage resident in conversation that is meaningful to the resident; Provide verbal and visual reminders." * "Resident has history of falling R/T poor eyesight, generalized weakness s/t [sic] advanced age" with ". . . Provide toileting assistance every AM, HS before and after meals and PRN [as needed]." The current care plan does not identify a problem with urinary (or bowel) incontinence. Observations included and identified the following: * 01/31/17 at 12:19 p.m. Resident #5 sat in dining room in her wheelchair for noon meal; at 2:20 p.m. two certified nursing assistants (CNAs) (#10 and #11), pivot transferred with a gait belt, the resident from her wheelchair to bed and did not provide or offer toileting; resident wearing an incontinence brief. The CNAs did not check to see if Resident #5's soiled her brief. At 3:24 p.m., two CNAs (#4 and #12) pivot transferred the resident from the bed to the wheelchair and did not offer nor attempt toileting. At 3:55 p.m., two CNAs (#4 and #12) returned the resident to her room for toileting. Upon removing the resident's brief, observation showed the resident incontinent of stool into the attends which fell to the floor. The CNAs removed the brief and sat the resident down on the toilet and the resident urinated. The CNA (#4) stated the resident don't always ask to go to the bathroom, and staff just need to take her "if it has been awhile."	F 315		

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F 315	Continued From page 53 * 02/01/17 at 9:00 a.m., two CNAs (#7 and #11) transported the resident in to her room. Prior to pivot transferring the resident into bed, one of the CNAs asked the resident if she needed to use the bathroom and the resident said, "I don't think so." After transferring the resident to bed, with the resident wearing the incontinence brief, neither CNA checked the brief for incontinence until requested by the surveyor (at which time the brief was dry). The CNA toileting documentation for the month of January 2017 identified urinary incontinence occurred 26 times, nearly every day on average. On three occasions both urinary incontinence and continence occurred. The CNA toileting documentation for the month of January 2017 identified bowel incontinence occurred 18 times, over every other day on average. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease, dementia, depression, anxiety, and history of urinary tract infections (UTIs). An annual MDS, dated 10/01/16, identified severely impaired cognitive status, usually able to understand others, make self understood, frequently incontinent of urine and occasionally incontinent of stool, and extensive assistance of two for toileting. The current care plan, dated 01/31/17, identified: * "Urinary Incontinence . . . Approach . . . Observe for S/SX [signs and symptoms] of UTI . . . Provide privacy and normal area for voiding. . . . Report areas of skin redness or breakdown . . .	F 315		

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F 315	Continued From page 54 Will be assisted with incontinent product and pericares as needed by staff." The facility failed to identify, evaluate, and respond to Resident #6's current urinary incontinence status. * "Problem . . . Falls . . . Approach . . . Nursing will anticipate resident's need for toileting and will apply normalized toileting Once A Day; 08:00 . . ." The care plan did not identify normalized toileting and identified toileting one time a day. A Progress note, dated 12/30/16, stated, "Does not use call light, therefore needs are anticipated. Toileted in morning and every 2 to 3 hours." CNA toileting documentation identified the following: * 01/23/17 at 9:52 p.m.: incontinent * 01/24/17 at 1:34 p.m.: incontinent (over 15 hours since last toileted). * 01/24/17 at 4:46 p.m.: incontinent (over 3 hours since last toileted). * 01/24/17 at 8:14 p.m.: incontinent (over 3 hours since last toileted). * 01/25/17 at 1:39 p.m.: incontinent (over 5 hours since last toileted). * 01/25/17 at 8:40 a.m.: incontinent (over 7 hours since last toileted). * 01/25/17 at 1:28 p.m.: incontinent (over 4 hours since last toileted). * 01/25/17 at 8:18 p.m.: continent (over 5 hours since last toileted). * 01/26/17 at 12:59 a.m.: incontinent (over 4 hours since last toileted). * 01/26/17 at 1:30 p.m.: incontinent (over 12 hours since last toileted). * 01/26/17 at 4:32 p.m.: incontinent (over 3 hours since last toileted). * 01/26/17 at 9:54 p.m.: incontinent (over 5 hours	F 315		

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F 315	Continued From page 55 since last toileted). * 01/27/17 at 2:03 a.m.: incontinent (over 4 hours since last toileted). * 01/27/17 at 1:21 p.m.: incontinent (over 11 hours since last toileted). * 01/28/17 at 1:29 a.m.: incontinent (over 12 hours since last toileted). * 01/29/17 at 5:34 p.m.: incontinent (over 16 hours since last toileted). * 01/30/17 no documentation * 01/31/17 at 3:25 a.m.: incontinent. * 01/31/17 at 9:45 a.m.: incontinent (over 6 hours since last toileted). * 01/31/17 at 1:30 p.m.: incontinent (over 3 1/2 hours since last toileted). Observations showed the following: * 01/31/17 at 1:30 p.m.: two CNAs (#7 and #8) transferred Resident #6 from wheel chair to the bed using a mechanical total body lift. During the transfer urine dripped onto the floor from Resident #6's brief. During an interview on 02/01/17 at 5:15 p.m., an administrative staff member (#1) confirmed Resident #6's care plan intervention/approach regarding urinary incontinence "provide privacy and normal area for voiding" is not appropriate and staff should update the care plan; Resident #6 can occasionally answer yes or no questions but not sure if could tell staff she needs to use the bathroom; and the CNAs should check and change Resident #6 every two hours, and document each toileting occurrence including if continent or incontinent.	F 315		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		3/9/17

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F 329	Continued From page 56 (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure each resident's drug regimen is free from unnecessary medications for 2 of 7 sampled residents (Resident #5 and #8) with dementia who received or are receiving psychotropic medications. Failure to assess and develop a plan of care for behaviors and a comprehensive plan of care for pain (Resident #5), assess and develop a plan of care for wandering and resistive behaviors (Resident #8) resulted in the use of anti-anxiety and anti-psychotic medications to control/address behaviors. This placed these residents at risk of receiving unnecessary medication.	F 329	F Tag 329 - 483.45 Drug Regimen is Free from Unnecessary Drugs 1. The drug/medication review for Resident #5 was completed on March 1, 2017. The drug/medication review for Resident #8 was reviewed on 2.23.2017 and the physician documented in resident's medical record "reduction will result in exacerbation of symptoms." 2. All residents with dementia receiving an antipsychotic medication have the potential for drug regimen not to be free	

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F 329	Continued From page 57 Findings include: Review of the facility "Antipsychotic Medication Use" policy occurred on 02/02/17. The policy, undated, stated: * Policy Statement: Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. Policy Interpretation and Implementation: 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The Provider and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks. . . . 4. Nursing staff will document in detail an individual's target symptoms(s). 5. The Provider will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 6. The staff will observe, document, and report to the Provider information regarding the effectiveness of any interventions, including antipsychotic medications. . . . 11. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering . . . c. Restlessness . . . f. Insomnia . . . 13. If antipsychotic medications are administered as PRN [as necessary] dosages repeatedly over several days . . . determine whether the use is appropriate and symptoms are responding to the medication. 14. Nursing staff shall monitor and report any of the following side effects to the Provider: . . . i.	F 329	from unnecessary drugs. Education was completed on 2.24.17. 3. All nurses, including newly hired and agency staff, will be educated related to drug regimens being free from unnecessary drugs. All nurses will sign off on educational material as being read and understood related to regulations of unnecessary drugs. 4. The DON or designee will monitor, starting 2.3.17, any new medication orders for six (6) consecutive weeks to ensure appropriate indications for use are clearly documented in the medical record. Random compliance monitoring will continue with any new medication orders over an additional sixty (60) days to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for correction of deficiency is March 9, 2017.	

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F 329	Continued From page 58 Extrapyramidal effects [drug induced movement disorder]; j. Akathisia [movement disorder characterized by a feeling of inner restlessness and a compelling need to be in constant motion]. . . . 15. The Provider shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences." - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a fractured neck obtained while living at home prior to admission, vascular dementia, major depressive disorder and anxiety disorder. An admission Minimum Data Set, dated 11/18/16, identified the resident severely impaired in cognitive status, able to understand others and make self understood, with mild depression which included "Thought of you being better off dead, or of hurting yourself in someway" two to six days a week. Physician orders, dated 11/11/16, included: * Ativan (Lorazepam), an anti-anxiety medication, as needed (prn) * Norco, a narcotic pain medication for moderate to severe pain, every four hours prn * oxycodone 5 mg (milligrams) one-half a tablet three times a day * Tylenol 650 mg two times a day, On 11/21/16, the physician ordered Duragesic (fentanyl) (a potent narcotic pain reliever) 12 mcg/hr (micrograms per hour) every three days On 01/05/17, a progress note identified when the	F 329		

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F 329	Continued From page 59	F 329		

resident saw the psychiatrist "she was crying stating 'I'm scared, I want my family to take me home.' I reassured [resident] that she was at RHC [Richardton Health Center] and that she was safe, continued to sob [cry noisily], [psychiatrist] notes some of the conversation and suggested we increase celexa to 15 mg and f/u [follow-up] in one month." On 01/06/17, the provider increased the dose of Celexa, a medication used to treat depression.

Resident #5's care plan lacked evidence the facility identified a problem with behaviors, including depression. The care plan identified the problem of acute pain which included approaches of "Nursing will administer narcotics, analgesics, and muscle relaxants as needed."

Progress notes identified the following:
* 11/21/16, a social services note stated the resident felt she would be better off dead, however would not do anything to hurt herself.
* 01/05/17, refusing her medications and stated the medications were just "prolonging my life and I don't need that." Nursing staff noted the resident as tearful and sad, and medicated her with Lorazepam.

The medication administration record (MAR) for the month of December 2016 showed nursing staff administered Ativan once a day for a total of 11 days, consistently between the hours of 8:00 p.m. and 12:07 a.m. Nursing staff documented reasons on all occasions were the resident yelling out, unable to redirect, and restless. On one occasion of those 11, the resident denied having pain. The MAR identified the medication effective on each occasion. On 01/05/17, nursing

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F 329	Continued From page 60 staff administered the Ativan as the resident was "crying, yelling in room, very upset." During the month of December, nursing staff administered eight doses of the Norco for pain. Of those eight doses, staff administered no more than one dose each day; did not rate the level of pain, and identified each dose as effective. Facility staff failed to implement measures to address Resident #5's symptoms of depression feeling she would be better off dead, and not wanting to prolong her life. Resident #5's medical record identified nursing staff did not develop a behavior management plan, and develop a comprehensive pain assessment plan to aid in determining the resident's needs and to determine the causative factors including anxiety or pain. This resulted in nursing staff administering Ativan for symptoms also indicators of pain. This may have resulted in the use of the Ativan, an unnecessary medication. - Review of Resident #8's medical record occurred on 02/02/17. Diagnoses included dementia with behavioral disturbances. An admission MDS, dated 08/12/16, identified severe cognitive impairment, minimal depression, and no behaviors. A quarterly MDS, dated 11/05/16 identified severe cognitive impairment, no signs/symptoms of depression, no behavioral symptoms, and rejection of care occurred one to 3 days per week. Physician's orders included Olanzapine (Zyprexa), an anti-psychotic medication, once a day ordered on 12/21/16. The care plan identified the following problems	F 329		

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F 329	Continued From page 61 and approaches: * "Psychotropic Drug Use. Resident receives antipsychotic medication R/T [related to] decreased cognition and delirium s/t [sic] Alzheimer's disease." Approaches included "Monitor resident's behavior and response to medication. Pharmacy consultant review." * "Cognitive Loss/Dementia. Disturbed thought process r/t dementia with behavioral disturbances." Approaches included: ". . . Orient patient to environment . . . Assess patients ability for thought processing. Observe patient for cognitive functioning, memory changes, disorientation, difficulty with communication, or changes in thinking patterns." The care plan did not identify a problem with behaviors and related approaches. Progress notes stated: * 08/12/16 at 5:00 a.m.: stated at 2:00 a.m. "went to the right neighbor lady doorway to use bathroom and said someone was in her bathroom. Redirected . . ." * 08/12/16 at 1:30 p.m.: a social service designee progress note: ". . . diagnosed with Dementia w/ [with] behavioral disturbances, altered mental status, Delirium d/t [due to] known physiological condition and Alzheimer's Disease and has been prescribed Memantine [Namenda - used for treatment of dementia] and Olanzapine." * 08/22/16 at 11:16 a.m.: "Pharm [pharmacy] note: no irregularities. * Note to pharmacist: Follow up on olanzapine. Notes so far indicate she's sleeping fine, no behaviors, no agitation, no anxiety. Originally initiated for Sun Downing and encephalopathy." * 09/07/16 at 6:16 a.m.: "noted confusion, was sitting in another resident's room and she didn't	F 329		

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F 329	Continued From page 62 know why she was there." * 09/22/16: a nurse visited with the resident's daughter regarding the medications to slow progression of dementia. "How behaviors have seem to have gotten worse." * 11/02/16 at 2:56 p.m.: a note regarding the resident suspicious of certified nursing assistants (CNAs) when they entered her room to pick up dirty laundry or refill her water mug, and the resident thought staff were stealing from her. * 11/05/16 at 3:40 p.m.: a note stated during bathing the resident threw the washcloth at the CNA and refused washing of her hair During interview on 02/02/17 at 11:32 a.m., an administrative staff member (#1) stated the facility lacked an assessment process for wandering residents or to determine and implement measures to ensure residents do not wander outside of the facility. The staff member agreed Resident #8 needed monitoring for behaviors. The staff member stated the staff inform the psychiatrist of resident behaviors based on asking staff prior to appointments or staff document these behaviors in the progress notes, and no tracking or trending occurs. Resident #8's medical record lacked indications for use of the Zyprexa. Facility staff failed to assess, and develop approaches to lessen the behavior including wandering into other resident's rooms, and develop an assessment process for wandering residents within and out of the facility.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35	F 356		3/9/17

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F 356	Continued From page 63 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356		

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F 356	Continued From page 64 for review at a cost not to exceed the community standard. (4) Facility data retention requirements. 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 (RN), licensed practical nurses (LPNs), and certified nurse aides (CNAs) directly responsible for resident care at the beginning of each shift during 2 of 3 days of survey (January 31 - February 2, 2016). Failure to post the nurse staffing data at the beginning of each shift in a prominent place denied residents and visitors the opportunity to be informed of current staffing levels. Findings include: Observations on the morning of 01/31/17 and 02/01/17 at 7:30 a.m, showed the posting of staff directly responsible for resident care obstructed by the modular furniture at 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 the nurse staffing data at the beginning of each shift in a prominent place readily accessible to residents and visitors. During an interview on 02/01/17 at 7:30 a.m., an administrative nurse (#1) reported she was unaware the facility should post the nurse staffing data at the beginning of each shift in a prominent	F 356	F Tag 356 - 483.35 Posted Nurse Staffing Information 1. Residents were not affected by this deficient practice. 2. Residents were not affected by this deficient practice. 3. All nurses, including newly hired and agency nurses will be educated related to nursing staff posting requirements. All nurses will sign off on education materials as being read and understood. Education was completed on 2.24.17. 4. The DON or designee will monitor compliance, starting 2.3.17, of the posting of the Daily Staffing sheet to be visible to all visitors and residents daily for thirty (30) days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, random compliance monitoring will continue for an additional thirty (30) days to ensure deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting for four (4) weeks to ensure	

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F 356	Continued From page 65 place readily accessible to residents and visitors.	F 356	deficient practice is corrected. The DON or designee will submit a report to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for deficiency correction is March 9, 2017.	
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to ensure the appropriate use of assistive devices during meals for 1 of 1 sampled residents (Resident # 1) who required a divided plate. Failure to ensure the availability of a divided plate placed Resident #1 at risk for decreased meal intakes and a loss of dignity related to food spillage. Findings include: The facility policy titled "Dining Room Guidelines" occurred on 02/07/17. This policy, undated, stated "Our facility monitors the nutrition and dining services department regularly to ensure that resident needs are met and that dining is safe . . . The monitor will assess . . . If assistive	F 369	F Tag 369 - 483.60 Assistive Devices 1. A correction for Resident #1 is a divided plate will be available at all meals, if needed. 2. All residents needing a divided plate have the potential for a divided plate not to be available at all meals. 3. All Food and Nutrition Services staff and all nursing staff will be educated related to availability of divided plates if needed. All Food and Nutrition Services staff and all nursing staff will sign off on education materials as read and understood. Education was completed on 2.24.17.	3/9/17

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F 369	Continued From page 66 devices are available when required . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included impaired swallowing, cerebral vascular accident (CVA), and significant weight loss. The quarterly Minimum Data Set (MDS), dated 11/13/16, identified moderately impaired cognition, supervision and set up during meals, pureed honey thickened liquid diet, and significant weight loss. The current diet card, located on the table next to Resident #1's meal, identified the following: "Special Utensils: Divided Plate." The current care plan stated, " . . . Problem Category: Nutritional Status . . . Altered Nutritional Status R/T [related to] post CVA and Impaired Swallowing and Significant Weight loss. . . . Approach . . . Monitor need for changing diet consistency to increase ease of eating. Divided plate with meals to aid in self feeding. . . ." Observation on 01/31/17 at 12:25 p.m., showed Resident #1 sat at an assisted table in the dining room and attempted to feed himself. On one occasion, Resident #1 dropped part of a spoonful of pureed tomatoes onto the table. During the observation, staff failed to ensure the resident had his divided plate. Observation on 02/01/17 at 08:15 a.m., Resident #1 sat at an assisted table in the dining room and attempted to feed himself. On three occasions, Resident #1 dipped his spoon into the hot cereal bowl and took a bite of an empty spoon. During the observation, staff failed to ensure the resident	F 369	4. The Food and Nutrition Services Manager or designee will monitor compliance, starting 2.3.17, of divided plates being available to all residents needing them at all meals each day for three (3) weeks, then randomly over all meals for three (3) weeks. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, then random compliance monitoring will continue for thirty (30) days to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The Food and Nutrition Services Manager or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting, for further action, if necessary. 5. Date of completion of deficiency correction is March 9, 2017.	

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F 369	Continued From page 67 had his divided plate. During an interview on 02/01/17 at 5:15 p.m., an administrative staff member (#1) confirmed staff should ensure this resident received a divided plate during meals.	F 369		
F 428 SS=F	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 428		3/9/17

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F 428	Continued From page 68 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure documentation of any irregularities noted by the pharmacist during monthly drug regimen reviews occurred and sent to the attending physician, the medical director, and director of nursing (DON) to act upon for 9 of 9 sampled resident's records (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) reviewed and one closed record (Resident #10). Failure to ensure documentation of irregularities, and ensure the physician, medical director, and DON acted upon the report, has the potential for the resident to receive unnecessary medication and/or experience adverse consequences related to the medication. Findings include:	F 428	F Tag 428 - 483.45 Drug Regimen Review 1. For Residents #1,2,3,4,5,6,7,and 8 a correction was made on February 28, 2017 related to the attending physician/Medical Director and DON acting upon reports from the consulting pharmacist related to irregularities in drug regimens. No correction related to drug regimen review was completed at this time related to Resident #9 being admitted to RHC on 1.5.2017 and on 1.29.2017 and 2.19.2017 the consulting pharmacist documented "No irregularities at this time" in the	

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F 428	Continued From page 69 Review of the facility policy titled "Medication Regimen Reviews" occurred on 02/02/17. The policy, undated, states, "Policy Interpretation and Implementation . . . 5. The primary purpose of this review is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. . . . 7. The Consultant Pharmacist will document his/her findings and recommendations on the monthly drug/medication regimen review report. 8. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. . . . If the Physician does not provide a pertinent response, or the Consultant Pharmacist identified that no action has been taken, he/she will then contact the Medical Director . . . 9. The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions. 10. Copies of drug/medication regimen review reports, including physician responses will be maintained as part of the permanent medical record. . . ." Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 medical records identified pharmacy notes which identified irregularities in each resident's drug regimen. The medical records identified the process the facility utilized for each resident's drug regimen review: * The pharmacist enters the irregularities in the	F 428	resident's chart. 2. All residents have the potential for drug regimen reviews not to be acted upon by the attending physician/Medical Director or DON. 3. The attending physician/Medical Director and DON was educated on February 28, 2017 related to acting upon irregularities noted by the consulting pharmacist during monthly drug regimen reviews. Compliance monitoring, started on 2.3.17 will be completed after each occurrence of drug regimen reviews, at a minimum monthly according to the consulting pharmacist review schedule. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring of the Medical Director and DON acting on irregularities noted by the consulting pharmacist will continue monthly for six (6) to ensure the deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring weekly to ensure deficient practice is corrected. The MDS Coordinator/RN or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion for correcting deficiency is March 9, 2017.	

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F 428	Continued From page 70 computerized medical record within the progress notes * The staff nurse documents the response to the irregularity within the progress notes. Those notes identify who, either the physician or the nurse practitioner, and the response given by the provider. During interview on 02/01/17 at 2:45 p.m., an administrative staff member (#1) confirmed this process and stated the facility had no written document, signed by the physician, the medical director, and DON to confirm the review. Record review identified this process in all sampled resident records reviewed. Examples included: - Resident #6's progress notes stated: * 08/22/16: "Pharmacy Note - Please consider reducing Sertraline [an anti-depressant medication] and Risperidone [anti-psychotic medication] due for a gradual dose reduction (GDR)." * 09/08/16: Nursing note: "Dr. . . . seen resident, GDR [gradual dose reduction] contraindicated at this time, is tolerating the dose well and has been on this dose for awhile." - Resident #3's progress notes stated: * 05/26/16: [Pharmacist Note]: "Irregularity: [resident] is currently taking scheduled doses of both ibuprofen and meloxicam [nonsteroidal anti-inflammatory drug] daily. Concurrent usage is generally deemed a duplication of therapy and not recommended. [Resident] also has reduced kidney function with a GFR [glomerular filtration rate] of 50. Recommendation: When [resident]	F 428		

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F 428	Continued From page 71 returns to [care center], please consider discontinuation of either ibuprofen or meloxicam." * 05/26/16: "Fax from [FNP] regarding pharmacy recommendation. NP [FNP] orders to D/C [discontinue] scheduled Ibuprofen." * 09/24/16: A pharmacy irregularity to discontinue Tramadol (prescribed for pain) due to lack of use since 04/21/16. The progress notes identified the FNP addressed this recommendation and discontinued the Tramadol on 10/13/16. * 11/29/16: A pharmacy review regarding discontinuing a Ventolin inhaler and a nursing progress note identified a physician response on 12/02/16. The facility failed to ensure the attending physician documented a response to each irregularity presented by the pharmacist, in the resident's medical record. This documentation must identify, if any, the action taken including rationale. Failure to ensure an acknowledgement of pharmacist recommendations, through a written document by the physician and medical director, and DON may result in inadequate reviews and result in unsafe medication practices.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		3/9/17

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F 431	Continued From page 72 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 73 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner on 2 of 3 days (January 31-February 1, 2017) of survey. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Storage of Medications" occurred on 02/01/17. This policy, revised April 2007, stated, ". . . The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. . . . Policy Interpretation and Implementation . . . The nursing staff shall be responsible for maintaining storage . . . Compartments . . . containing drugs and biologicals shall be locked when not in use, . . ." On the morning of 02/01/17 at approximately 8:00 a.m., observation showed an administrative maintenance staff member (#15) opened and entered the "storage room" on the west hallway. The facility stored the following medications in two cupboards and/or stacked along the wall: Acidophilus (normal flora), Antacid, Anti-Diarrheal, Aspirin (pain), Acetaminophen (pain), Bisacodyl (laxative), Calcium Carbonate (vitamin), Cranberry (urinary tract infection), Dairy Aid (digestive aid), Ear Drops, Fish Oil (lowers cholesterol/anti-inflammatory), Glucosamine Chondroitin (protein), Hemorrhoidal	F 431	F Tag 431 - 483.45 Drug Records, Label/Store Drugs 1. Residents were not affected by this deficient practice. 2. Residents were not affected by this deficient practice. 3. All nurses, newly hired and agency nurses will be educated related to storage of over the counter medications must be in a secured area where only licensed nurses have access. All nurses will sign off on educational material as being read and understood. Education was completed on 2.24.17. 4. The DON or nurse designee will monitor compliance, starting 2.3.17, of over the counter medications being stored in a secured area where only licensed nurses have access daily for fourteen (14) days, then monitor five (5) times per week for four (4) weeks, then monitor randomly for ninety (90) days. If any concerns are noted, immediate corrective action will be implemented. If no concerns are noted, then random compliance monitoring will continue for ninety (90) days to ensure the deficient practice has been corrected. The clinical interdisciplinary will review	

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F 431	Continued From page 74 Ointment (pain/anti-inflammatory), Ibuprofen (pain), Loratadine (antihistamine), Medicated Chest Rub, Melatonin (sleep), Milk of Magnesia (laxative), Mucinex (decongestant), Mucous Relief, Mylanta (anti-gas), Naproxen Solution (pain), Nasal Moisturizing Spray, Ocular Untanim (eye care), Senna (laxative), Tussin DM (cough), and Vitamins B, C, D, E, Iron, and Magnesium. During an interview on 02/01/17 at 8:15 a.m., an administrative nurse (#1) reported "the CNAs (certified nursing assistants), RNs (registered nurses), and Management [staff] all have access to the supplies . . . and medications, I guess." She further stated the items "have always been [stored] like this, just like in the old building."	F 431	compliance monitoring at a weekly meeting to ensure deficient practice has been corrected. The DON or nurse designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion of deficiency correction is March 9, 2017.	
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		3/9/17

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F 441	Continued From page 75 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store,	F 441		

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F 441	Continued From page 76 process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: INFECTION CONTROL PROGRAM 1. Based on record review, review of facility policy and procedure, and staff interview, the facility failed to establish an infection prevention and control program (IPCP) including prevention, identification, investigation, and control of infections/communicable diseases during 9 of 9 months (May 2016 - January 2017) reviewed. Failure to identify the source of all infections and appropriateness of treatment resulted in the inadequate treatment of Resident #3's UTI resulting in a deterioration of her condition, resulted in the delayed treatment of Resident #10's UTI, and may result in the spread of infections/communicable diseases to other residents, staff and/or visitors. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 02/02/17. The policy, revised August 2016, stated, ". . . The elements of the infection prevention and control program consist of . . . surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The "Policy Interpretation and Implementation" included, ". . . Surveillance data and reporting	F 441	F Tag 441 - 483.80 Infection Control INFECTION CONTROL PROGRAM 1. A correction for Resident #3 related to timely identifying the appropriateness of treatment cannot be made related to the time lapse between occurrence of May 2016 and current date. A correction Resident #10 cannot be made related to the resident no longer residing in the facility. 2. All residents have the potential to be affected related to failure to identify the source of all infections and appropriateness of treatment. 3. The Infection Control Preventionist will be educated related to the infection control report form to include, but not limited to, culture reports, organism/causative agent of the infection and the sensitivity of the organism to medications sensitive to the organism, cautionary measures/actions taken to prevent spread of infections, tracking and trending of information and analyzing organism clusters by March 1, 2017. The	

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F 441	Continued From page 77 information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: (1) whether physician management of infections is optimal; (2) whether antibiotic usage patterns need to be changed because of the development of resistant strains; (3) whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion; and (4) where there is appropriate follow-up of acute infections. . . ." Review of the facility infection control tracking map and "Order Report by Drug Class" occurred on February 01-02, 2017. The reports from May 2016 through January 2017, identified the name of specific residents with infections with the following identifying data: * Start and End date of an antibiotic * Order description: name of antibiotic, dosage and frequency * Provider (physician or nurse practitioner) giving the order * Diagnosis of the resident * Category of the medication order, i.e. "Antibiotics" (always) * Drug class of medication ordered: "Anti-Infective Agents/Antibacterials/Penicillins" * Location of room including room number and unit name The report form lacked information about whether the facility obtained/did not obtain cultures, the organism/causative agent of the infection, the sensitivity of the organism to medications (to ensure treatment with medication sensitive to the organism), and the cautionary measures/actions taken to prevent the spread of infection within the	F 441	Infection Control Program policy/procedure will be reviewed and revised, as appropriate, before or on March 8, 2017. The Infection Control Preventionist and the DON will attend an education seminar on "Regulatory Compliance Infection Prevention and Control". The Infection Control Preventionist will sign off on all educational materials as read and understood related to infection control regulations. 4. The DON or designee will monitor compliance, starting 2.3.17, related to the infection control report form to include, but not limited to, culture reports, organism/causative agent of the infection, the sensitivity of the organism to medications and medication sensitive to the organism, cautionary measures/actions taken to prevent spread of infection, evidence of tracking and trending of information and analyzing organism clusters five (5) times weekly for four (4) weeks, once weekly for thirty (30) days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue weekly for an additional sixty (60) days to ensure deficient practice is corrected. The clinical interdisciplinary team will review compliance monitoring at a weekly meeting to ensure deficient practice is corrected. The DON or designee will submit a report to the QAPI committee at each scheduled monthly meeting for	

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F 441	Continued From page 78 facility. The report form also failed to include the date the infection resolved and lacked evidence the facility tracked and trended the infection control information and failed to analyze organism clusters for changes in prevalence or increases in the rate of infection. The facility staff cannot make effective recommendations for the prevention of infections and control of the spread of infections with incomplete information. During interview on the morning of 02/02/17, an administrative staff member (#1) stated the facility relies on a technician at the hospital to track results ordered to ensure the facility obtained a result. - Review of Resident #3's medical record occurred on all days of survey and identified the resident hospitalized on May 08-09, 2016 with a diagnoses of a urinary tract infection (UTI). The "Instructions for after Discharge" included a follow up with the resident's primary care physician, orders for Ciprofloxacin (Cipro) (an antibiotic) for nine days, and hospital urinary cultures pending for the UTI. The final culture report, dated 05/10/16, identified the organism of Escherichia coli (E coli), greater than 100,000 colony forming units/milliter. The culture identified the organism resistant to Cipro. The facility failed to ensure a change in antibiotic to one sensitive to the organism identified. This resulted in inadequate treatment of the resident's UTI and a deterioration resulted. Refer to F309 Base #1. - Review of Resident #10's medical record occurred on 02/01/17. Diagnoses included a history of UTIs. On 10/18/16, a "UA [urinary analysis] [was] collected per doctors order . . ."	F 441	further action, if necessary. 5. Date of completion for deficiency correction is March 9, 2017. GLUCOMETER CLEANING 1. Residents were not affected by this deficient practice. 2. All residents requiring finger stick glucose tests have the potential to be affected by this deficient practice. 3. All nurses, including newly hired nurses and agency nurses will be educated related to policy/procedure of disinfecting the glucometer. The nurse performing the deficient practice was educated on February 3, 2017. All nurses will sign off on educational materials as being read and understood related to infection control regulations. Education was completed on 2.24.17. 4. The DON or designee will monitor compliance, starting 2.3.17, of disinfecting the glucometer daily for fourteen (14) days, then at a minimum of four (4) times weekly for (2) weeks and then randomly for the next thirty (30) days. If concerns are noted, immediate corrective action will be implemented. If no concerns are noted, compliance monitoring will continue randomly for an additional thirty (30) days to ensure the deficient practice is corrected. The clinical interdisciplinary will review compliance monitoring at	

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F 441	Continued From page 79 The final culture report, dated 10/21/16, identified ". . . Organism of Escherichia coli, > [greater than] 100,000 colony forming units/milliliter. Extended Spectrum Beta-Lactamase (ESBL) producing organism. Attention: Antibiotic Resistant Alert. CDC [Centers of Disease Control] Recommends Contact Isolation. . . ." The panel further identified the organism was susceptible to Nitrofurantoin. The nurse practitioner (NP) reviewed the final culture on 10/24/16, and wrote an order for "Nitrofuranten [sic] (Macrobid) BID [twice daily] x [times] 10 days." The facility also put "isolation precautions in place" and "moved [Resident #10] to [a] private room." There was no indication in the record the facility attempted to obtain Resident #10's lab results prior to 10/24/16. The facility failed to ensure Resident #10's lab results (information about culture results and/or antibiotic resistance) were received in a timely fashion. This resulted in delayed treatment of Resident #10's UTI. CLEANING OF GLUCOMETERS 2. Based on observation, review of professional reference, review of manufacturer's instructions, and staff interview, the facility failed to properly disinfect the blood glucose meter for 1 of 1 supplemental residents (Resident #10) observed during blood glucose testing. Failure to disinfect the glucose meter between residents may result in the transmission of organisms and pathogens to other residents, staff, and visitors. Findings include: A Centers for Disease Control and Prevention	F 441	weekly meetings to ensure deficient practice is corrected. The DON or designee will submit a report of QA monitoring to the QAPI committee at each scheduled monthly meeting for further action, if necessary. 5. Date of completion of deficiency correction is March 9, 2017.	

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F 441	Continued From page 80 publication titled "Frequently Asked Question (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration, "dated 03/08/11, stated, "Infectious agents, such as HBV [hepatitis B virus] can be transmitted through indirect contact transmission, even in the absence of visible blood . . . indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated objective (e.g., blood glucose meter) . . ." The Super Sani-Cloth Germicidal Disposable Wipe manufacturer's directions for use to disinfect stated, "To disinfect nonfood contact surfaces only: . . . unfold clean wipe and thoroughly wet surface. Allow treated surface to remain wet for two (2) minutes . . . let air dry . . ." Observation on 02/01/17 at 11:20 a.m. showed a staff nurse (#2) entered a resident room, performed a blood glucose test, wiped off the glucometer with a sani-cloth, and failed to allow it to dry. The staff nurse placed the visibly wet glucose monitor into the plastic tote on top of the clean supplies (cotton swabs, lancets, test strips, and alcohol swab packets). During an interview on the afternoon of 02/02/17, an administrative staff (#1) confirmed staff should sanitize the glucometer with a sani-cloth and allow it to completely dry before placing it back into the plastic tote with the clean supplies.	F 441		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		3/9/17

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F 520	Continued From page 81 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520		

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F 520	Continued From page 82 by: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, the facility failed to maintain a Quality Assurance (QA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice to ensure compliance with federal requirements. Findings include: Refer to F 157, F 278, F 280 and F 309 for specific findings. Failure to effectively utilize QA resulted in the facility not maintaining compliance in the following: * F 157 - physician notification * F 278 - accuracy of Minimum Data Set Assessments * F 280 - reviewing and revising the comprehensive care plans * F 309 - to provide quality of care and services, specifically to manage urinary tract infections and prevent sepsis, and aspiration precautions	F 520	F Tag 520 - 483.75 QAA Committee-Member Meet Quarterly Plans 1. Residents were not affected by this deficient practice. 2. All residents have the potential to be affected by ineffectively utilizing a QAPI program to maintain compliance with state and federal regulations. 3. The facility's QAPI program members will attend an educational session related to the process of development and implementation of an going comprehensive program to attain and maintain compliance of all regulations. All members of the facility's QAPI committee will sign off on educational materials as being read and understood to attain and maintain substantial compliance of state and federal regulations. Through the facility's development and implementation of a QAPI program the primary focus will be on repeat and deficient practices until substantial compliance is maintained for six (6) months. Education of QAPI was initiated on 2.28.17, comprehensive training to happen on March 21st by established QAPI coordinator. 4. The QAPI committee will meet the last Tuesday of each month. QA initiated 2.28.17. The Medical Director will be invited and plans to attend each month. The Medical Director will be physically present not less than quarterly. Written	

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 _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 83	F 520	agendas and minutes will be reviewed and signed by all members of the QAPI committee at every monthly meeting. The QAPI committee will discuss, but not limited to, all monitoring compliance related to plans of corrections to continually maintain substantial compliance with state and federal regulations. The facility's QAPI program will be ongoing and eventually comprehensive of all services offered by the facility. 5. Date of completion for correction of deficiency is March 9, 2017.	