STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____ JUN 18 2010	C 05/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 and complaint survey, started on 05/17/10 and completed on 05/20/10, the sample included 5 residents for complete review, 18 residents for focused review, and 3 closed records.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 06/11/09. Based on record review, review of facility policies and procedures, and resident and staff interview, the facility failed to provide medically-related social services to assist residents to maintain their highest practicable psychosocial well-being for 1 of 3 sampled residents (Resident #4) who experienced a death in their family in the past six months. Findings include: Review of the facility document, "Social Services Responsibilities" occurred on 05/20/10. The undated document stated, ". . . 7. Complete charting for SS [social services] issues prn [as needed] as you work with residents and families. 8. Meeting and visiting with residents and families	F 250	**F-0250 Provision of Medically Related Social Services** 1. Resident #4 will be followed up on for grieving issues and programming will be implemented as needed. 2. All residents identified with a psychosocial need/issues will be assessed. 3. Social Services Policy will be implemented addressing resident psycho/social needs. Semi-Annuals Q.A. will be performed. *Policy included in POC. 4. Q.A. will be completed at lease semi-annually. *Q.A. form included with POC. 5. Social worker will be accountable for completing Q.A.	6/25/10

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

Craig Thompson — CEO — 6-17-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	Continued From page 1 on issues of concern/changes. . . ." Following the entrance conference, on the morning of 05/17/10, the facility provided a list of interviewable residents. The list included Resident #4. - When interviewed on 05/17/10 at 5:30 p.m., Resident #4 stated her son had recently died. She expressed regret that she had not taped her memories for him, as he had asked her to do, and now it was too late. During the group interview, on 05/18/10 at 3:45 p.m., Resident #4 again discussed her son's recent death with a second surveyor. Review of Resident #4's medical record, on May 17-20, 2010, identified diagnoses including depressive disorder. Progress notes identified the following: * 03/28/10 at 1 p.m. - "Son [name] here to inform resident that son in California passed away this AM [after] his battle [with] cancer. Nsg [nursing] staff did spend time [with] resident - [chaplains's name] notified and came to spend time [with] resident." * 03/28/10 at 9 p.m. - "Resident has visited [with] staff about losing her son et [and] friends were [with] her his evening." * 03/29/10 at 7 a.m. - "Resident has slept poorly. Is not weepy but states, 'I'm just thinking about my son, I'll be OK.'" * 04/02/10 at 11 a.m. - "Res [resident] is doing well [with] son's death, does talk about it often." Review of the resident's care plan identified a problem, dated 03/29/10, "Son passed away 3/28/10. Lived in California." Approaches to the problem included, "Staff visits, comforting words	F 250		

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F 250	Continued From page 2 to res & [and] allow res to talk about her feelings & grief, allow reminiscing of son . . ." The record lacked evidence social services visited with the resident following her son's death to assist Resident #4 with the grieving process. Social service notes, dated 05/10/10 and 05/18/10 indicated visits with the resident for a quarterly review and assistance with shopping, but failed to identify discussion of her son's death. A telephone interview with a social worker (#4) occurred on 05/20/10 at 9:45 a.m. The social worker stated she did visit with Resident #4, but did not indicate when the visit(s) occurred. When interviewed on 05/20/10 at 10 a.m., Resident #4 stated she could not recall any visits from the social worker following her son's death.	F 250		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		

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F 278	Continued From page 3 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 06/11/09. Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 8 of 23 sampled residents (Resident #7, #9, #14, #15, #18, #20, #22, and #23). Failure to accurately complete the MDS for each sampled resident did not allow each resident the opportunity to receive care consistent with their individual needs, problems, and strengths, and retain/maintain their maximum level of function. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 2.0, revised December 2008, page 1-25, stated, "The importance of accurately completing and submitting the MDS cannot be overemphasized . . . The MDS information is the basis for the development of an individualized care plan . . . Medicare Prospective Payment	F 278	**F-0278 Assessment Accuracy** 1. MDS's for the following residents will have Significant Corrections done. Section G will be corrected for the following residents, #7, #9, #14, #15, #18, #20 & #22. Resident #23 has died since the survey. Careplans will be updated to match the Corrections made. 2. All nurses that complete the MDS are aware of the guidelines for Section G as per the RAI manual and will follow these guidelines. 3. All nurses that complete the MDS have read through the RAI manual in regards to Section G in order to clarify. 4. MDS QA will be done quarterly and PRN to assure that the MDS coding is correct. *QA is included with this POC. 5. DON, QM nurse and nurse managers are responsible to monitor this.	6/25/10

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F 278	Continued From page 4 System, State Medicaid reimbursement programs, quality monitoring activities . . ." Pages 3-76, 3-77, and 3-81 defined the following: * "Extensive Assistance - While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times: --Weight-bearing support provided three or more times; --Full staff performances of activity (3 or more times) during part (but not all) of last seven days." * "Total Dependence - Full staff performance of the activity during entire seven-day period. There is complete non-participation by the resident in all aspects of the ADL [Activities of Daily Living] definition task. If staff performed an activity for the resident during the entire observation period, but the resident performed part of the activity himself/herself, it would not be coded as a "4" (Total Dependence)." * "Transfer - How the resident moves between surfaces - i.e., to/from bed, chair, wheelchair, standing position . . ." * "Toilet Use - How the resident uses the toilet room . . . transfers on/off toilet . . ." Observation and record review identified a contradiction in the residents status and the coding on the following resident's MDSs: - Review of Resident #14's medical record occurred on all days of survey. The care plan, revised 11/03/09, stated, "Requires extensive/total assist with ADL's . . . Interventions: Transfers with standing lift or assist of [one - two] depending on ability for the day [dated 01/12/10] . . ." The MDSs, dated 02/12/10 and 11/02/09, identified Resident #14 required total assistance of 1 person for transfers and toilet use during the seven day assessment reference period.	F 278		

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F 278	Continued From page 5 Resident #14 assisted with transfers and toilet use by holding onto the handles of the lift and bearing weight during the following observed transfers: * 05/17/10 at 4:00 p.m. - Two certified resident assistants (CRAs) (#10 and #11) utilized the mechanical standing lift (MSL) (a sit to stand lift) and transferred the resident from the recliner to a wheelchair. * 05/17/10 at 5:45 p.m. - Two CRAs (#10 and #11) utilized the MSL and transferred the resident from a wheelchair to bed. * 05/18/10 at 9:30 a.m. - Two CRAs (#12 and #13) utilized the MSL and transferred the resident from a wheelchair to the toilet and from the toilet to the recliner. * 05/18/10 at 1:45 p.m. - Two CRAs (#12 and #14) utilized the MSL and transferred the resident from the bed to the toilet and back to bed. Resident #14 required only extensive assistance with transfers and toileting and is not totally dependent as identified on the MDS's. - Review of Resident #15's medical record occurred on all days of survey. The resident's care plan, revised 10/15/09, stated, "Requires extensive/total assist with ADL's . . . Interventions: . . . Transfers with assist of one, and/or MSL PRN [as needed] . . . Toilet per schedule . . . occ. [occasionally] will take self to BR [bathroom] [dated 01/19/10] . . ." The MDS's dated 04/14/10, 01/14/10, and 10/14/09, identified Resident #15 required total assistance of one person for toilet use during the seven day assessment reference period. Observation on 05/18/10 at 9:10 a.m. showed the	F 278		

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F 278	Continued From page 6 CRA (#15) utilized a gait belt and assisted Resident #15 from a wheelchair to the toilet and back to the wheelchair. The resident assisted by holding onto the arms of the wheelchair for support as she walked. - Review of Resident #18's medical record occurred on May 19-20, 2010. The resident's care plan stated, "Requires total assist with ADL's . . .Transfers with MSL and assist of 1-2 . . ." The MDSs, dated 04/10/10, 01/10/10, and 07/10/09, identified Resident #18 required total dependence of one person for toilet use. The Resident Assessment Protocols (RAPS), dated 04/10/10, stated, "ADL's - Requires total assist [with] ADL's - unable to participate . . ." Observation on 05/19/10 at 4:00 p.m., showed two CRAs (#16 and #17) utilized a MSL and transferred Resident #18 from a wheelchair to the toilet and back to the wheelchair. The resident participated in the toilet use by holding onto the handles of the lift and bearing weight during the transfer. - Review of Resident #23's medical record occurred on May 19-20, 2010. The current care plan, initiated 03/23/10, stated, ". . . extensive assist with all ADL's . . ." and the approach of ". . . stand-up lift to transfer to toilet and is extensive assist to meet tioleting [sic] needs . . ." The MDS, dated 03/22/10, identified the Resident #23 required total assistance for toileting during the seven day assessment reference period. The ADL RAP, dated 03/31/10, identified the location of documentation on ADLs as "CRA interviews 03/15/10, progress notes and H&P [history and physical] 3/10-3/16/10 [during 14 day assessment period]." The RAP stated, " . . . Extensive assistr	F 278		

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F 278	Continued From page 7 [sic] with . . . toileting needs. Transfers with . . . a stand-up lift. . . ." During an interview on 05/19/10 at 4:00 p.m., a CRA (#1) identified Resident #23 transferred with a mechanical standing lift to use the toilet. Observation on 05/19/10 at 5:45 p.m. showed Resident #23 assisted by one CRA (#1) to transfer with a mechanical standing lift. The resident participated in transferring by holding onto the handles of the standing lift and bearing weight during the transfer between the bathroom and his recliner. - Resident #22's medical record, reviewed May 19-20, 2010, identified an annual MDS, dated 05/06/10. The MDS identified Resident #22 as requiring total dependence with transfers. Documentation in Resident #22's medical record indicated the resident assisted with transfers during the seven day look back period. Progress notes stated the following: * 05/05/10 at 9 p.m. - ". . . Resident transferred to bed [with] assist of [two] pivot transfer. Resident assisted staff [with] transfer. . . ." During an interview on 05/19/10 at 5 p.m., an administrative nurse (#5) stated she codes the MDS based on assistance occurring three or more times in the seven day look back period. She stated she coded total dependence since a Hoyer lift was used during the look back period. This conflicts with the RAI user's manual, which identified full staff performance must occur during the entire seven-day period for staff to code total dependence. - Review of Resident #20's medical record occurred on May 19-20, 2010. The most recent	F 278		

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F 278	Continued From page 8 MDS, dated 04/19/10, indicated Resident #20 required total assistance from one person with dressing and personal hygiene. Resident #20's care plan, last revised 01/26/10, stated ". . . Limited to extensive assist with grooming, dressing. . . ." On 05/18/10 at approximately 1:15 p.m., observation showed Resident #20 entered the nurses' station and washed her hands at a sink. A CRA (#6) assisted the resident to put soap on her hands. The CRA stated Resident #20 frequently washes her hands when she sees a sink because she is used to doing it with cares. On 05/19/10 at 4:47 p.m. a CRA (#9) assisted Resident #20 to the bathroom. After the resident used the toilet, she pulled up one side of her brief and pants while the CRA pulled up the other side. The resident then ambulated to the sink and washed her hands after being prompted by the CRA. During the observations, the resident required limited assistance with dressing and personal hygiene and is not totally dependent as identified on the most recent MDS. - Review of Resident #7's medical record occurred on May 17-19, 2010. The care plan for ADLs, revised 12/15/09, stated, "Res [resident] requires total assist with ADL's . . . Interventions: "TRANSFERS PER MSL . . . TOILETED PER SCHEDULE. . . ." Resident #7's most recent MDS, dated 03/15/10, identified the resident required total assistance of one person for transfers and total assistance of two or more people for toilet use.	F 278		

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F 278	Continued From page 9 On 05/18/10 at 8:35 a.m., observation showed a CRA (#21) transferred Resident #7 using an EZ stand mechanical lift from her bed to the toilet and then to her chair. The residetn participated in transferring by holding onto the handles of the standing life and bearing wieght during the transfer. Observation showed Resident #7 required extensive assist for toilet use and transfers, not total assistance as noted on the MDS and careplan. - Review of Resident #9's medical record occurred on May 17-19, 2010. The care plan for ADLs, revised 01/28/09, stated, "Requires extensive/total assist with ADL's . . . Participation and strength varies d/t [due to] res alertness and breathing. . . . Interventions: TRANSFERS WITH ASSIST OF 1-2 AND/OR MSL DEPENDING ON ALERTNESS. . . . TOILETED EVERY 2 HOURS AND PER REQUEST. . . ." Resident #7's most recent MDS, dated 04/25/10, identified the resident as required extensive assistance of one person for transfers and total assistance of one person for toilet use. On 05/18/10 at 10:00 a.m., observation showed a CRA (#22) transferred Resident #9 by standing and pivoting her from the bed to her wheelchair, from the wheelchair onto the toilet, and then back in the wheelchair. The resident participated in the toileting by bearing weight during the transfers. Observation showed Resident #9 required extensive assist with toileting, not total assist as noted on her MDS. During an interview on 05/19/10 at 4:45 p.m., an	F 278		

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F 278	Continued From page 10 administrative nursing staff member (#20) indicated per facility decision, they code all residents using a stand lift for transfers as "total assist," and do not consider how a resident is transferred on/off the toilet when coding toilet use. This contradicts the guidelines outlined in the RAI manual for coding extensive assistance and total assistance of the resident by facility staff. The residents' ability to participate in cares does not meet the coding definition for total dependence on the MDS.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE SURVEY CONDUCTED ON 06/11/09. Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess and implement fall prevention measures and ensure residents received the supervision and assistive devices necessary to prevent accidents for 3 of 12 sampled residents (Residents #2, #12, and #20.) identified as experiencing falls. Failure to assess residents for changing status (e.g. cognitive, functional) and provide necessary supervision and assistive	F 323		

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F 323	Continued From page 11 devices poses a risk to resident safety and has the potential to result in avoidable accidents. Findings include: Review of the facility policy entitled "Guide Lines [sic] for Moving, Positioning, Lifting, & Transferring a Resident" occurred on 05/20/10. This policy, dated January 2008, stated, ". . . Purpose: Residents will be moved or re-positioned in a manner that will ensure Resident comfort and not cause injury to Resident or Staff. . . . 1. Check with Unit Nurse or Resident Care Plan before attempting to move, lift, or transfer resident whom you are not familiar with. . . ." Review of the facility policy "Gait Belts/Mechanical Lifts" occurred on 05/20/10. The policy, reviewed on January 2008, stated, ". . . Purpose: 1. To prevent resident from injury. 2. To prevent employees from injuring themselves. . . . Mechanical lifts must be used when transferring a resident when it has been determined necessary by the charge nurse or multi-disciplinary team. When a mechanical lift is determined as necessary, it will be put on the resident's care plan. Full mechanical (hoyer) require 2 people be present. The standing lift requires one person be present. It is the CNA's [Certified Nursing Assistant's] and RCNA's [Restorative Certified Nursing Assistant's] responsibility to read the resident's care plan and to deliver the care as stated in the care plan." - Review of Resident #20's medical record occurred on May 19-20, 2010. Diagnoses included dementia, osteoarthritis, and a history of cerebrovascular accident. Resident #20's most	F 323	**F-0323 Accidents and Supervision** 1. Resident #20 had shoes removed from room along with all other shoes, only has gripper socks to be worn. Resident #12 had the walker removed from her possession. Resident #2 has the remote control for the recliner kept in the pocket of the chair, which is out of his reach. 2. All residents will be assessed according to the Fall Risk Form. New residents will be assessed upon admission, quarterly and PRN. Current residents will be assessed quarterly and PRN. New Interventions will be put into place as needed to prevent falls. 3. Nurses were educated on June 9, 2010. *Meeting Minutes included in this POC. This education included the need for nurses to communicate new interventions put into place. Nurses will put new interventions on report, on the 72-hour report, and on careplan. CRA's will be educated on June 17, 2010 in regards to following careplans for fall interventions. *Agenda is included in this POC 4. Quarterly QA will be done for residents that have fallen. A fall committee will be started. This committee will review falls and assure	

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F 323	Continued From page 12 recent Minimum Data Set (MDS), dated 04/19/10, indicated an unsteady gait, a fall in the past 30 days, and a fall in the past 31-180 days. According to this MDS, the resident required total assistance of one person for dressing, and limited assistance of one person for transfers, walking, and locomotion. Resident #20's care plan, last updated 04/19/10, stated, ". . . Focus . . . Potential for injury from falls. . . . Interventions . . . gripper socks instead of shoes. . . ." Observation of Resident #20 on 05/19/10 at 8:15 a.m. showed a large bandage across her forehead, a scrape on the bridge of her nose, and a small abrasion to her right forearm. Review of nurses' notes revealed the following: "05/19/10. . . 7:55 a.m. . . . Resident noted on the floor sitting on R) [right] side [with] legs bent @ the knees et [and] extended out behind resident, resident supporting self up [with] R) hand et arm. Noted resident to have some bleeding to middle of forehead et nose later noted upon assessment. Resident to have [sic] a 2.2 cm [centimeter] x 0.1 cm laceration to R) arm [sic] forearm posterior side. . . . Resident noted to have black shoes on . . . resident was changed into gripper socks as well. . . ." During an interview on 05/20/10 at 10:25 a.m., a staff member(#5) stated Resident #20 is supposed to wear gripper socks instead of shoes because her ankles turn outward when she walks and shoes cause her to be unbalanced. The staff member stated during the time of the fall, a new certified resident assistant (CRA) working with Resident #20 didn't know gripper socks were care	F 323	interventions are in place. *QA is included with this POC. A fall committee will be started in July 2010. It will be made up of Nurse Management, Nurses, CRA's, Restorative Aides, Social Services, Activities and Housekeeping/Laundry. 5. The fall committee will be responsible to monitor falls and safety of the residents	6/25/10

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F 323	Continued From page 13	F 323		

planned and shoes were put on Resident #20 by mistake.

- Review of Resident #12's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and osteoarthritis. Medications included Risperdal (an antipsychotic which may cause dizziness). Resident #12's most recent MDS, dated 05/13/10, indicated a short-term and long-term memory problem, moderately impaired decision making skills, an unsteady gait, a fall in the past 30 days, and a fall in the past 31-180 days.

Resident #12's most recent care plan, revised 08/19/09, stated ". . . Focus . . . Potential for falls r/t [related to] dx [diagnosis] Alzheimer's disease . . . leaves walker, walks around walker, or refuses to use fww [front-wheeled walker] as recommended per PT [physical therapy] . . . Interventions . . . Reintroduce walker at various times to see if Res [resident] accepting . . . Supervision to limited assist with transfers and ambulation prn [as needed] during times of unsteadiness . . ."

Resident #12's most recent PT note, dated 07/10/08, stated ". . . While walking [with] resident using FWW make attempts at minisquats 5-15x [times]. . . Goal is to keep resident ambulatory and stable [with] FWW. . . ."

Review of Resident #12's nurses' notes indicated the resident fell on 01/07/10, 01/27/10, 02/12/10, and 02/26/10, while the resident ambulated in the hallways or dining room. The record lacked indication the resident utilized a walker or refused to use one prior to the falls. A nurses' note from 04/27/10 (Resident #12's most recent fall)

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F 323	Continued From page 14 indicated the resident forgot her walker in the hallway and wandered into another resident's room. Throughout the survey, the following observations identified facility staff inconsistent in approaches to promote Resident #12's safety with the encouragement of a walker for ambulation: * 05/17/10 @ 10:45 a.m.: Resident #12 ambulated in the hallway without a walker, staff members walked by the resident and did not offer a walker. * 05/17/10 @ 4:58 p.m.: Resident #12 seated at a dining room table, no walker within reach. * 05/18/10 @ 7:50 a.m.: A CRA (#6) assisted Resident #12 with morning cares. The CRA then walked with Resident #12 from her room, down the hallway, and to the dining room. The CRA failed to ambulate the resident with a walker or offer one for the resident to use. * 05/18/10 @ 9:55 a.m.: A CRA (#6) assisted Resident #12 from the dining/activity area to the main bathroom. The CRA failed to ambulate the resident with a walker or offer one for the resident to use. * 05/18/10 @ 1:30 p.m.: A CRA (#6) stated Resident #12 ambulated to the main bathroom with the CRA's assistance and then ambulated back to the dining/activity area. The CRA reported not using a walker to assist the resident. Observation at this time showed the resident seated in a recliner without a walker in reach. * 05/18/10 @ 2:20 p.m.: Resident #12 ambulated in the hallways and dining room. Numerous staff walked by and failed to offer Resident #12 a walker. The resident sat in a chair by a dining table and stated, "I need to sit. My legs get tired." * 05/19/10 @ 3:40 p.m.: Resident #12 sleeping in a recliner in the activity/dining area. Observation	F 323		

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F 323	Continued From page 15 showed a walker placed in front of the resident. * 05/19/10 @ 5:30 p.m.: Resident #12 seated in a recliner, no walker within reach. * 05/20/10 @ 8:00 a.m.: Resident #12 asleep in bed, no walker noted in her room. * 05/20/10 @ 8:35 a.m.: A CRA (#7) assisted Resident #12 with morning cares. The CRA used a walker to assist the resident with ambulation to and from the bathroom. The resident also used the walker to ambulate down the hallway and into the dining room. * 05/20/10 @ 10:15 a.m.: Resident #12 was in the main bathroom with a staff member (#8). Observation showed the resident's walker in the dining room. - During the initial tour of the facility on the morning of 05/17/10, observation identified Resident #2 with dressings to the right forearm and upper arm. A social worker (#4) present during the tour stated the resident had recently sustained a fall. The medical record for Resident #2, reviewed on all days of survey, identified diagnoses including Parkinson's Disease, orthostatic hypotension (low blood pressure with position changes), and congestive heart failure. An annual MDS, dated 05/11/10, identified Resident #2 required extensive assistance with transfers and toileting, and had falls in the past 30 and 31-180 days. Resident #2's current care plan identified a problem "Potential for injury R/T [related to] falls . . . *Does not like to wait for assistance. Will attempt to get up independently if call light not answered immediately. . . . Revised date: 8/5/2008." Approaches to the problem included, ". . . Answer [call light] promptly as does not like to	F 323		

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F 323	Continued From page 16 wait . . . Alarm cushion in recl. [recliner] chair, Keep chair remote out of res [resident's] reach (dated 04/16/10), Use standing lift when unsteady (dated 05/12/10) . . . ." During an interview on 05/19/10 at 8:20 a.m., an administrative nurse (#5) stated Resident #2 sleeps in his recliner most nights and rarely sleeps in his bed. Resident #2's progress notes identified the following: * 09/09/09 at 6:50 p.m. - "CRA heard resident yelling 'Help me' et [and] found resident laying on bathroom floor . . . Resident stated walked to bathroom, went to bathroom et then fell down." * 09/10/09 at 6:50 p.m. - "This nurse entered residents room to give him his 7 pm pills. Found resident's leg rest to recliner half way up et resident sitting on toilet. . . ." * 09/29/09 at 3:30 p.m. - "Resident found on the floor stated 'I was coming back from bathroom' large skin tear on RT [right] elbow. . . ." * 10/14/10 at 6 p.m. - "CRA found resident attempting to walk to bathroom alone. CRA asked resident to sit back down in chair so she could get residents walker et assist resident [with] ambulating to bathroom. . . ." *10/16/09 at 7 p.m. - "Resident found standing in middle of room [with] chair alarm sounding. . . ." * 11/25/09 12:45 p.m. - "CRA passing by Res room saw [Resident #2] on buttocks &[and] legs on floor in front of his recliner. With the control he had put it up high like position to get out of chair . . . Res upper back & head were resting on foot rest area of chair. . . ." * 11/25/09 at 6:30 p.m. - ". . . Resident continues to have tab alert in recliner. Tab alert sensor was going off et CRA found resident standing in front	F 323		

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F 323	Continued From page 17 of recliner [without] walker . . ." * 12/25/09 at 11:45 a.m. - "CRA found res on his knees on the floor in front of his recliner. . . ." * 12/25/09 at 4 p.m. - "Resident denies any pain or discomfort from fall. Resident states 'didn't fall I slid out of the chair.'" * 04/16/10 at 5:30 p.m. - Res found sitting on the floor of his room in front of his recliner, which was raised up. . . ." * 05/02/10 at 9 p.m. - "Res found on floor [after] staff heard a loud crash sound @ [at] approximately 8:40 p.m. Res was lying on his (R) [right] side, TV off stand et on floor in front of bathroom door. Res sustained several skin tears; (R) side of forehead above eye, (R) forearm near elbow, et (R) knee. . . ." * 05/15/10 at 6:30 a.m. - Resident yelling for help et found him on floor beside his bed. Was put in bed @ 5:30 a.m. because his recliner was stuck in up position et not safe to sit in like that. . . . has 4 cm [centimeter] skin tears on (R) outer forearm et one large 7 in [inch] x 2 in wide on upper arm. . . ." Observation on 05/19/10 at 5:45 p.m. identified Resident #2 seated in his recliner with the remote, within reach, on the seat next to his right hand. At 5:55 p.m. the surveyor notified a CRA (#19). When informed that Resident #2's care plan stated the remote should not be placed within his reach, the CRA (#19) stated "We thought he was supposed to have it." Another unidentified CRA went to Resident #2's room and placed the remote out of his reach. Although Resident #2 experienced multiple falls involving the recliner and self toileting, staff failed to place the remote control out of his reach, as identified in the care plan. This practice placed	F 323		

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F 323	Continued From page 18 the resident at risk for further falls and possible injury.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature,and staff interview, the facility failed to administer oxygen continuously and at the correct liter flow for 1 of 2 sampled residents (Resident #9) with physician orders for continuous oxygen. Failure to provide oxygen as ordered resulted in Resident #9 experiencing respiratory distress. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th ed., Pearson Education, Inc., New Jersey, page 1361, regarding oxygen use and chronic obstructive pulmonary disease (COPD) stated, "In clients with chronic obstructive lung disease, administering too much supplemental oxygen can actually cause the client to stop breathing."	F 328		

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F 328	Continued From page 19 Review of Resident #9's medical record occurred on May 17-19, 2010. Diagnoses included COPD. The current careplan for COPD stated the resident becomes short of breath with increased anxiety/exertion, and to use oxygen as ordered. A physician's order, dated 01/01/10, identified oxygen at 2 liters/minute per nasal cannula. Observations of Resident #9 showed the following: * 05/17/10 at 4:05 p.m. - In a wheelchair in her room, oxygen on at 3 liters by nasal cannula. * 05/18/10 at 8:13 a.m. - In bed in her room, oxygen on at 3.5 liters by nasal cannula. On 05/18/10 at 10:00 a.m., observation showed a certified resident assistant (#22) assisted Resident #9 to sit at edge of bed, placed a gait belt around her waist, removed the oxygen tubing from her nose, and assisted the resident to stand and pivot into a wheelchair. Observation identified the resident audibly wheezing. The CRA (#22) wheeled the resident into the bathroom and assisted her with toileting, morning cares, and dressing, then transferred her back to the wheelchair at 10:25 a.m. The resident continued wheezing, and stated, "I can't catch my breath." Observation showed an oxygen tank on the back of Resident #9's wheelchair and the CRA placed the nasal cannula and oxygen at 3 liters on the resident. The CRA pushed her in her wheelchair to the dining room for brunch. During an interview on 05/18/10 at 4:05 p.m., an administrative nursing staff member (#20) confirmed the physician's order for Resident #9's oxygen as 2 liters/minute continuous. On 05/20/10 at 9:30 a.m., this staff member stated, "I	F 328	**F-0328 Special Needs** 1. Resident #9 had oxygen order changed to continuous at 2-4 liters. Careplan was updated to reflect this. All CRA's that work with this resident were made aware of continuous need for oxygen with her. 2. All residents that use Oxygen will be monitored to assure that oxygen is being used as ordered. Staff will review the facility policy on appropriate procedures of Oxygen use. 3. Oxygen policy was updated and staff will be educated in regards to the policy. Nurses were educated on June 9, 2010 and CRA's will be educated on June 17, 2010. Policy is included in the POC. *Nurses Meeting Minutes are included in this POC. *CRA meeting Agenda is included in this POC. When residents are started on oxygen or are admitted on oxygen CRA's will be educated in regards to the oxygen order and the use of it. 4. QA will be completed quarterly for the residents that use oxygen to assure compliance with orders. *QA is included in this POC. 5. DON, QM nurse, Nurse Managers and CRA Supervisors will be responsible to monitor the oxygen use and assure policy is followed.	6/25/10

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F 328	Continued From page 20 would expect staff to keep oxygen on continuous [if ordered continuous] throughout cares." The facility failed to ensure Resident #9 received the proper treatment and care regarding the administration of oxygen. Failure to follow the careplan, which indicated the resident became short of breath with exertion, and failure to follow physician orders led to respiratory distress and prevented Resident #9 from achieving her maximum physical functioning.	F 328	**F-0333 Resident Free of Significant Med Errors** 1. Nurse was educated individually in regards to insulin administration. Educated that she needs to be more observant and assure she is giving the right med, right dose, right time, right resident and right route. She verbalized understanding and was aware of the error. 2. All staff that administers medication was trained on appropriate Medication Pass skills to prevent medication errors. 3. Education regarding "Basic Medication Administration" was done at the June 9,2010 nurses meeting. Medication Administration Handout included in this POC. Education on Insulin Administration will be completed by 6/25/10. 4. QA will be done quarterly on a sample of residents that take medications. QA is included in this POC. 5. DON, QA nurse and nurse managers will be responsible to monitor medication administration.	6/25/10
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 4 sampled residents (Resident #14) observed receiving insulin. Failure of facility staff to follow professional standards resulted in Resident #14 receiving the incorrect dose of insulin and placed the resident at risk for adverse health effects. Findings include: Kozier, Erb, Blais, Wilkinson, "Fundamentals of Nursing, Concepts, Process, and Practice," 5th ed., Addison Wesley Longman, Inc., California, page 1322, regarding insulin injections stated, "1. Verify the order for accuracy. Check the label on the ampule or vial carefully against the MAR [Medication Administration Record] or client's	F 333		

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F 333	Continued From page 21 chart to make sure that the correct medication is being prepared . . ." Observation of a medication pass occurred on 05/17/10 at 4:15 p.m. A registered nurse (RN) (#18) entered Resident #14's room with an insulin vial and a syringe and stated the resident required 22 units of NPH insulin. The nurse drew up 22 units in the syringe and administered the insulin in the resident's abdomen. The nurse (#18) left the room and reviewed the MAR. Resident #14's MAR indicated the physician ordered 10 units and not 22 units of NPH for administration at that time. The nurse acknowledged her mistake, assisted Resident #14 to the dining room, gave her some juice, and notified the physician. During an interview on 05/17/10 at 5:30 p.m., an administrative nursing staff member (#20) stated the nurse (#18) should have checked the MAR before she administered the insulin to Resident #14. Review of Resident #14's blood sugar checks at 5:00 p.m. and 8:00 p.m. on 05/17/10, and 6:00 a.m. on 05/18/10 showed normal values. Failure of facility staff to follow the professional standard of medication administration resulted in Resident #14 receiving the wrong dose of insulin and had the potential to result in a hypoglycemic reaction.	F 333		
F9999	FINAL OBSERVATIONS Based on observation, record review, resident and family interview, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		

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